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**COMPLEX REPRODUCTION:
GAMETE DONATION IN THE CONTEMPORARY U.S.**

A Dissertation in

Sociology and Demography

by

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ABSTRACT

Reproduction is a fundamental social process that both shapes and reflects how we as a society feel about the creation of human life, the meaning of parenthood, the value of children, and relationships between different social groups. Reproductive technology is an important aspect of our culture to examine sociologically because it intervenes and disrupts what are often taken-for-granted processes. In this project, I focused on gamete donation and the US fertility industry. Although there has been a great deal of public and scholarly discourse on these topics, there is still a lack of empirical insight that I think is needed in order to further discussions on how these technologies are actually being used and some of the implications of these uses. In this project, I address four major research questions that speak to some of the more controversial social and ethical issues raised by the NRTs: 1) How do organizations in the fertility industry help to create and delineate families? 2) Do they facilitate particular definitions of family? 3) Do egg and sperm donors, as men and women involved in analogous reproductive decision-making, have similar control over donating their reproductive cells? 4) What issues are posed by gamete donation in the context of a medical marketplace? My major research design was based on a content analysis of organizational materials from ART clinics, egg donation agencies, and sperm banks across the US. I chose this approach, as opposed to in-depth interviews with practitioners, in order to gain a more meso-level perspective on the structure and organization of the NRTs.

To address the first question, I examine organizational boundary work in creating families out of donors, recipients, and donor-conceived children. I argue that organizations carefully regulate these relationships even as the industry is adopting more open policies. Regarding the second research question, I focus on access to services for lesbian and single women. Although explicit gate keeping is in the past, implicit barriers appear to persist through heteronormative framing of reproductive services. Next I turn to differences between egg and sperm donors in terms of their decision-making autonomy. I find differences in expected partner and family involvement in the donation process, suggesting that egg donors have less control over disposal of their gametes than sperm donors. I argue that this has broader repercussions for women's bodily and reproductive control. Finally, regarding my fourth question, I examine characteristics associated with two particularly controversial practices in the medical market for human eggs: increasing donor compensation and selective donor recruitment. My results suggest that these practices are influenced by contextual factors, such as local competition, and organizational practices indicative of the increasing commercialization of egg donation. Notably, industry self-regulation does not appear to deter ethically questionable practices.

Overall, I stress the need to analyze 'on the ground' practices in order to provide a clearer agenda for possible regulation as well as the need for feminist and other scholarly attention to this vast and growing medical industry.

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Chapter 1

Complexities in Reproduction

Early in 2009, the headlines were ablaze with the story of a Southern California woman, Nadya Suleman, who gave birth to octuplets. Dubbed “octo-mom” by some,¹ the details of her life were splayed out before the nation. Suleman was divorced. She was unemployed. She had six children prior to the octuplets. All fourteen of her children were conceived using in-vitro fertilization (IVF) and sperm from the same donor.

Suleman’s life was pictured as one of chaos. Some stories looked for mental pathology in a woman who desired that many children.² Other reports claimed that she was materially unfit to care for her children. She already received disability payments for three of her older children and had been using food stamps.³ The media also speculated about the costs of delivering the babies and caring for them⁴ – especially in the future when their health status and capability to function would become more apparent.

¹ Collins, Scott. 2009. “Call it Octo-Mom's webchild.” *Los Angeles Times*, Mar 2, 2009. pg. E.1. Retrieved March 2009. Pro-Quest Online Newspaper Database.

² Anonymous. 2009. “Octo-outrage; For Suleman, curiosity quickly turned to anger after birth of octuplets.” *Chicago Tribune*, Feb 26, 2009. pg. 3. Retrieved March 2009. Pro-Quest Online Newspaper Database.

Garrison, Jessica and Kimi Yoshino. “Mom fears she may not get octuplets; Nadya Suleman says she may have to prove that she can care for them before they are released by hospital.” *Los Angeles Times*, Feb 25, 2009. pg. B.3. Retrieved March 2009. Pro-Quest Online Newspaper Database.

Lloyd, Robert. 2009. “How many is too many? As the mother of octuplets speaks, the rest of us wonder -- and perhaps look for signs of pathology.” *Los Angeles Times*, Feb 7, 2009. pg. E.1. Retrieved March 2009. Pro-Quest Online Newspaper Database.

Yoshino, Kimi, Jessica Garrison, and Andrew Blankstein. 2009. “Before the octuplets; She wanted babies as a teenager. Then came miscarriages, injury, wild mood swings and divorce.” *Los Angeles Times*, Feb 6, 2009. pg. A.1. Retrieved March 2009. Pro-Quest Online Newspaper Database.

Huguenin, Patrick, Julian Kesner, and Gina Salamone. 2009. “SHE MUST BE KIDDING!” *New York Daily News*, Feb 3, 2009. pg. 22. Retrieved March 2009. Pro-Quest Online Newspaper Database.

³ Anonymous. 2009. “Taxpayers likely to foot octuplet’s bills.” *St. Louis Post*. Feb 12, 2009. Retrieved April 2009. Pro-Quest Online Newspaper Database

⁴ Garrison, Jessica, Kimi Yoshino, and Catherine Ho. 2009. “Public fury overtakes awe after the birth of octuplets; As the economy sours, many express concern over a variety of costs.” *Los Angeles Times*, Feb 7, 2009. pg. B.1. Retrieved March 2009. Pro-Quest Online Newspaper Database.

A few stories questioned the morals and motives of the fertility doctor who implanted the six embryos (two divided into twins) for Suleman. They noted that he went against best practice guidelines from the American Society for Reproductive Medicine (ASRM) to transfer only one or two embryos at most during in-vitro fertilization.⁵ Some suggested he did this to make his clinic success rates look better.⁶ There were calls for oversight and legislation, referring to the U.S. as the “Wild West” of the global fertility industry because it generally lacks cohesive, national regulation.⁷

There were multiple threads running through this tale: amazement at the new technology and its capabilities; anger at the way a private decision made between a woman and her fertility doctor could turn in to a major social responsibility; and backlash that there should be more solid guidelines for this technology. There were interacting layers, actors, and entities that were all part of this story: Nadya and her children; the sperm donor; the fertility doctor; the medical team that helped deliver the babies; the larger fertility industry and overseeing bodies such as the SART and ASRM; public opinion(s) on assisted conception, single mothers by choice, and welfare moms; media outlets; and policy and regulation (or lack thereof). This is not an exhaustive list, but it emphasizes the point that feminists have long conveyed: reproduction is a complexly social and political process as opposed to strictly individual (or dyadic), and biological.

Yoshino, Kimi and Jessica Garrison. 2009. “Octuplets' care could end up costing taxpayers millions; Their Medi-Cal tab is rising and their mom is eligible for substantial public assistance.” *Los Angeles Times*. Feb 11, 2009. pg. B.1. Retrieved March 2009. Pro-Quest Online Newspaper Database.

⁵ Graham, Judith. 2009. “Wishes vs. risky treatment; birth of octuplets to California woman spotlights the ethical questions fertility doctors, their patients face.” *Chicago Tribune*. Feb 5, 2009. Pg. 1. Retrieved April 2009. Pro-Quest Online Newspaper Database.

Tucker, Cynthia. 2009. “Our Opinions: Legislature should stick to our business.” *The Atlanta Journal – Constitution*. Mar. 8, 2009. pg. A22. Retrieved April 2009. Pro-Quest Online Newspaper Database.

⁶ Anonymous. 2009. “Octuplet mom helped boost doctor’s stats.” *St. Louis Post*. Feb 22, 2009. Retrieved April 2009. Pro-Quest Online Newspaper Database.

⁷ Yoshino, Kimi. 2009. “Fertility industry oversight is urged.” *Los Angeles Times*. Mar 5, 2009. Pg. A8. Retrieved April 2009. Pro-Quest Online Newspaper Database.

Feminists have pointed to issues of power and privilege that play out in reproductive decisions and options (Agigian 2004; Greenhalgh 1995; Ginsburg and Rapp 1991; King and Meyer 1997; Markens 2007; Pollitt 1995), identifying reproduction as a crucial site to explore social relations. They have urged us to *situate* reproduction within the broader social and political contexts at local, national, and global levels in order to make sense of it (Greenhalgh 1995; Ginsburg and Rapp 1991). In the last few decades, we have witnessed the exponential expansion of the fertility industry in the U.S. and on a global level (Spar 2006). This industry has become a major entity figuring in contemporary reproductive politics. I suggest that a crucial part of situating reproduction in the U.S. hinges on analyzing this industry and, more specifically, the organizations involved in rendering fertility services. The organizational level, the locations where women and men actually come in contact with reproductive technologies, is a key site for mediating between individual experiences and broader structures. This is also a crucial site to engage with given that the industry is relatively unregulated at the national level. It allows us to take a step back and ask about the practices and relations that people enter in to or are potentially barred from entering. It is also a site where cultural norms about reproduction are imported, reinforced, and transformed (Cussins 1998).

Feminist scholars have paid ample attention to reproductive issues, but have seemingly overlooked a major growth industry. Additionally, although all reproductive technologies (birth control, abortion, pregnancy and prenatal technologies, and infertility treatments) are inherently interconnected (Lublin 1998), they still produce unique issues that cannot be thoroughly understood by using perspectives developed through analyzing other technologies. As such, I suggest we need to turn our attention to this industry.

Research Questions

In this project, I turn the focus on the fertility industry as one of the primary controllers of the new reproductive technologies (NRTs) in the U.S. Spar (2006) lays out the contours of this “modern fertility market,” noting that the main players deal in hormones, sperm, and eggs, but it is a “wide and disparate market” (p. 35) that includes physicians, marketers, reproductive lawyers, financiers, and other specialized ancillary services. To focus my inquiry within this vast industry, I use gamete donation⁸ as my lens and point of entry. Gamete donation displays the more transgressive possibilities of the NRTs for changing the relations that men and women, and certain groups of men and women (e.g. gay and lesbian family building) have to reproduction. It allows for the extreme mobility of reproductive cells between bodies and explicitly removes heterosexual sex as a pre-requisite of procreation. In doing so, it also produces a great deal of social anxiety (Agigian 2004; Baker 2005; Franklin 1995). Franklin (1995) describes this anxiety as a “crisis of legitimacy [...] in traditional beliefs about parenthood, procreation, and kinship” that is occurring as a result of these postmodern forms of procreation (p. 335).

As a feminist sociologist, I am particularly interested in interrogating practices of gamete donation as a potential site for reinforcing or altering social institutions and social inequality. I am also interested in the possibilities for dialoguing between bioethics and social science inquiry, as a major avenue for framing how we can think about these technologies. Within these broader themes, my project hones in on these more specific research questions:

⁸ Donation of human eggs (oocytes) or sperm by known or anonymous donors.

- How do organizations in the fertility industry help to create and delineate families?
- Do they facilitate particular definitions of family?
- Do egg and sperm donors, as men and women involved in analogous reproductive decision-making, have similar control over donating their reproductive cells?
- What issues are posed by gamete donation in the context of a medical marketplace?

These questions are not only intriguing, but they also identify particularly controversial points in the industry that have sparked intense discussions in both professional and public discourse and where I think social science perspectives can be fruitfully used to explore and evaluate on-the-ground practices.

To address these questions, I draw on a content analysis of various materials from fertility clinics, egg donation agencies, and sperm banks across the U.S.: organizational websites, donor applications, brochures, consent forms, and other informational packets prepared for donors and recipients. I also communicated with physicians and staff members when documents did not provide adequate detail or information for the questions at hand. I chose this approach as opposed to another method, such as in-depth interviewing, in order to gain a broader, more systematic view of industry practices across the country. Elsewhere scholars have focused more on the experiences of donors and patients in this industry (Almeling 2007; Greil 1991; Thompson 2005). While my approach does sacrifice some depth that a smaller-scale qualitative study could provide, I suggest that it creates a much needed meso-level framework in order to ask questions

about the structure and organization of gamete donation in the U.S., especially since practices are so de-centralized (Spar 2006). Steinberg (1997) points to the trend in feminist theorizing to emphasize the personal experiences of infertile women undergoing treatment. While these experiences are definitely important, if we only look at the individual level of analysis, we risk making invisible the ways that the NRTs are structured and enacted.

Markens (2007) and other social scientists (van Balen and Inhorn 2002; Hanson 2001) have pointed out that empirical work lags greatly behind philosophical and theoretical discussions generated from the NRTs. Markens (2007) in particular suggests that this lacuna creates space for more extreme perspectives to take hold, framing public opinions and policy responses when controversies like Nadya Suleman's octuplets become front page news. As such, we need a more systematic approach to looking at industry practices so we can understand what is "business as usual," what provokes controversy internally (i.e. within the industry) and externally (i.e. between the industry and society), and the implications of both. Additionally, because the fertility industry is such a central entity in contemporary reproductive politics, feminist scholars need a solid grounding in practices and perspectives that occur in this quasi-private realm. Various reproductive technologies are often examined in disparate analyses by feminist scholars under the assumption that they are different enough to require such separation (Lublin 1998). Even though I focus in on one such technology in this project, I aim to show throughout that gamete donation is inextricably linked to core issues that inform other reproductive technologies: issues about what defines family and parenthood, and how social differences and inequalities manifest most fundamentally through reproduction.

Finally, given that there has been a paucity of empirical and social sciences work done on the fertility industry, I engage my research questions with medical, legal, and bioethical discussions. My goal here is to bring sociological insight to bear on questions that cut across multiple disciplines, all in pursuit of examining the meanings and tensions created by the NRTs.

Feminism and the Research Process

I identify as a feminist sociologist and this is an explicitly feminist project: I am concerned with issues of power and inequality that cut across various axes, such as gender, sexuality, family structure, and social class. Although I do not address race in my project, it is not because it is less important than these other issues, but that my questions and method of analysis did not explicitly bring race to the forefront here. From a growing history and tradition of feminist theory and method, we know that feminist research can have many different appearances. Many scholars draw attention to feminist commitments and research practices as opposed to dictating a particular model of what feminist research looks like. A key feminist research practice is reflexivity: being conscious of the limitations of our methods and the ways that our own experiences as researchers drive the research questions that we have (Allen 2000; Allen and Demo 1995; Marks 1996 and 2000). Another related practice is to view the production of knowledge as partial and *situated* rather than objective truth (Haraway 1988). This questions both the absolute authority of the researcher in analyzing findings and whether findings can be generalized to others. This approach can work to defray what Smith (1974) called *conceptual imperialism* whereby experiences are administered or determined by the researcher rather than being voiced by the research subject. The point is not to eliminate the capability of

generalization in sociological research; rather Alway (1995) suggests that feminist sociology hopes to tell “less false stories.” The aim is for a middle ground rather than the extremes of totalizing theory or complete postmodern relativism.

I find the issues of reflexivity and conceptual imperialism particularly salient to my project. As a (currently) voluntarily childless woman I do not have personal knowledge of infertility or involuntary childlessness. I am also very conscious of the fact that my project does not systematically include the actual experiences or perspectives of people who are engaged in gamete donation (donors, recipients, physicians, and staff), although I did make use of their insights when offered through my communication with them. My questions and interpretations, then, should be seen as one perspective as opposed to an exhaustive analysis, despite my aim to gauge a broad picture of organizational practices. I find Walker’s (2000) suggestion for humility in research practices a salient point to provide nuanced interpretations and help to counter the pitfalls of conceptual imperialism.

Chapter Outline

The substantive chapters in this project can be read as separate analyses of different aspects of gamete donation and the infertility industry, but several themes carry throughout. First, these are complex matters that cannot be reduced to simple cause and effect analyses. Reproduction is socially, culturally, and historically situated. As such, where relevant, I have tried to provide some background detail to situate the question at hand, although I do not claim to provide comprehensive historical and legal analyses. Other scholars have taken on this endeavor (see e.g., Agigian (2004), Barney (2005), and Spar (2006), among others). Appendix C does provide a brief demographic snapshot of

clinics, agencies, and banks currently operating across the U.S. Second, questions about reproductive rights such as access and autonomy, which most heavily come to play in chapters five and six, require normative stances. For example, in order to critique the lack of equal access by lesbian and single women in chapter five, I take the stance that access and parenthood *should be* an equally granted right for these groups of women. Finally, throughout, my aim has been to bring sociological insight to questions that arise from various disciplinary perspectives, including women's studies, bioethics, legal studies, and reproductive medicine. As such, the literature that I draw from throughout this project is necessarily multi-disciplinary and my aim is to speak not only to sociologists, but across these other disciplines.

In chapter two, I provide some theoretical underpinnings to the project.

Although each substantive chapter draws from disparate literature to frame the questions at hand, the guiding framework for the overall project is informed by feminist perspectives on reproductive technology. In particular, I address feminist perspectives in Science and Technology Studies (STS) in order to move into a brief analysis of the interplay between the fertility industry and society, which is an important interaction. In chapter three, I address my research design and method in more detail and provide an overview of my data sources, as well as a discussion of data collection and coding.

Chapters four through seven provide the main substantive analyses. In chapter four I ask how organizations offering donation services (fertility clinics, egg donation agencies, and sperm banks) delineate boundaries between donors, recipients, and donor-conceived children. Although gamete donation has historically been under strict professional control (Braverman 2010), including minimal information exchange and

anonymity between parties, there have been signals of transformation in how it is being conducted. Recently, scholars have pointed to trends for greater openness and more flexible and consumer-oriented ways of creating donation arrangements (Holster 2008; Greenfeld 2002). How does this impact the ways in which organizations manage donations? How widespread are trends for more open arrangements across the industry? I address strategies of organizational boundary work, including terminology used to designate donor and recipient roles; managing information exchange; and managing interactions between parties. I also explore four specific practices that are generally recognizable across organizational contexts: using donor photographs, informing donors of a cycle outcome, anonymity before or during a cycle, and post-cycle contact between parties. My analysis suggests that there is a decided shift away from a strictly controlled, anonymous-only model, but there were also decided differences stemming from organizational context. Additionally, no organizations let parties have free and total access to one another. All exchanges were characterized rather as *bounded relationships* (Allan and Barber 2005).

In chapter five I problematize the types of families that these organizations help to create – looking at clinic receptivity of clients desiring alternative family arrangements. Some scholars (Agigian 2004; Thompson 2005; Spar 2006) note that physicians have been increasingly willing to accept more diverse (i.e. non-married, non-heterosexual) clients as long as they can afford services. Thompson (2005) in particular suggests that provisioning of infertility treatment in the U.S. has moved from what is conventionally referred to as a ‘best interests of the child’ model to one of reproductive choice and

privacy.⁹ I question how institutionalized this shift actually is in the U.S. fertility industry—in other words, how much are clinical services advertised and designed based on an imagined client who is a married, heterosexual woman? I identify clinics officially willing to accept single women for treatment, based on reports to SART, and then look for the presence or absence of explicit discussions on their websites about treatment for both lesbian and single women. I focus on the disjuncture between the number of reporting clinics and attempts to reach potential clients through explicit discussion of relevant procedures and/or targeted advertising. I also examine the ways in which lesbian and single, heterosexual women may not always be simultaneously included in the category “single woman.”

In chapter six, I address the differences in partner involvement in egg versus sperm donation through the lens of donors’ medical and reproductive autonomy. While some countries explicitly regulate partner involvement by requiring a donor’s spouse to consent to the procedure, this is not the case for the U.S. In the absence of formal regulation, I focus on local, program-specific policies that are enacted to involve donors’ partners. Three main practices emerge for involving partners: through support, screening, and formal involvement (signing paperwork). Although partner support is assessed at similar rates for egg and sperm donors, egg donors’ partners are more frequently expected to be involved in the screening and legal processes of the donation. I also interpret three social roles for partners in the donation process: as sources of support, as safeguards, and as stakeholders in the reproductive decision-making. Again, these are

⁹ The ‘best interests of the child’ model makes the assessment of parental fitness a natural extension of physicians’ duties and has tended to favor traditional families as optimal arrangements for child development. In contrast, the ‘reproductive choice’ model places reproductive decisions more firmly in the hands of the intended parent(s) as consumer(s).

much more prevalent in egg donation. I argue that these findings are evidence that men and women have different levels of control over their reproductive and medical decision-making, with broader implications for women's bodily control in other medical and reproductive processes.

In chapter seven, I turn to the commercialized context of gamete donation in the U.S. I examine two highly controversial issues that arise from the market in human eggs: rising donor compensation levels and selective donor recruitment. I examine which contextual and organizational characteristics are relevant to these commercialized practices and compare these to similar practices that decidedly cross ethical boundaries as stated by the ASRM: donor compensation greater than \$5,000; and advertising "exceptional donors"¹⁰ who are compensated specifically for their select traits. These issues are important for feminists to examine because they can reinforce hierarchies among women in different social positions. They also raise the question about placing economic values on human bodies. My results suggest that the two practices have different relationships to organizational, market, and contextual characteristics. Notably, however, professional membership in the ASRM did not deter organizations from engaging in these practices, suggesting that self-regulation by the industry is not effectively managing on-the-ground practices across the industry.

The concluding chapter revisits some of the overarching issues raised in this project, particularly social justice and other ethical issues, and industry regulation. Because the fertility industry is a central entity in contemporary reproductive debates, feminist scholars need a solid grounding in practices and perspectives that occur in this

¹⁰ "Exceptional donors" are donors that can provide evidence that they are above average in terms of intellectual or academic achievement: evidence usually includes educational test scores, IQ tests, or advanced degrees.

quasi-private realm. This can help to better understand the possibilities of reproductive technology for changing or reinforcing the status quo. I think that we also need to be open to dialogue about regulation of this industry because of the ways in which the NRTs are used in an uneven playing field. Some families being created are left with minimal social and legal protection. Some participants in the NRTs are not being treated as equally as others, or are being treated in ways that jeopardize their own self-determination. Feminists and other scholars need to be vigilant about analyzing these practices and thinking about ways to move forward.

Acronym Glossary

AI/AID: artificial insemination/artificial insemination by donor

ART: Assisted Reproductive Technology

ASRM: American Society for Reproductive Medicine

CDC: Center for Disease Control

DI: donor insemination

IVF: in-vitro fertilization

NRTs: new reproductive technologies

SART: Society for Assisted Reproductive Technology

Gamete Donation: A Brief Primer

Egg and sperm donation are often described as theoretically equivalent (Englert et al. 2004), but they are enacted in contexts that differ across numerous dimensions: historical/technological, medical, legal, and social. This section briefly describes some of these differences.

Historical and Technological Developments

The infertility treatments used in conjunction with sperm and egg donation are artificial insemination (AI) and in-vitro fertilization (IVF), respectively. As a medical procedure, AI has existed for over a century in the U.S. (Marsh and Ronner 1996). Technological advancements in the 1970s and 1980s produced the first test tube baby and, ultimately, IVF as a viable solution for infertility (Marsh and Ronner 1996; Spar 2006). Following this, the first successful egg donation pregnancy was detailed in a 1984 letter to *Nature* by an Australian medical research team (Lutjen et al. 1984). Initial egg donation efforts in the U.S. began as a research project at the University of California, Los Angeles (UCLA) (Sauer 2001). By the time egg donation was introduced, sperm donation seemed comparatively routinized in the fertility industry.

Technological differences in freezing and storing gametes also create differences for the two types of donation. Cryo-preservation for human semen was first introduced in the early 1950s (Sherman 1990). This was especially important in the aftermath of the AIDS crisis, although new FDA requirements to quarantine and freeze sperm for six months also caused many smaller banks to go out of business (Barney 2005). Cryo-preservation provided the capability to ship products across the country, however, so a handful of sperm banks could serve a large area. Egg donation programs have typically

been more locally based because of the lagging capability to freeze and thaw eggs without damage (Akin et al. 2007). The six month quarantine period for donor semen contributes to the more impersonal nature of the procedure – a donor could be done with his commitment to the program by the time a client views his profile and orders a specimen. Egg donation cycles, however, are typically “fresh” transfers between donors and recipients, suggesting some implications for creating closer connections between parties.

Egg and sperm donation also differ in the use of known versus anonymous donors. While sperm donation initially relied on the good will of medical students to donate anonymously (Marsh and Ronner 1996), egg donation initially required many recipients to identify their own donors, such as a friend or family member (Steinbock 2004), or receive eggs from another woman in a clinic’s patient population (Sauer and Paulson 1995). In the contemporary state of the fertility industry, however, anonymous and non-familial egg donors are becoming more common (Cohen 1996).

The Legal Environment

Legal precedent and regulation vary greatly for the two procedures. Currently, thirty-six states plus the District of Columbia have statutes regarding donor insemination (Seibel 1996; Human Rights Campaign n.d.). Many of these explicitly remove the parental rights and responsibilities of the donor. In contrast, only eight states have explicit legislation designating roles and responsibilities of egg donors and recipients (Crockin and Jones 2010). The legal landscape of egg donation makes it particularly difficult to determine because it fragments biological motherhood, which has historically been the basis for determining social and legal motherhood (Anderson 2009). With egg

donation, there can be potentially three women recognized as mothers: 1) the egg donor, 2) the intended parent/recipient, 3) the gestational carrier if the recipient did not personally carry the pregnancy. As such, egg donation potentially creates more legal difficulties than sperm donation and is also more difficult to regulate because of the variety of pathways through which a woman might claim connection to a donor-conceived child.

Medical Context

Another major difference that shapes professional and public discourse is that egg and sperm donation procedures are situated in very different medical contexts. One sperm donation cycle is relatively quick and painless (although donors do sign on for extended commitments and have significant restrictions to their behavior during that commitment—see chapter six for more detail on this): sperm donors come in to the bank and produce a sample through masturbation. Meanwhile, for one egg donation cycle, donors inject fertility drugs suppress their hormonal cycles, which is followed by ovulation induction to stimulate multiple egg production (New York State Task Force n.d). Donors' and recipients' menstrual cycles are artificially synched so the recipient woman's uterus is primed to receive the embryo created through IVF. Egg retrieval is done using transvaginal ultrasound aspiration (i.e. an ultrasound guided needle that goes through the vaginal wall) (ASRM 2006). Donors are put under twilight anesthesia and need someone to drive them to and from the procedure. Beyond discomfort from the hormonal injections, egg donation risks include non-controlled ovarian hyper-stimulation,¹¹ infections, and other complications that may require hospitalization. In a

¹¹ Abdominal distension due to enlarged ovaries from overproduction of eggs; side effects of nausea, diarrhea, and shortness of breath, ranging from mild to severe

sample of 587 egg donors at a university-based IVF clinic, Maxwell et al. (2007) concluded that serious complications occurred in less than 1% of donation procedures, but minor complications, requiring at least one doctor visit, occurred in about 8.5% of the procedures.

Procedural differences are directly relevant to differences in informed consent. Because of the medical risk involved and the invasiveness of the procedure, physicians need to be certain that donors are fully informed of risks and benefits to give appropriate consent. Informed consent also impacts recommended minimum age for donors. The ASRM Practice Committee recommends that sperm donors should be of legal age (18), but preferably younger than 40 (ASRM 2006).¹² Age range is also more restricted for egg donors precisely because of the biological decline in female fertility that the procedure is often used to remedy. ASRM guidelines note that egg donors should be at least 18, but preferably 21-34 (ASRM 2006). Patient literature comments on egg donor age, noting “the rationale for the younger limit is to ensure that the donor is mature enough to provide true informed consent” (ASRM 2006, p. 5) and “the lower limit ensures that a woman can legally enter into a contract” (New York State Task Force, p. 5). Recent guidelines from the ASRM recommend that egg donors younger than 21 undergo psychological evaluation and the decision to proceed should be made on an individual basis. These recommendations complicate feminist issues with differential treatment of donors. Although the sentiments expressed in patient and professional literature reflect the greater procedural risks of egg donation, they can also be construed as paternalistic.

¹² In my sample, more than 70% of the sperm banks set their minimum donor age at 18.

For instance, the reference to donor maturity¹³ could similarly apply to the fact that egg and sperm donors alike are contributing their genetic material to the creation of a new human being. This is especially salient in a cultural context that has historically privileged genetic ties over social bonds (Rothman 1990) and is experiencing a renewed emphasis on genetic bonds in light of genetic testing (Finkler 2000). In other words, donor age limits developed for procedural differences do not necessarily take into account all of the social and psychological issues that any gamete donor might be confronted with.

Procedural differences also impact donor compensation. Egg donors are compensated several thousand dollars for one donation cycle for “the time, inconvenience, and physical and emotional demands and risks associated with oocyte donation” (ASRM 2008). Based on the banks in my sample, sperm donors are paid anywhere from \$40 to \$100 per sample, which is meant to be for their “time and expenses” (ASRM 2008). Yet, egg donation has also evolved into a more high-demand, high price service in the medical marketplace than sperm donation. During the UCLA research stage, donors were paid \$50 a day (or \$250 total) to participate (Sauer 2001). The escalating price of eggs during the 1990s caused the American Society for Reproductive Medicine to recommend a cap on donor compensation: more than \$5,000 requires justification and more than \$10,000 is considered unethical, possibly causing coercion for a donor in a financially vulnerable situation (ASRM 2007).

Donor Recruiting and Donor Demographics

¹³ As a point of perspective, sperm donors at the minimum age are not deemed mature enough to legally drink alcohol in the United States, but they can help create babies.

Little is currently known about egg and sperm donor demographics, though recruitment practices and professional guidelines do suggest some differences. Sperm donors in the U.S. have traditionally been recruited from colleges or medical schools (Marsh and Ronner 1996). This appears to still be the case: many of the sperm banks in my sample required a college degree or degree in progress or indicated they heavily recruited from local colleges and universities. Egg donors are also likely to be recruited from colleges (Almeling 2007), but programs, and recipients, may prefer donors with proven fertility. As Almeling (2007) pointed out, college education is often in direct competition with a donor's fertility. Women with proven fertility in the recommended age range for donating may not have attended college, especially since younger donors are often deemed more desirable;¹⁴ they are generally more fecund and younger donor age has been shown to correlate with greater pregnancy success for recipients (Cohen et al. 1999). The dual emphasis on youthfulness and proven fertility suggests that egg donors are more likely to come from the general population of women whereas sperm donors are often picked from more select groups of men.

Other personal characteristics about donors are largely unknown about the donor population as a whole because most studies report only on demographics at one particular clinic or sperm bank. Studies that have reported these demographics, however, suggest that sperm donors are frequently college students or young professionals, overwhelmingly heterosexual¹⁵, unmarried, and childless (Shover et al. 1992). Sperm donors are also typically white, although if you browse through online sperm bank

¹⁴ A staff member at one clinic that I corresponded with noted that although their maximum age for donors was 30, most intended parents wanted a donor in her mid-twenties.

¹⁵ The FDA places gay men in a "high risk" category for donating – lasting aftermath of the AIDS crisis (ASRM n.d.).

catalogs now, there are increasingly racially diverse selections to make. Studies from individual ART clinics have consistently reported that egg donors are older than 25, tend to be married, more educated, and are primarily white (e.g., Kan et al. 1998; Sachs et al. 2010). Some agencies and clinics, however, specifically target younger donors and only take donors who are college educated or particular race/ethnic background (see chapter seven for more discussion of this issue).

In sum, although egg and sperm donation are often discussed under the umbrella term “gamete donation,” there are a great number of differences that affect the ways in which these two procedures may be enacted and socially interpreted. Egg donation practices can draw on sperm donation for precedent, but they also presents new controversies, such as the ethics of undergoing invasive procedures to benefit other people, and problems with defining biological, legal, and social motherhood. As such, these various differences need to be kept in mind to properly contextualize the ways in which practices occur on the ground. Although the two procedures are theoretically equivalent (Englert et al. 2004), they are decidedly different in their legal, social, and ethical implications.

Chapter 2

Theoretical Perspectives

Each of the substantive chapters are framed by more specific literature relevant to the individual research question(s) at hand, but throughout, my perspective is informed more generally by feminist thinking on reproductive technology. Because there is no one agreed upon feminist perspective, I first briefly address this diversity and position myself in relation to some of the arguments made.

Feminists have been thick in the middle of discussion and debates on reproductive technologies¹⁶ in order to better understand and respond to the implications for women's lives. As debates and perspectives have changed over time, there has been some impetus to reflect back on modes of feminist thinking. Thompson (2002) distinguished between Phase One (early 1970's to the mid 1980's) and Phase Two (late 1980's and 1990's) in feminist theorizing. During Phase One, feminists emphasized structural stratification and issues of access, and tended to have divisive perspectives on whether reproductive technology was inherently liberating or oppressive for women. Phase Two was not a clear transition, but feminists began to focus more on women's experiences and shifted from a moral certainty (i.e. technology as inherently good or bad) to moral ambivalence. This ambivalence arose largely from focusing on differences among women: the same technology could be liberating or oppressing for different women based on their race, class, or sexuality. I agree with Steinberg's (1997b) critique that an emphasis on women's experiences can marginalize or ignore the larger structural questions that were

¹⁶ Broadly defined, reproductive technologies encompass any "technological intervention in the womb" (Lublin 1998: xi). This includes birth control, abortion, prenatal and birthing technologies, and infertility and assisted conception technologies.

important during Phase One—I think we need a combination of viewpoints from the macro-level issues of structure and organization to the micro-level experiences of women and men engaging with these technologies. I also agree with the moral ambivalence arising in Phase Two about the inherent nature of the NRTs. Thompson’s (2005) work on women’s “agency through objectification” in the context of IVF particularly speaks to the issue that women may not feel entirely oppressed or liberated, but perhaps some combination, in their experiences of the technology. As such, it is not beneficial to wholly categorize the NRTs as either inherently bad or good for women (or men).

Criticisms of (Earlier) Feminist Frameworks

Lublin (1998) identified earlier theorizing as either technophilic (extremely pro-technology), technophobic (technology as inherently anti-woman), or over-emphasizing privacy (attempts to restore women’s control over reproduction by removing it from male and/or state jurisdiction). The technophilic and technophobic approaches do not allow for the possibility that different women have different experiences with the same technology or that the same woman might have differential relationships to reproductive technology throughout her lifetime. The privacy perspective does not tackle unequal control over reproduction among women. By moving reproduction in to the private sphere, there is little to be done to address unequal access to technologies or unequal relations that various women have to reproduction. Lublin (1998) advocates a materialist feminist perspective, which she describes as a mixture of other perspectives:

Like technophilia, materialist feminists find technological intervention in the womb to be a potential savior – though under just conditions of administration and development [...]. Like the technophobes, materialists question social hierarchies and find power in gender. And like the privacy feminist, materialist solutions focus upon legal strategy and political efficacy (p. 140).

Lublin's main call to action is that the extreme positions in feminist theorizing have led more to division than fruitful exploration of diverse ways that technology can affect women's lives. Additionally, she provides a sense of urgency by noting that feminist opposition from religious and political sectors are highly cohesive in their framing and desire to regulate reproductive technologies. Feminist scholars need to be able to recognize difference, but also come together with a cohesive plan of action. I think in order to do this we need a solid empirical grounding in actual industry practices as well as women's experiences.

Feminist scholars working in science and technology studies (STS) have similarly critiqued extreme stances of technology as inherently patriarchal, inherently neutral, or deterministically reinforcing social inequality (Wajcman 2009; Faulkner 2001). Feminist STS scholars advocate a more nuanced understanding of the relationship between gender and technology, drawing on a social constructivist framework that "conceives of technology as both a source and consequence of gender relations" (Wajcman 2009: 7). The social constructivist framework in STS moved the focus from "downstream" social impacts of technology to the "upstream" process of design in order to stress that technology is not created in a social and cultural vacuum (Bray 2007). Feminists criticized this shift for ignoring the roles of women and impacts on women's lives (who tended to be overrepresented on the receiving end). The shift also did not account for feedbacks from those who were using the technology. Incorporating these critiques, the social constructivist framework now posits a bi-directional influence between technology and society, accounting for feedbacks along the pathways of design, delivery, and

consumption. It also allows for unintended consequences to enter in to the picture (Bray 2007; Faulkner 2001).

Nordqvist (2008) points to a major and problematic continuity in feminist thinking: “heterosexuality remains an unquestioned and ‘naturalized’ framework” (p. 277). This has affected feminist scholarship on reproductive technologies at both the analytic and theoretical level. Some scholars have recently begun to focus on non-heterosexual experiences of reproduction in order to shed light on the ways that social institutions reinforce one another through a heterosexual understanding of family (Agigian 2004; Barney 2005). I speak to this issue especially in chapter five, when I focus on the discursive exclusion of lesbian and single women at fertility clinics even as they are officially accepted in clinic reports to SART. Much more work, however, needs to be done to address the ways in which the fertility industry draws from social and cultural resources to designate which family structures are privileged and sanctioned. This is also a charge for increasing dialogue between bioethics and social sciences, because the recent ASRM Ethics Board decision to encourage that practitioners not discriminate by marital status or sexual orientation was heavily informed by social science research findings on alternative family structures and child outcomes.

Moving Forward

A key feminist contribution from STS has been to broaden our understanding of technology from just the artifacts themselves to the cultures and practices that surround them (Wajcman 2009). Combining this broader understanding of technology with the perspective of a bi-directional influence between technology and society offers a powerful and flexible framework for analyzing how the social relations of reproduction

are potentially both reinforced and altered by the NRTs. By taking the view that technology also includes culture and practice, analyses of NRTs expand to include such elements as policy and legislation, ethical and clinical guidelines, and everyday technological practices.

So how do we think about the interplay between industry practices and society? Some scholars address how developments in reproductive medicine have changed the ways that we think culturally about reproduction. This is the impact that new scientific knowledge has on social norms and practices. A second way is to look at how broader cultural values and social change affect industry practices.

Specialists in reproductive medicine have produced several new concepts that alter how we think about (women's) reproductive processes. One example is the conceptual break down of early pregnancy. Phrases such as chemical pregnancy,¹⁷ and clinical pregnancy¹⁸ conventionally appear in human fertility journals. These degrees of pregnancy differ from the way that most (lay) women and men may think about pregnancy as a discrete status. This also turns the experience of infertility treatment into a series of "pregnancy moments," attempting to pinpoint the mechanism of (women's) bodily failure (Sandelowski 1993).

The female biological clock has also been redefined by new scientific knowledge. The relatively recent concept of *ovarian reserve* (i.e. the quality of a woman's eggs) as a major factor of conception has altered age-related fertility knowledge from the previously relied upon signals of menopause to the new discourse of "old eggs" (Friese et al. 2006).

¹⁷ *Chemical pregnancy* is acknowledged by changes of particular hormone levels in blood or urine (Wilcox et al. 1999).

¹⁸ *Clinical pregnancy* is the verification of a gestational sac by ultrasound, several weeks after implantation has occurred (Van Steirteghem et al. 1993).

Friese et al. (2006) point out that while this new concept has shortened the reproductive life span for some women, it has also extended the possibilities of pregnancy for older women who can now use eggs from young donors.

One last example, Sandelowski and de Lacey (2002) note that the term ‘infertility’ itself came into being after 1978 when in-vitro fertilization proved successful with the birth of the first ‘test-tube baby,’ Louise Brown. This new terminology changed the presumed state of permanent inability to have children to a state of being “not yet pregnant” (Greil 1991; Sandelowski and de Lacey 2002). The movement to a more open-ended definition facilitates the ‘never enough’ mindset in the pursuit of technological solutions (Sandelowski 1993).

The above examples illustrate how new developments in research and technology can change ways of thinking about reproduction and how specialist knowledge can directly affect human reproduction on a social level. Other scholars have addressed how cultural values influence scientific knowledge and medical practice. In her now classic piece, “The Egg and the Sperm,” Martin (1991) highlighted the appearance of (white, heterosexual, middle class) gender norms in medical texts to describe the act of fertilization. Scientists designated sperm and eggs in to active and passive roles respectively in the fertilization process even when new scientific evidence suggested that the egg was more instrumental. Textbooks also used fairytale metaphors to depict eggs as brides and sleeping princesses who were “activated” by sperm.

The personification of gametes with stereotypically male and female attributes does not simply rest as an outdated example in medical textbooks. Martin (1991) suggested that one consequence would play out through endowing personhood at earlier

stages of pregnancy, further encroaching on women's bodily integrity and contributing to the constructed antagonism between woman and fetus. Fast forward fifteen years and Almeling (2007) describes the gendering of gametes in donor profiles at egg agencies and sperm banks. This displays another consequence: misconceptions about which traits are actually heritable, which may further inscribe biological aspects of reproduction with socially constructed preferences.

Broader social and cultural changes have also impacted industry practices. The end point of infertility services (producing a child) puts practitioners in a position to make both medical and moral assessments of their patients (Agigian 2004; Steinberg 1997a; Thompson 2005). In response to changing norms about family structures, the ASRM Ethics Committee handed down a decision in 2006 stating that unmarried persons, gay men, and lesbians should not be barred from receiving services. The Committee concluded that "there is no persuasive evidence [in the social science literature] that children raised by single parents or by gays and lesbians are harmed or disadvantaged by that fact alone" (The Ethics Committee 2006: 1333). They urged practitioners to accept patients "without regard to marital status or sexual orientation" (p. 1333). Here we see, at least on the surface, that a major social change in American family structure has impacted the ways in which practitioners have to think about their clinical policies.

As is evident from the above discussion, reproductive medicine and the fertility industry provide key sites where we can look at the interplay between science, technology, and society. They are a complicated picture involving medical, ethical, legal, and social issues. From the beginning, work on reproduction has struck a social nerve.

Deeper moral questions are evoked about the definition of (human) life, beliefs about parenthood, femininity, and masculinity, among others (Clarke 1998; Markens 2007). As such, no single perspective or discipline has jurisdiction over these topics and insights; rather, the best way forward is a polyvocal, multidisciplinary engagement. As one scholar from one discipline, this project is my attempt to traverse various bodies of literature in order to engage with questions and issues that are hopefully salient to women and men as both users and practitioners of the NRTs.

Chapter 3

Method

Research Design: Overview and Justification

My primary research design was a content analysis of various organizational materials from fertility clinics, egg donation agencies, and sperm banks across the U.S. This included websites, brochures and catalogs aimed at both donors and recipients, donor applications and profiles, consent forms, and contracts. I drew the majority of my data from websites, which 99.1% of fertility clinics, 100% of agencies, and 100% of sperm banks had developed. I also made contact with physicians, donor coordinators, agency representatives, and other staff members to request more information about policies and practices. Appendix A provides an analysis of the final response rates and available data for each substantive analysis.

I chose to conduct a content analysis, as opposed to another method, such as in-person interviews of organizational staff, in order to gauge a broader picture of industry practices in the U.S. While this does sacrifice some depth that other methods could provide, I suggest that it creates a much needed meso-level framework in order to ask questions about the structure and organization of the new reproductive technologies. From a sociological perspective, researchers using content analysis treat texts (i.e. websites and other media) as a “window into the human experience” (Ryan and Bernard 2003: 259). Websites and other organizational materials can be thought of as *organizational routines*:

[F]orms, rules, procedures, conventions, strategies, and technologies around which organizations are constructed and through which they operate. It also includes the structure of beliefs, frameworks, paradigms, codes, cultures, and knowledge that buttress, elaborate, and contradict formal routines (Levitt and March 1988: 320).

As such, these materials are media with manifest and latent possibilities—overtly conveying information to potential clients and donors, but also expressing cultural and organizational norms about reproduction, gender, and family. These are not unmediated expressions – they are affected by the personal and professional perspectives of the practitioner, by regulations for internet health information (Abusief et al. 2004), and by contextual aspects such as state legislation (ASRM 2005) and variations in local framing of reproductive issues (Markens 2007).

Although content analysis has been a commonly used technique in the social sciences, it often lacks firm definition and universal terminology. Here I draw on some recent methodological discussions for clarification. Hsieh and Shannon (2005) classify qualitative content analysis into three different approaches: conventional, directed, and summative. The approach I use throughout this project is most similar to what they describe as a summative content analysis. This is a two-fold strategy that combines the quantification of content with qualitative interpretation. As part of this approach, my unit of analysis throughout is typically the *thematic unit*—chunks of text relevant to a larger theme or pattern (Ryan and Bernard 2003)—as opposed to the entire text such as the entire website or brochure that a program has produced. The advantage of the summative approach is that it combines both manifest and latent aspects of content analysis; however, as Hsieh and Shannon noted, it does not necessarily draw on some of the broader meanings in the data. Given the extent of information I collected and processed for this project, however, this approach was well-suited to provide the meso-level analysis I was seeking.

A main question in content analysis, and any type of qualitative analysis, is how one identifies themes and patterns in the data. Some suggest that researchers should allow themes to “flow” or “emerge” from the data without any preconceived categories or theories; Hsieh and Shannon (2005) describe this as the conventional approach. This is the more traditional perspective on content analysis and other related methods such as grounded theory, but such blind or naïve analyses have been critiqued for being largely unrealistic because researchers do not come to their research questions and data unbiased by previous theoretical and personal knowledge (Corbin 2009). A second perspective is that researchers can begin their coding with categories created from key theoretical concepts and categories relevant to the existing literature. Hsieh and Shannon (2005) describe this as the directed approach to content analysis. As coding continues, researchers can refine and add categories to better fit the data. Although I typically began with a relatively directed approach, coding for specific categories gleaned from prior literature and knowledge gained through data collection and communicating with physicians and staff, there were also some instances where, after becoming more immersed in the data, I found that certain new directions and research questions became more relevant than my initial ones (e.g. chapter six evolved in a somewhat different direction than initially anticipated). Acknowledging the critiques from Corbin (2009), however, these were not completely naïve developments, because I was still sensitized to conceptualizing the gender dynamics of gamete donation.

Data Sources

Each chapter in this project draws on a slightly different subsample of fertility clinics, egg agencies, and sperm banks. For instance, chapter five focuses solely on

fertility clinics. Chapters four and six use agencies, sperm banks, and clinics with on-site egg donation programs. Chapter seven only addresses egg donation practices in clinics and agencies. I used several main sources to create my larger sampling frames for each of these organizational populations.

Fertility Clinics. The 1992 *Fertility Clinic Success Rate and Certification Act* requires all fertility clinics to report annual success rate data as well as additional clinic-level information to the Center for Disease Control (CDC) and the Society for Assisted Reproductive Technology (SART). These annual reports are publicly available dating back to 1995. There is, however, a lag between reporting and dissemination to the public. I pooled together the most recent reporting years available (2005-2007) to capture any clinics that may have gone unreported during one of those years. I then identified both the total number of clinics presumed to be currently operating in the U.S., as well as those which specifically had on-site gamete donor recruitment. For the latter classification, I only included programs that recruited donors who were not personally known to the intended recipient and were not women who donated eggs while undergoing their own IVF cycle (“egg sharing”). For the purposes of this project, I specifically focused on commercial, stranger donors to 1) understand the dynamics at work when unfamiliar persons play a role in family formation and 2) preserve greater comparability with commercial sperm donation.

Egg Donation Agencies. It is more difficult to identify the population of egg donation agencies and sperm banks in the U.S. The ASRM has published a list of egg donation agencies that agree to comply with their guidelines regarding donor compensation (The Ethics Committee 2007). I also sought more egg donation agencies

through listings from Resolve and the American Fertility Association—two national patient advocacy groups for infertility. Finally, I tracked additional agencies through fertility clinic websites as clinics often partner with outside agencies if they do not have their own program on site. Although I cannot be sure that I successfully recreated the current population of egg donation agencies with my sampling sources, another recent study (Holster 2008) came up with a similar total number of agencies using slightly different sampling sources.

Commercial Sperm Banks. Sperm banks are the most difficult organizations to locate. I compiled my sampling frame using three sources: 1) information from the American Cancer Society on male fertility preservation services, 2) information on lesbian artificial insemination from the Human Rights Campaign, and 3) listings from the American Fertility Association. I initially came up with fifty-five sperm banks, but only thirty-one of these recruited donors for commercial purposes. The rest only conducted cryopreservation and semen analysis for male infertility patients. Similar to egg donation agencies, there is no way to know for sure whether this accounts for the current population of commercial sperm banks; however, a 2007 study by Scheib and Cushing came up with the exact number found here using two of the same sampling sources and two different sources than I used.

Differences in the capacity to freeze and store gametes as well as FDA requirements to quarantine donor sperm have impacted the size and organization of the egg and sperm donation sectors. In the 1980s, new FDA requirements to quarantine and freeze sperm for six months (to test for HIV) caused many smaller banks to go out of business (Barney 2005), but cryo-preservation also provided the capability to ship sperm,

so a handful of banks could serve the country. Egg donation has been more locally based because of the lagging capability to freeze and thaw eggs without damage (Akin et al. 2007); egg donation cycles are typically “fresh” transfers between donors and recipients. As such, the sperm donation sector is significantly smaller, but also more consolidated into larger corporations compared to the egg donation sector. Table 3.1, below, shows the distribution of organizations that I came up with in my own data collection efforts as well as comparative numbers of the industry from other sources.

3.1 Industry Size Estimates

Source	Fertility Clinics I ^a	Fertility Clinics II ^b	Egg Agencies	Sperm Banks
Author's Primary Data Collection	436	227	101	31
Holster (2008)	n/a	n/a	68-112 ^c	n/a
Scheib and Cushing (2007)	n/a	n/a	n/a	31

^aAll known *operating* clinics in the US

^bAll clinics with onsite egg donor program

^cDepending on source used

Other Data Sources. Beyond the data on clinics, agencies, and sperm banks, I also relied on various other publicly available data sources to provide physician-level, clinic-level, and contextual information for different parts of my analysis. The measures developed from these additional sources are largely concentrated in chapter seven. Table 3.2 summarizes these different data sources and the specific measures I created for this project.

3.2 External Data Sources

Source	2000 Census SF3	ASRM Resources
<i>Measures</i>	Census place: % college ed women	Professional membership list
	Census place: median income	Infertility insurance mandates
	State: median income	
	State: total population	

Data Collection

The listings from SART, CDC, ASRM, and the various sources for sperm banks typically provided, at minimum, a physical address for each organization. I found web

addresses for the majority of organizations by entering the names and a secondary detail, such as state or zip code, into a web search engine. Many of the organization names were unique enough that websites could be matched without doubt. Others required more triangulation through searching for full address or physician contact information on the websites and matching these with institutional reports.

After exhaustively searching and coding websites for available data, I attempted three contacts through mail, email, or phone with each organization in order to gain (more) information (see Appendix A for final dispositions). Although I did not have clearance to actually interview staff members and physicians, I frequently relied on their communication to “fill in the gaps” where my content analysis was lacking. For instance, in my initial contact, I asked for copies of donation program materials, but if I actually made contact with a live person I followed up with several more specific questions about program practices if there was not enough detail in the materials they supplied to me. During summer and fall 2010, an undergraduate research assistant made follow-up phone calls to several programs that were missing on key variables. She identified herself as a potential egg donor in order to gain a quicker response and to increase the likelihood of response. We did not attempt to re-contact any programs that had initially refused to participate during my three open attempts. All methods of contact and data collection were approved through Institutional Review.

I compiled all program materials into a data archive to preserve original files. Websites, which comprised the bulk of my raw data for content coding, provide innovative opportunities for analyzing human behavior, but web-based data presents its own challenges because it is a more dynamic source than other texts used previously in

content analysis (McMillan 2000). To minimize these problems, I downloaded and saved copies of all organizational websites. I downloaded all fertility clinic websites between January and April 2009 and all agency and sperm bank websites during spring 2010. In follow up contacts, I stated a preference for electronic files in my communication to programs, but some only had hard copies available, which I scanned in prior to coding.

Coding

Coding was an ongoing process throughout the project because each analysis relied on a slightly different set of substantive variables. In content analysis, coding is viewed as inseparable from the analysis; content analysis is often described as “subjective interpretation” through classification of themes and patterns (Hsieh and Shannon 2005). Despite the subjective nature of coding, there are strategies to bolster data credibility, such as relying on multiple coders to achieve agreement. Throughout the coding process, I had the help of four undergraduate research assistants. Given time and financial constraints for more in-depth training, I decided to have assistant coders work only on directed, manifest coding and I personally did all coding for more interpretive aspects of the project. Coders were given specific variables or sets of variables to work on at a time with detailed instructions on the definitions, coding values for each variable, and search terms to use when scanning web pages with large amounts of text (see Appendix C for a sample coding task). After they finished coding each set of variables, I went through all coding decisions until we reached agreement. I had coders fill in both the categorical or numeric response to a given variable as well as brief contextual excerpts from the text in reference to the variables; these were designated as “notes” variables in the final dataset. These excerpts assisted me when going back through the coding decisions to check for

consistency and agreement. They also provided some of the data for the qualitative analyses. For more in-depth qualitative analysis, I created memos containing specific sections of relevant text from websites and other materials for each individual program. I imported these memos into a qualitative software program for more refined coding and analysis.

Coding the content of donor applications¹⁹ was a lengthy task done by two assistant coders in the early stages of the project (Summer 2009). I initially developed a codebook for these materials based on a pilot examination of ten randomly selected donor applications. I conducted checks for inter-coder agreement during the first several weeks by calculating the percentage of matched coding decisions out of all possible coding decisions for a given application. After these checks either met or exceeded a 90% match, I gave coders their own separate batches of applications to code. Contact with organizations was an ongoing process through the fall and winter of 2009-10 so I personally coded all donor applications that came later due to delayed responses. The final products from the content analysis coding were a master quantitative dataset, which will be archived for public use in the future, and three qualitative data projects organized in QSR N6.

The bulk of my analyses throughout the project combined qualitative and quantitative data. Chapter seven diverges from the other three by specifically incorporating regression analysis. Most of the measures are specific to individual chapters, so I do not detail them here because they are better suited to be read in the context of each individual analysis.

¹⁹ Variables from these are primarily used in chapters four and seven.

Chapter 4

Making Families:

Managing Donor, Recipient, and Child Relations in Gamete Donation

“Disclosure tricky for parents of egg donor kids.” *Chicago Tribune*, Mar 12, 2008.

“Daughter of sperm donor sues for identity.” *Montreal Gazette*, September 29, 2010.

Abstract

Gamete donation and other third party reproductive techniques create distinct issues about identifying family boundaries. Historically, gamete donation has been under strict medical control, which minimized contact and information change between parties, but open arrangements and disclosure have become increasingly common between donors, recipients, and donor-conceived children. In this chapter, I focus on organizational practices that address these boundary issues. Fertility clinics, egg donation agencies, and sperm banks are central in providing and shaping donation arrangements in the U.S., so it is important to consider the organizational level of analysis. To what extent do organizations have relatively “open” policies? Given the disruptive potential of gamete donation, how do organizations manage relationships between parties? Data came from a content analysis of organizational materials across the U.S. I focused on four specific practices across organizations: anonymity, use of photographs, sharing the cycle outcome, and post-cycle contact. I also identified three major strategies of organizational boundary work: 1) using socially and legally meaningful terminology, 2) information management, and 3) interaction management. Although there is a growing trend toward more open arrangements between parties, this also varied depending on the organizational context (clinic, agency, bank) and type of donation (egg versus sperm). Additionally, all organizations decidedly shaped and controlled relations; parties were never given free and complete access to one another. Even more open arrangements were decidedly *bounded relationships*. Organizations continued to exercise social control over donation arrangements even as they offered increased opportunities for connections between parties.

Introduction

Gamete donation and other third party reproductive techniques frequently have been framed as socially disruptive or transgressive technologies (Michelle 2006) in need of social control. In particular, using third party techniques can create distinct issues for identifying and maintaining family boundaries (Shenfield 1994). Historically, gamete donation has been under medical jurisdiction in the U.S. The medical approach or model was characterized by strict professional control over the donation arrangement (Braverman 2010), including anonymity of the involved parties (Haines 1993)—

although the extent to which boundaries were enforced between donors and recipients has also differed for egg and sperm donation (Becker 2000).

Over the past few decades, however, there have been signals of transformation in how gamete donation is conducted. Ample attention has been paid to increasingly open arrangements between donors, recipients, and donor-conceived children (Greenfeld 2002). This includes disclosure to donor-conceived children about their conception and use of donors willing to release their identities. Additionally, newer considerations for rights, obligations, and interests of gamete donors (The Ethics Committee 2009) make donor personhood more difficult to ignore in the process. These changes are evidence that the traditional medical model of gamete donation is being dismantled (Braverman 2010). Such transformations also raise questions about how donation arrangements are currently managed in the United States.

Although recipients can put out their own searches for donors, most are encouraged to use organizations such as fertility clinics, egg donation agencies, and sperm banks in order to minimize risks (ASRM 2006). As such, organizations providing donation services have a key role in shaping donation arrangements. In this chapter, I address two main questions, focusing on organizational practices. First, given the purported shift away from a traditional medical model, to what extent do organizations have more open policies in the U.S.? Second, given the disruptive potential of gamete donation, how do organizations manage relationships between donors, recipients, and children?

Anonymous or Open? Changing Models in Gamete Donation

Throughout the 20th century, sperm donation was often conducted as a secretive, anonymous procedure where donors and recipients did not know one another and children were not told about their conception (Marsh and Ronner 1996). Early discussions of sperm donation relayed a sense of professional anxiety about the disruptive nature of the procedure. Physicians and lawyers struggled with defining medical, legal, and moral boundaries between donors, recipients, and their spouses (Bartholomew 1958; Seymour and Koerner 1936), such as illegitimacy of the child and accusations of adultery from the donor and recipient's spouses. Problems with navigating these boundaries continued to surface throughout the first few decades of the 20th century as courts in the United States, Canada, and Europe weighed in on the controversial nature of donor insemination (Bartholomew 1958; Bernstein 2002). Anonymity and disclosure continue to be prevalent issues that parents and physicians consider (Becker 2002). As demand for donor sperm came increasingly from lesbian and single women in the 1970s and 1980s, anonymity remained desirable to keep donors from exerting parental rights (Harlow 1996), but disclosure to children became more relevant as peers, family members, and others inevitably commented that "everybody's got a dad" (Haimes and Weiner 2000).

In contrast to sperm donation, egg donation is often noted for being a much more open process (Becker 2000). This is partially due to technological differences: donor sperm is cryopreserved and quarantined for six months (ASRM n.d.), but egg donation is usually a "fresh" transfer between the donor and recipient because of the lagging capability to freeze and thaw human eggs without damage (Akin et al. 2007). The women's cycles are coordinated, prepping the donor for egg retrieval and the recipient for embryo transfer within a few days from each other (Resolve n.d.). While sperm donation

initially relied on the good will of medical students to donate (Marsh and Ronner 1996), egg donation initially required many recipients to identify their own donors, such as a friend or family member (Steinbock 2004), or receive eggs from another woman in a clinic's patient population (Sauer and Paulson 1995). Gendered, cultural interpretations of egg and sperm donation reinforced the greater acceptability of known egg donors versus known sperm donors (Becker 2000). Donor choice increased as clinics began to offer pools of anonymous dedicated donors (i.e. women whose sole affiliation with the clinic was to donate their eggs) (Sauer and Paulson 1995) and egg donation agencies came onto the scene (Levine 2010). By the 1990s, donor eggs had escalated into a high demand, high price product in the medical marketplace (Spar 2006; Steinbock 2004). This actually promoted a movement away from known donors toward anonymous arrangements; but trends have been moving again in the direction of openness with stranger donors (Cohen 1996).

For both egg and sperm donation, there have increasingly been calls for greater openness between donors and recipients and disclosure to donor-conceived children, including options for knowing or meeting donors when the child reaches adulthood (Greenfeld 2002). Several countries have enacted legislation for donor identities to be made available for donor-conceived children upon reaching adulthood (Frith 2001). Other countries continue to officially or unofficially allow a 'double-track' model (Pennings 1997) where both anonymous and donor identity-release options coexist. Still, some countries explicitly legislate all donations as anonymous (Frith 2001). In the U.S., however, there have been no official policies to address this issue and the fertility

industry generally lacks overarching regulation (Spar 2006), making it an open question regarding what protocols are currently used across the industry.

Conceptual Framework: Family Boundaries and Boundary Work

Questions about openness and disclosure in gamete donation can be interpreted as questions about demarcating family boundaries through controlling contact and communication between parties. Donors and recipients enter into arrangements that involve disclosure of personal information and the transfer of bodily products that symbolize highly intimate aspects of human relationships—sexuality and reproduction (Becker 2000). During the exchange there is both a need and a desire to permeate personal and family boundaries through disclosing relevant health and social information that may impact the donation procedure or the potential child; this is often coupled with the emphasis on maintaining or reconstructing boundaries in order to protect each party from unwanted intrusion by the other (Cohen 1996; Burr 2009).

Boundaries serve important social, legal, and political functions for families. Family boundaries acknowledge “who, when, and how, members participate in family life” and physically and psychologically distinguish “members of a family from one another and from other groups” (Carroll et al. 2007: 210-11).²⁰ Demarcating boundaries—referred to as *boundary work* or boundary maintenance (Allan and Barber 2005; Nippert-Eng 1996)—is typically a task engaged in by family members. More broadly, Nippert-Eng (1996: 654) defined boundary work as “the strategies, principles,

²⁰ Feminist scholarship has decidedly criticized conceiving of families as distinctly separate from the rest of society (Thorne 1992). Feminist scholars have also focused on the notion that family privacy and strict family boundaries are a luxury for those in more privileged family structures (e.g. married, two-parent, heterosexual, middle class) (Rapp 1992). As such, I acknowledge that discussion of family boundaries in some contexts can be highly problematic, but they also become much more visible and challenge the “natural family” in the context of gamete donation.

and practices that we use to create, maintain, and modify cultural categories,” such as what constitutes “home” versus “work” or “family” versus “non-family.” Delineating family boundaries, as one specific type of boundary work, can be done through such acts as controlling access to parental rights and responsibilities (Nelson 2006); designating ability to claim emotional, financial, and social support (Ihinger-Tallman 1988); and controlling access to intimate knowledge about families and individual members (Serovich and Greene 1993). Symbolic boundaries, identifying who is inside versus outside of a family unit, are then drawn around those who have rights and responsibilities for children or those who can claim support or access to information about family members.

Boundaries conceptually include notions of privacy. Altman (1976) explicitly described privacy as an “interpersonal boundary control process” by which an individual limits access to oneself or one’s group. Laufer and Wolfe (1977) identified two interpersonal dimensions of privacy that I suggest are particularly relevant to the family boundary work in gamete donation: *information management* and *interaction management*. Information management refers to the ability to control access to information about oneself or one’s significant others. For example, Miall (1986) described information management strategies used by infertile couples to control how and to whom information about their childlessness was released. Interaction management refers to the ability to control physical interaction with others, such as who participates in the interaction, how often interaction occurs, and the length and content of specific interactions (Leino-Kilpi et al. 2001). In donation arrangements, these management strategies become relevant in the process of deciding how much information to share

between donors, recipients, and donor-conceived children and how much contact or interaction should be allowed between parties.

In the instance of gamete donation, however, we are not only focused on boundary work as an interpersonal process between donors, recipients, and donor-conceived children. Organizations such as clinics, agencies, and sperm banks set policies and shape expectations for whether and how these parties should interact with one another. Thompson (2005) discussed the “kinship work” that patients, practitioners and third parties engaged in to “establish and disambiguate kin relations” (p. 145). She pointed to important social processes that take place within the context of these organizations: making sense of the structure and content of social relationships that have little precedent for expected behavior. Haimes (1993) called for examining the perspectives and interests of clinicians rather than assuming they were neutral go-betweens. She argued that, historically, clinicians had an interest in maintaining anonymous donations in order to avoid social stigma of being considered “an accomplice to adultery and to the production of illegitimate children” (p. 1519). Secrecy and anonymity also provided a way to “avoid detailed scrutiny” (p. 1519) of physicians’ ability to deal with both the medical and social aspects of gamete donation. This suggests that practitioners and other organizational actors provide expectations for relationships between donors, recipients, and donor-conceived children and may have particular interests in how they manage these relations. As such, the focus of this study is not on the ways in which individual donors, recipients, and donor-conceived children navigate their own relationships, but on the strategies and practices of organizations that mediate these arrangements.

Method

Data came from a content analysis of websites and other donor/recipient materials for sperm banks, fertility clinics with onsite egg donor recruitment, and egg donation agencies across the United States. Elsewhere I have described the sample sources, response rates, and missing data (see chapter three and Appendix A). All program materials were coded for specific measures I describe below, but I also drew a smaller sub-sample of clinics and agencies for more in-depth analysis of organizational practices. I included all commercial sperm banks in the more in-depth analysis because there were only thirty-one across the country. In contrast, the egg donation sector is much larger: 227 clinics and 101 agencies were in my initial sample. There are marked regional differences in attitudes about egg donation openness versus anonymity (personal communication, program staff) so I drew a stratified, random sample of five clinics and five agencies from each of the four major Census regions.

Coding and Measures

Drawing from previous literature on gamete donation as well as knowledge gained during initial stages of data collection, I began with a directed content coding (Hsieh and Shannon 2005) of four different variables for all programs in my sample. These variables addressed program practices that were universally recognized across different types of organizations.

Photographs indicated whether a program made photographs of donors available during donor selection. Possible categories included: 1) unknown policy; 2) no photographs used; 3) unspecified photographs requested/unsure if shown to recipients; 4) photo-matching services only/staff view on recipients' behalf; 5) baby or childhood

photographs only; and 6) recent or lifetime photographs. *Anonymity* indicated whether programs only had anonymous arrangements or if they allowed for non-anonymous arrangements between donors and recipients, such as semi-open or open donations. *Cycle outcome* referred to whether donors were informed of the donation cycle outcome, such as the number of eggs retrieved, pregnancy test results, and any information about the birth or child. This variable included the following categories: 1) unknown policy; 2) non-disclosure to donor, 3) pro-active disclosure to donor, and 4) negotiable disclosure if recipient desires. Finally, *post-cycle contact* included: 1) unknown/mentioned but no clear policy; 2) not allowed; 3) medical reasons only; 4) negotiable options between donors and recipients; and 5) formalized options (e.g., identity-release programs).

Policies on photograph use and anonymity were available from the majority of clinics, but policies to disclose the cycle outcome or for post-cycle contact were less likely to be addressed in program materials, which was the primary method of data collection. As such, more data is missing on the latter two practices, so trends for these should be interpreted with caution.

I then focused in more closely on the randomly selected sample of clinics and agencies and used a relatively open coding scheme, with boundary work as a sensitizing concept. In my initial analysis of program materials, I noted that *terminology* seemed to differ when organizations referred to donors and recipients, so I systematically coded up to five descriptive terms used to refer to donors and recipients, privileging any descriptions that referred to families or parental status of either donors or recipients. I also created memos for each of the organizations in my sub sample, with extensive notation of organizational practices that addressed social, psychological, or legal

relationships between donors, recipients, and donor-conceived children. Table 4.1 shows the major coding categories and the corresponding samples used for this analysis.

4.1 Major Coding Categories

Themes	Description	Sample
<i>Organizational Policies</i>	Four policies addressed across organizations: 1) use of donor photographs, 2) sharing the cycle outcome, 3) anonymity/contact before or during the cycle, and 4) post-cycle contact.	Full sample
<i>Symbolic Boundaries</i>	Terminology used to describe donors and recipients.	All sperm banks, 20 clinics, 20 agencies
<i>Information Management</i>	References to sharing information between parties.	All sperm banks, 20 clinics, 20 agencies
<i>Interaction Management</i>	References to interactions between parties.	All sperm banks, 20 clinics, 20 agencies

Organizational Policies

My first research question asked how open gamete donation is currently in the U.S. Although the traditional medical model advocated anonymity between parties and minimal information sharing, scholars have argued that the industry has changed over the past several decades, and openness between parties is increasingly discussed in both professional and public outlets (Braverman 2010). Table 4.2 shows the range of four different policies in the industry: photographs, anonymity, disclosing the cycle outcome, and post-cycle contact.

4.2 Policies by Type of Program

	Clinic (n = 219) %	Agency (n = 101) %	Bank (n = 30) %
Photographs			
Unknown policy	7.8	0.0	16.7
No photographs	20.5	2.0	16.7
Requested but unspecified type/use	5.0	14.9	0.0
Photomatching only	5.9	3.0	16.7
Baby/childhood only	19.2	5.9	20.0
Recent/lifetime	41.6	74.3	30.0
Anonymity			
Unknown policy	0.5	2.0	0.0
Anonymous only	90.4	34.7	90.0
Non-anonymous options	9.1	63.4	10.0
Cycle Outcome			
Unknown policy	37.9	30.7	46.7
Non-disclosure	35.2	7.9	36.7
Pro-active disclosure	23.7	43.6	13.3
Negotiable	3.2	17.8	3.3
Post-Cycle Contact			
Unknown/no clear policy	46.5	44.5	30.0
Not allowed	42.5	16.8	20.0
Medical reasons only	4.6	5.9	0.0
Negotiable between donor and recipient	4.1	26.7	0.0
Formalized/Identity-release	2.3	5.9	50.0

Egg donation agencies were generally more open with providing any type of photographs compared to both clinics and sperm banks, and the majority (74.3%) had recent donor pictures available for recipients to view. Sperm banks more frequently offered baby pictures (20%) and photo matching services (16.7%). Photo matching services were also much more institutionalized for sperm banks—offered as one among many services that prospective clients could purchase to help select a donor.

Agencies were also more likely to have non-anonymous options between donors and recipients. Most clinics (90.4%) and sperm banks (90%) had anonymous-only policies, while nearly two-thirds of agencies had non-anonymous options available. Although, similar to issues for “open” adoption (Sobol et al. 2000), non-anonymous options during a donation cycle ranged from donors and recipients communicating via

phone or email to in-person meetings. There were also various possibilities for exchanging fully or partially identifying information during such interactions. As such, non-anonymous options could include both “open” (i.e. full disclosure of information and in-person contact) and “semi-open” arrangements between parties.

Agencies were much more likely to have explicit policies in place that the donor would be informed of the cycle outcome (43.6%), and an additional 17.8% left this negotiable, allowing for information to be shared if the recipient agreed to disclose the information. In comparison, less than one-quarter of clinics and only 13.3% of sperm banks had explicit policies to inform donors, and less than 5% of each left this as a negotiable aspect of the arrangement. Although agencies had much more open policies on average, the data do show a trend across all organizational contexts for increasing communication between donors and recipients and recognition that donors have an interest in knowing more details about the donation cycle. The fact that any clinics and banks had policies to inform donors suggests a shift away from treating the donor as a marginal or relatively inconsequential actor in the arrangement.

Not all programs displayed clear policies about post-cycle contact between parties. It is possible though that these were only made available through internal documents that donors and recipients were given upon acceptance to the program. Still other programs left this aspect as negotiable between donors and recipients. Sperm banks were more likely to have formal identity-release programs in place (half of all banks). Donor identity-release programs allowed a donor-conceived child to have information about and possible contact with their donor upon reaching adulthood. In online databases and donor catalogs, sperm donors were typically categorized in terms of their identity-

release status. Sperm banks maintained primary responsibility for managing relationships between parties. Agencies were more likely to have negotiable options compared to clinics or banks. The possibility of future contact was typically addressed as part of any legal agreements that donors and recipients entered into prior to cycling. As a result, boundaries may have been more flexibly created and possibly differed by individual donation arrangements; however, they were still clearly defined and managed with the involvement of third parties, such as counselors and reproductive lawyers. A few programs mentioned that post-cycle contact would only occur in the case of a medical emergency, where a donor's biological connection to the child could provide life-saving resources, such as blood, organs, or other tissues. In these situations, programs noted that they would contact the donor on behalf of the recipient and child's family, but it was unclear if any direct contact would result between the donor and the recipient or child, unless medically necessary.

Overall, there was a notable trend across programs to allow greater information and interaction between parties relative to the traditional medical model (Braverman 2010). Agencies appeared to provide more open arrangements across most practices. They were more likely to provide donor photographs, have pro-active policies to inform donors of the cycle outcome, and have non-anonymous options. Sperm banks were much more institutionalized in their approach to managing donor-recipient-child relations, offering more concrete and often commercial services, such as photo-matching and identity-release programs. Clinics appear at times more conservative in their willingness to open up donation arrangements than both agencies and banks, although there is also considerable variation as some have adopted more donor or consumer-oriented policies in

how they handle information and interactions between parties (e.g. showing photographs), yet most continue to provide anonymous-only donation arrangements.

In the next section, I turn to the second major question I raised: given the disruptive potential of gamete donation, how do organizations manage relations between these different parties? How do they demarcate families out of donors, recipients, and donor-conceived children?

Symbolic Boundaries: Donor and Recipient Terminology

After analyzing donor and recipient materials and organizational websites, I observed that the terminology used for donors and recipients appeared to be a key site for organizations to construct *symbolic boundaries* (Lamont and Molnar 2002). Symbolic boundaries, the product of boundary work, are “conceptual distinctions made by social actors” with the intent to place people into different groups and foster “feelings of similarity and group membership” (Lamont and Molnar 2002: 168). Table 4.3 shows the more systematic coding of donor and recipient terminology from the smaller subsample I focused on.

4.3 Donor and Recipient Terminology

	<i>Clinic</i>	<i>Agency</i>	<i>Bank</i>	<i>Total</i>
Donor				
Donor	19	20	27	66
Candidates	5	0	1	6
Giving hope, gift of life	1	1	3	5
Parties/3rd party	2	0	2	4
Healthy/fertile men/women	4	0	0	4
Pool/specimen	1	0	2	3
Biological Parent	0	0	2	2
Fertility helper	0	1	0	1
Wish to have children in their lives but do not wish to raise them	0	0	1	1
Perfect egg donor [for the couple]	0	1	0	1
"Father" [quotes in original]	0	0	1	1
Donor, who is not the legal parent	0	0	1	1
Uncle-type	0	0	1	1
Recipient				
Recipient	16	12	17	45
Couple/Individual	12	12	9	33
Client	1	11	19	31
Patients	9	3	18	30
Prospective/intended Parent	6	15	8	29
Infertile couples/singles	8	1	5	14
Dreaming/desiring family	3	4	5	12
Parent	2	5	4	11
Loving/deserving/wonderful couple	1	3	0	4
Parties/candidates	2	0	2	4
Families	1	1	0	2
Childless women who may not be able or willing to conceive in any other way	0	0	1	1
Families in need	1	0	0	1
Childless people	0	0	1	1
Lesbians and other women seeking to form alternative families	0	0	1	1
Someone who needs a little help having a baby	0	0	1	1
Women and men who choose to create or expand their families through donor insemination	0	0	1	1
Women in need of anonymous sperm	0	0	1	1

Besides the overwhelming use of “donor,” donors were also referred to as “candidates,” “[third] parties,” and generous or special men and women who could give hope or the “gift of life” to couples wanting a child. One agency described their donors and surrogates as “fertility helpers.” Other programs spoke about donors as people who could help fulfill “the dream of parenthood” for couples and individuals and give

someone “the family they’ve always wanted.” In contrast, recipients were frequently referred to as “intended” or “prospective” parents, “couples,” “clients,” and “patients.” More than half of clinics (55%) and sperm banks (58%) referred to recipients in terms of their future parental status or parental desire. Ninety-five percent of agencies invoked the language of “intended” or “prospective” parent to describe recipients. In contrast, minimal references were made to donors having parental links with a donor-conceived child. For instance, one sperm bank invoked the phrase “biological father” when referring to a donor-conceived person learning about the donor upon reaching adulthood. A second bank referred to single women using donor sperm so that they might avoid having a relationship with the “biological father.” In both of these references, the parental link was weakened by describing the donor as an absent party during childrearing. Another bank used the term “father,” complete with the quotes, to indicate that this was really not the intended social relationship, but that there was not necessarily a better word available to describe the donor-child relationship.

I suggest that organizations using these different descriptions for donors and recipients strategically deploy future parental status and parental desires or intentions to position donors and recipients in relation to the donor-conceived child. Gamete donation and other third party options such as traditional and gestational surrogacy have complicated definitions of parenthood, particularly motherhood, which traditionally rested on the notion that a woman who gave birth was defined as the biological, and often the legal and social, mother (Anderson 2009). After disputes arose in determining parental status for a gestational surrogacy arrangement, the California Supreme Court used the concept of procreational or parental intent to determine who should be

recognized as the legal and social parents (Douglas 1994). Because the commissioning parents intended to bring about the child and initiated the process by which the child would come about, they were recognized as having been the “fundamental cause of [the child’s] creation” (Douglas 1994: 637). The reference to parental intentions has gained broader use in reproductive contracts as evidence of parties’ intentions when entering into a contract even if the contract itself is not legally recognized (Anderson 2009; Vorzimer 1999). By referring to recipients in terms of their future, desired parental status, programs distinguished from the start of the donation process that recipients were the parties *intending to become parents* and donors were not. In this same vein, by referring to donors as those who helped others fulfill “dreams” or “desires” of having a family, donors were constructed as not being a part of the imagined future family; rather, as the agency noted above described, they were “fertility helpers”—“integral” to the process of conception, but marginal in the final family construct.

Not all programs used the language of parental intent for recipients. Clinics and sperm banks were less likely to use this terminology than agencies. Rather, recipients were frequently referred to as “patients,” “clients,” and “infertile couples.” The legal demarcation of parental rights in sperm donation is relatively solidified in the United States compared to egg donation (Human Rights Campaign n.d.; Crockin and Jones 2010). For many donor sperm statutes, physician involvement and spousal consent are more integral to removing the parental rights and obligations of the donor (see Seibel (1996)), so evidence of parental intention of a (married) recipient is less relevant in sperm donation. The difference between agency and clinic language use is less clear. One possible interpretation is simply the difference between the medical services sought at

clinics versus the social/legal services sought through egg donation agencies. Agencies tended to rely on legal contracts mediated through reproductive attorneys in order to have donors and recipients clarify parental rights; in contrast, clinics frequently included clauses about donors relinquishing parental rights in informed consent forms used to convey information about the egg retrieval procedure (author's own data collection and personal communication, program staff). Signing the consent form was simultaneously a signal of consent to undergo the medical procedure and relinquish claims or parental rights to "eggs, embryos and any children born." As such, referring to the recipient as a "patient," "client" or "infertile couple" may have been viewed as sufficient in the medical context of informed consent as opposed to a legal context looking for evidence of parental intent.

Managing Information Exchange

A second major boundary work strategy was visible through policies and practices for managing information exchange between donors, recipients, and donor-conceived children. Programs have to make decisions about how much and what type of information to present to each party. There are also different expectations about the type and extent of information that should be provided about donors and recipients (Broderick and Walker 2001).

Sharing Donor Information

Donor profiles are a common method of presenting donor information to prospective recipients. Donors fill out applications, which are then translated into briefer, and often more aesthetically pleasing profiles for clients to view (Almeling 2007; Holster 2008). In the materials that I analyzed, sections of donor applications were literally

marked to distinguish what was confidential information—for means of physician or program use only—versus what would be shown to prospective recipients. Programs also frequently assigned donor identification codes, pseudonyms, or only allowed donors' first names in searchable databases. Profiles provided an extensive amount of personal information, often down to intimate details about a donor's sexual and reproductive history, but programs controlled access to what they deemed as the most private information: full names and other personally identifying information.

Programs also controlled recipient access to donor information through their policies on donor photographs. Photographs can be integral to donor selection, especially given that physical resemblance is an important aspect of family legitimation in Western societies (Becker et al. 2005). Although many programs requested photographs from donors (see Table 4.2), these were not always freely given to prospective recipients. Decisions to offer childhood photos but not adult photos were often justified to maintain donor confidentiality. Adult photographs were considered risky by several programs because they might result in the recipient identifying the donor. Using baby photographs was one solution to preserve donor privacy while giving recipients some impression of how the donor's physical features might fit in with their own family's appearance and what the child might look like. A few had recent photographs that could only be viewed on location under staff supervision. Other programs only offered “photo matching” services: recipients could submit photos regarding what characteristics they desired in a donor and physicians or staff members would suggest donors based on how well they physically “matched” the photos. Photo matching helped to preserve boundaries and

strictly manage the transfer of information between parties as physicians and staff literally examined donor photographs on behalf of recipients.

Several programs referred to staff members' personal knowledge of both the donors and recipients as valuable insight for helping to match donors and recipients:

Knowing our egg donors and our intended parents personally also greatly assists with the matching process [Agency # 111].

The donor egg team gets to know both donors and recipients prior to the matching process [Clinic # 20050223].

Our bank is small enough that we have the opportunity to get to know our donors. Phone counselors can provide you with personal impressions of donors [Sperm Bank # 90033].

This helped to preserve anonymity between donors and recipients, while creating a means for more subjective information—that could not be captured in profiles—to be passed between donors and recipients. For instance, one program mentioned that by getting to know egg donors in person, staff could better assess their commitment to going through with the cycle. Staff knowledge—typically referred to as 'staff impressions'—was also regularly institutionalized as part of donor profiles at sperm banks. Approximately one-third of the sperm banks offered this feature. Staff impressions provided quality assurance measures to recipients during the sperm donor selection process: they offered more subjective, personal information about the donor to bolster the credibility of how the donor presented himself in his profile. Although staff knowledge created a means to convey such information about a donor, it also symbolized that these donation arrangements were not opportunities for donors and recipients to develop personal relationships, but rather, to preserve distance and anonymity.

Sharing Recipients Information

Changes in the recognition of donor interests and rights in the donation arrangement have also brought about issues of how much donors should be informed

about recipients and the outcome of the donation cycle (Cohen 1996; The Ethics Committee 2009). Many of the programs in my sample had recipients fill out brief profiles, preference forms, and wish lists of what they were looking for in a donor. Some shared the brief profiles with potential donors, though this was a relatively infrequent practice and was only done by agencies (in my sample). Sharing recipient information with donors was framed as an opportunity to establish a closer, more informed relationship between the donor and recipient(s). As one program noted, it was an “opportunity to have the donor care almost as much about a positive outcome as you do.” Sharing the information could also give the egg donor some comfort in knowing about the recipients’ lifestyle and prevent any future legal claims if she had been unaware of and opposed to whom she was donating (e.g. a gay or unmarried couple or recipients with a different religious background). One program described this as an “informed donor” policy—a “unique standard” where they were committed to only working with parties who could equally assess whether they wanted to work with each other. Similar to the presentation of donor profiles, recipients’ identifying information was still heavily guarded in order to preserve anonymity when desired. Additionally, when recipient information was shared, it was not a symmetric practice: donors provided much more extensive information about themselves to recipients than vice versa. These justifications for sharing recipient information, however, were significant because they indicated that at least some programs were shifting away from the typically uni-directional, and minimal information exchange of the traditional medical model (Braverman 2010; Cohen 1996).

A second, more widely discussed aspect of sharing recipient information with donors is whether to disclose the cycle outcome. Learning the outcome of a donation

cycle is something that donors have particularly expressed interest in knowing (Broderick and Walker 2001; Kalfoglou and Geller 2000). Major arguments against informing the donor have included the analogy of gamete donation to blood donation where donors do not expect to learn, and are not informed of, whether a patient's transfusion was successful; the possibility that it could cause the donor distress due to various reasons, such as an unsuccessful cycle (The Ethics Committee 2009); and the recipients' desire for medical privacy (Zweifel et al. 2007). Other discussions imply that informing donors of a successful pregnancy could increase their emotional or psychological attachment to the child and they may try to make unwanted contact or intrude in the new family's life (e.g., Baetens et al. (2000) hint at this in their discussion section). Arguments for informing the donor include the donor's psychological "need to know"; preparation for the possibility of future contact by donor-conceived children (The Ethics Committee 2009); and the notion that the donor has a moral stake in knowing the outcome (Cohen 1996).

Having policies on outcome disclosure, then, is a key site where organizations manage expectations and information exchange between donors and recipients. While some programs saw outcome disclosure as negotiable in the context of individual donation arrangements, others implemented stricter policies that either preserved the recipient's right to privacy or the donor's right to know (see Table 4.2 above for the distribution of these policies). There was also considerable variation in what information was actually disclosed to donors. Some programs only disclosed the number and quality of eggs retrieved. Others provided information about the pregnancy and delivery. In some instances, programs only gave donors an overall sense of their success: for example, they would disclose the overall number or pregnancies achieved with the donor's gametes, but

not any information specific to a donation cycle. This approach was much more commonly practiced at sperm banks, where donors usually have multiple vials stocked and available simultaneously. As such, programs had to make decisions about how to convey information to donors, given the newer awareness of donors' rights and responsibilities, but also to protect recipients and children from any socially transgressive outcomes (e.g. the donor wanting to claim a donor-conceived child or other such scenarios), if donors were given too much information.

Managing Interactions

Organizations also set expectations for whether or how parties would interact with one another. Interactions between donors and recipients can take place before the parties agree to enter a donation cycle together, during the cycle, or after. These also tend to involve different sets of interactions. Before/during the cycle interactions focus on relations between donors and recipients, but post-cycle contact typically emphasizes relations between donors and donor-conceived children.

Before/During Cycle Contact

Because most sperm banks rely on cryopreserved specimen that have been quarantined for six months (Sherman 1990), sperm donors and recipients are less likely to meet before or during a cycle. Egg donation is often described as a more open process (Becker 2000), with possibilities for meeting one's donor, but this is also more likely to happen at agencies rather than fertility clinics (Treiser n.d.). For those programs that allowed non-anonymous options during the donation cycle, donors and recipients did not typically initiate contact. Program personnel continued to engage in interaction

management, taking responsibility for defining the terms of contact. For instance, some programs mentioned that any contact would involve staff supervision—at least initially:

Personal meetings are only arranged and conducted by our President who must be present for the introduction and meeting. You cannot meet on your own unless you've have [sic] one initial meeting [Agency # 111].

I am happy to arrange a meeting between you and your potential donor candidates assuming all Parties are agreeable to such a meeting. In some cases I am able to attend. [...] a non-refundable deposit of \$200 per meeting is required for my time, expense and protection [Agency # 24, italics my emphasis].

Some donors may be willing to meet with the recipient in the presence of a [agency name] representative [Agency # 2].

In other instances, staff supervision was not explicitly referred to, but programs emphasized their role in facilitating and mediating the contact between donors and recipients:

[T]here are some cases when both parties - egg donor and intended parent - choose to meet one another. *We will work to maintain everyone's privacy to the extent they wish while also working with those who are interested in a more open arrangement [Agency # 39, italics my emphasis].*

Assuming the donor agrees, *we will help arrange* for whatever level of contact you would like to have with your donor [Agency # 58, italics my emphasis].

As such, even in more open arrangements donor-recipient contact was supervised and facilitated by a third party in order to manage the terms and extent of interpersonal interaction. This implicitly reinforced the need or desire to maintain boundaries between donors and recipients even in situations of fostering connectedness.

Post-cycle Contact

After a donation cycle is completed, there are several possibilities for communication or contact between donors, recipients, and donor-conceived children. Some programs acknowledged that recipients might desire to express gratitude to donors and offered to deliver messages or gifts on their behalf. A more commonly addressed form of post-cycle revolved around the future relationship a donor might have with a donor-conceived child—although in some situations this also involved future contact

between donors and recipients as well. This included both negotiable and formalized options. As I mentioned previously, sperm banks were much more likely to have institutionalized identity-release programs through their facilities. Agencies tended to have more negotiable options that let donors and recipients work out the terms through a third party, such as a reproductive lawyer. Clinics were more likely to have explicit policies against any post-cycle contact, but not all had clearly stated policies in their materials. Because agencies and clinics focused more on options negotiated between parties, when contact was a possibility, they were less likely to detail these options than sperm banks, so below I focus more on the sperm bank programs for identity-release.

Most sperm banks offering identity-release specified that donors' personal information would only be made available to the donor-conceived child (and not the recipient(s)). They also stated organizational control over the type and extent of information that would be released and any other criteria that might need to be fulfilled in the process. For instance, one program required all donor-conceived children to attend a psycho-educational session on location prior to receiving any information about the donor. Even as many banks recognized the importance of having identity-release options, some made it explicit that these options were not created to redraw family boundaries to include the donor. They also emphasized that identity-release donors had no more legal parental standing than anonymous donors:

This program is designed to give adults conceived through donor insemination the option of learning their donor's identity in case they have unanswered questions about their genetic background. *It is not designed to create parental or family relationships between donors and their offspring* [Sperm Bank # 90033, italics my emphasis].

As with our anonymous donors, *ID Options Donors will have no legal relationship, rights or obligations to any offspring* born using their donated semen. Parents and offspring understand that *the ID Options program is not intended to create family relationships* between the ID Options Donor and their offspring [Sperm Bank # 90035, italics my emphasis].

Several banks set expectations that they might not be able to make contact with the donor, or, that contact could be quite minimal. For instance, not all identity-release donors were obligated to actually meet with donor-conceived children. One program required only one meeting; others left the level of contact solely to the donor's discretion whether it was through a phone call, email, or in-person. These caveats implied that programs were trying to downplay the possibility of establishing a close connection between the donor and donor-conceived child.

Institutionalized identity-release options particularly highlight the difficulty of negotiating family boundaries and privacy among donors, recipients, and children. Policies such as releasing the donor's identity only when the donor-conceived child reached adulthood were presumably aimed at protecting both the integrity of the recipient/child's family boundaries as well as protecting the donor from being legally or socially defined as a parent. Allowing access to donor information was typically framed as a balance between the child's "right to know" and the donor's personal privacy. These are also somewhat paradoxical positions, as Cohen (1996) noted: seeing the donor as a potentially threatening intruder on family life as well as seeing the recipient or child as threatening to intrude on the donor's privacy.

Only one sperm bank followed a noticeably different model for identity-release. Their philosophy was to create connections and enduring relationships between the donor, birth mother, and child as well as the local gay and lesbian community from where they received many of their donors and recipients [Sperm Bank # 90039]. Their policy was to release the donor's identity to the mother when the child was three months old. If the mother had not contacted the donor by the child's first birthday, the program released

the mother's information to the donor to initiate contact. In contrast to other programs, they explicitly envisioned possibilities for donors, recipients and children to form lasting and meaningful relationships:

Your child will grow up without secrets. [...]Your child will know that their donor is a regular guy who they will meet and maybe become friends with.

That is why [program name's] policy was designed so the donor, who is not the legal parent of the child, will be known to the child while they grow up. This is similar in concept to open adoption, where the birth mother is known to the child although she is not the child's legal parent.

Even as they were clearly differentiated from other programs, they also marked family boundaries, stating that donors would have no legal parental rights or responsibilities toward donor-conceived children. The philosophy of this program is likely closer to what feminists and other scholars have imagined in terms of the collaborative possibilities created by third party reproduction (Cohen 1996; Tong 1996): openness and recognition of the donor's contribution to creating the child; fostering connections between the family and the larger community; but with recognition of the mother(s) as the legal parent(s) for all relevant, authoritative purposes. The existing ties between the sperm bank and the local community likely fostered a model of donor-recipient-child relationships that would not be feasible for larger, corporate sperm banks attempting to serve clients across the country. Donors at this bank also donated with expectations that they might play an "uncle-type" role to the child they were helping to conceive, so there was also a selection effect in who applied to donate.

Discussion and Conclusion

Third party reproductive techniques such as gamete donation are rife with social, ethical, and legal controversy. Discussions are divided over the social problems created by these new techniques as well as the creative reproductive opportunities they bring. Recently, there have been increasing calls for openness among donors, recipients, and

donor-conceived children to the point where some countries have enacted legislation regarding the subject (Frith 2001; Greenfeld 2002). This, however, has yet to happen for the U.S., which is typically known for having little over-arching regulation of the fertility industry (Spar 2006).

In this chapter, I examined organizational practices for navigating donor, recipient, and child relations at sperm banks, fertility clinics, and egg donation agencies across the U.S. I addressed two main questions. First, to what extent do organizations have more open policies across the industry? Second, how do organizations manage relationships in donation arrangements? Overall, there was a notable trend across these three organizational types to allow greater amounts of information and interaction between parties relative to the traditional medical model, which minimized information exchange to medically relevant information and relied on anonymity between parties (Braveman 2010). Of the four major practices I examined, only twelve programs limited contact across all categories, meaning they had anonymous-only policies, did not allow photographs to be exchanged, did not inform donors of the cycle outcome, and did not allow post-cycle contact. In contrast, seventy programs (20%) allowed some form of contact or communication across all the practices, although this was not always the most open form of communication possible.

Organizations used three major strategies to draw boundaries between parties. First, they used designated and socially meaningful terminology for donors and recipients. Donors were construed as “helpers” or “assistants,” while recipients were frequently referred to in terms of their future parental status or desires. This created symbolic boundaries delineating who was in versus out of the final family construct.

Second, organizations managed information exchange between donors and recipients, making decisions about what types of information and how much information would be shared between parties. This was embedded in donor applications and recipient files, marking private from non-private information, and appeared in other practices such as photograph policies, and sharing information about the cycle outcome. Third, organizations managed interactions between donors, recipients, and donor-conceived children. This was done through policies about anonymous versus “open” or “semi-open” donation arrangements and policies on post-cycle contact between the parties.

It is important to recognize that programs have to manage boundaries on several fronts and not all programs act in similar ways. There were some broad distinctions by type of organization (clinic, agency, bank) and type of donation (egg versus sperm). Overall, agencies tended to provide more open arrangements on a number of measurable practices. They were more likely to provide donor photographs, inform donors of the cycle outcome, and have non-anonymous options before or during a donation cycle. Sperm banks were much more institutionalized in their approach to managing donor-recipient-child relations. They offered more concrete and often commercial services, such as photo-matching and identity-release programs. This suggested that recipients were treated more as consumers entering into transactions with sperm banks, as opposed to prospective parents creating a collaborative relationship with a donor. While the technological aspects of sperm donation (cryopreservation and 6 month quarantine) create some distance between donors and recipients, the formalized nature of the services offered, and the ability to virtually search and select a donor (Schmidt and Moore 1998) creates an even more remote relationship between parties. As such, the more consumer

oriented transition in gamete donation (Braveman 2010; Holster 2008) actually appears to have taken different trajectories for egg versus sperm donation. Donor sperm is more frequently offered as a product from a corporate entity, whereas donor eggs—at least those offered through egg donation agencies—are more likely to involve a certain extent of emotional labor on behalf of the donor (Almeling 2007) and perhaps more complexly negotiated boundaries between donors, recipients, and children. Clinics, as an organizational population, appear at times more conservative in their willingness to open up donation arrangements than both agencies and banks, although there is also considerable variation as some clinics have adopted more patient or consumer-oriented policies in how they handle information and interactions between parties.

Even as the industry appears to move toward a more open or negotiable model of how donor, recipient, and child relations are constructed in the contemporary U.S., organizations still placed constraints on these relationships. Analyzing the emotional boundary work that occurs in nurse-patient relationships, Allan and Barber (2005) drew on the idea of *bounded relationships* to address how nurses can create emotional connections and care for patients without overstepping professional boundaries. Bounded relationships create “a feeling of closeness, but at the same time maintains a distance” (p. 392). I suggest that organizations involved in donation arrangements may use such an idea in order to exert and maintain social control over gamete donation. In particular, we see bounded relationships created through actions such as providing partial information about a cycle outcome to a donor (e.g., whether a pregnancy was achieved, but not whether a baby was born); through staff mediating donor-recipient interactions in “semi-open” and “open” arrangements; and through sperm banks downplaying expectations for

establishing donor-child relationships with identity-release options. Through such actions, I argue that organizations attempted to balance different parties' desires for connectedness versus distance, as well as potentially acting out organizational interests to not have to negotiate and be responsible for socially or legally disruptive outcomes if boundaries and privacy are uncomfortably breached for any parties involved.

Chapter 5

The Lesbian and Single Woman Question: Persistent Barriers to U.S. Infertility Services?

“Does it make sense to apply controls to procreation by syringe in the midst of millions of instances of wholly unregulated baby making in the traditional mode?” Wikler and Wikler (1991)

"Artificial Insemination of Single Women Poses Difficult Questions." *New York Times*, Mar 9, 1979.

Abstract

Access to U.S. infertility services is typically framed in terms of socio-economic resources because such services are concentrated in a private medical market. A growing body of work examines disparities in access by race/ethnicity and socioeconomic status, but has less frequently addressed barriers posed by marital status and sexual orientation. Some conclude that the private market has reduced all barriers except economic ones; others are more critical, noting that inequality still exists for those looking to create alternative families. To assess clinic receptivity to serving lesbian and single women, I conducted a summative content analysis of U.S. fertility clinic websites. Most clinics (89.8%) officially accepted single women according to data from the Society for Assisted Reproductive Technology. Yet, less than one-third displayed explicit cues for alternative families on their websites; only 10% displayed non-discriminatory statements. Additionally, not all website references were inclusive of both lesbian and single, heterosexual women. Overall, these findings suggest that clinics may continue to intentionally or unintentionally gatekeep in subtle ways by maintaining a partnered, heterosexual framework of reproduction and parenthood.

Introduction

Reproductive technology encompasses the range of intervention into reproduction: birth control, prenatal and birthing technologies, and infertility treatments. Ability to access these technologies is a key element of women's reproductive autonomy (Lublin, 1998). In this paper, I focus on access to services for infertility and involuntary childlessness, such as donor gametes, alternative insemination (AI²¹), and in-vitro fertilization (IVF). In the U.S., most infertility services are concentrated in a private

²¹ Also referred to as artificial insemination. I adopt Chabot and Ames (2004) argument to not use the term *artificial* because it implies “not real” (p. 349). They use the phrase *donor insemination* (DI) as a more positive connotation for alternative modes of reproduction.

medical market (Spar, 2006). Unequal access has frequently been discussed in terms of socio-economic resources, such as income and insurance coverage (King & Meyer, 1997; Bell, 2009) or racial/ethnic differences in helpseeking behaviors (Stephen & Chandra, 2000). Research on infertility service seeking has presented a fairly consistent demographic profile of helpseekers: non-Hispanic white women, who are older, more educated, and have a relatively higher income (Stephen & Chandra, 2000). Yet substantially less work has addressed differential access based on marital status and sexual orientation. The private market model of services in the U.S. has led to relatively increased access for lesbian and single heterosexual women—if they can afford services (Agigian, 2004; Barney, 2005; Spar, 2006). Some scholars have gone so far as concluding that current barriers in the U.S. are primarily economic (Thompson, 2005). Yet, others have argued that a private market model does not automatically equalize access for lesbian and single women relative to heterosexual couples, primarily because it does not address the fact that reproduction and parenthood are still viewed predominantly through a partnered, heterosexual paradigm (Agigian, 2004; Barney, 2005). This leaves an open question about whether lesbian and single women continue to face obstacles when seeking infertility services in the U.S.

In this study, I focus on how services are portrayed by fertility clinics across the country, via a content analysis of clinic websites. I address two main questions: 1) What is the current picture of lesbian and single women's access to services in the U.S.? 2) What are the processes at work that might either support or undermine their access? Although non-medicalized options, such as using known sperm donors or self-inseminating, are frequently pursued and viable means of alternative reproduction (Bock,

2000; Chabot & Ames, 2004; Mamo, 2007; Mannis, 1999), most technologies remain concentrated in medical or other institutional settings. As such, a more holistic picture of women's access to reproduction has to assess both institutional and non-institutional channels. My analysis shows that although the majority of clinics in the U.S. officially report accepting *single* women (there is no formal reporting for lesbian women), content from their websites suggests a variety of clinic dispositions in terms of providing an explicitly supportive environment for alternative family building. Some evidence points to major changes within the fertility industry, but I argue that a closer look indicates the persistence of subtle gatekeeping. It is also important to note that gatekeeping of infertility services is not U.S.-specific. Scholars focusing on other Western nations (albeit with different health service systems), such as Canada and the U.K., have also noted gatekeeping practices that exclude those looking to create alternative families (e.g., Foster, 2005; Barney, 2005). So although my focus here is on U.S. services, the general findings may also apply in other contexts.

Non-Normative Motherhoods

Feminist scholars have developed the concept of *stratified reproduction* to address the ways in which reproduction is encouraged and enabled for some women, but discouraged or barred for others (Colen, 1986; Rapp, 2001). Single and lesbian women are among those who have been discouraged, stigmatized or otherwise barred from intentional motherhood. As Jacob (2000: 267) noted: "Historically, it has been assumed that lesbian couples were not, and single women should not be, mothers." Lesbian and single women may share similar experiences because they have historically been marginalized in reproduction and parenthood, but they are also confronted with different

issues. Lesbian women face challenges through the heteronormative focus of reproduction and parenthood (Ingraham, 1994; Oswald, Blume, & Marks, 2005), which privileges heterosexuality as the standard. This has often led to the denial of lesbian mothers' custody rights to children conceived through previous heterosexual unions (Falk, 1989) and lack of recognition of lesbian motherhood by institutions that frequently interact with family processes, such as medicine and law (Agigian, 2004). Single mothers by choice are confronted by stereotypes of single motherhood that undermine the legitimacy and agency of their decisions (Bock, 2000; Mannis, 1999) as single mothers are typically identified as young, irresponsible, and welfare dependent. The label 'single mothers by *choice*' distinguishes those women who intentionally choose a pathway to single motherhood as older, responsible, and financially independent women, even as it reinforces the stigma of those who are single mothers through other circumstances (Bock, 2000). The increasing demographic visibility of lesbian and gay families, single mothers by choice, and various family arrangements created through divorce and remarriage, have been hailed as the markers of the postmodern family era (Allen & Demo, 1995; Stacey, 1993). Yet, the nuclear, partnered, heterosexual family persists as the ideologically dominant model (Stacey & Biblarz, 2001).

Studies comparing intentional parenthood among lesbian and single women acknowledge different concerns from family and medical practitioners' perspectives. Reviewing the psychological literature, Jacob (2000) noted that common objections to lesbian motherhood assumed problems with a lesbian identity and lifestyle (e.g., emotional and sexual maladjustment and lacking maternal skills) as well as problems with the development and well-being of a child raised by a lesbian mother, such as

confused gender identity or stigma from having a lesbian parent. Objections to single motherhood problematized these women by referring to their emotional abnormality and selfishness for desiring a child. Criticisms have also emphasized the emotional and financial stress of single parenting (Jacob, 2000). While a two-parent family was seen as the “solution” for single, heterosexual women desiring motherhood, lesbian co-mothering arrangements would not resolve the presumed impact a lesbian mother’s sexuality might have on her child. Such perspectives, and studies that reinforce them, are an important piece of the larger picture of access to services, because they may shape practitioners’ decisions to accept or reject these women.

Research on healthcare experiences indicates that lesbian women may be reluctant to disclose their sexual orientation, fearing homophobic reactions from health care providers and moral judgments of lesbian motherhood (Harvey, Carr, & Bernheine, 1989; McManus, Hunter, & Renn, 2006; Stevens, 1995). For single lesbian and heterosexual women, the heterosexual structuring of healthcare, and particularly reproductive health care (Stevens, 1995), may undermine supportive interactions if providers assume a woman is involved in a (heterosexual) relationship. As such, even if practitioners are not intentionally barring certain groups of women, taken-for-granted assumptions may marginalize lesbian and single women, and deter them from seeking services.

Seeking Reproductive Services

In the U.S., infertility and involuntary childlessness is overwhelmingly viewed as a medical problem (Greil, 1991). Such medicalization places the definition of the problem and its treatment under medical jurisdiction (Conrad, 1992). The most common service that lesbian and single women use is AI with donor sperm. As a medicalized procedure,

AI usually entails physician supervision, and legal documents drawn up between recipients, donors, and the third parties facilitating the arrangements.

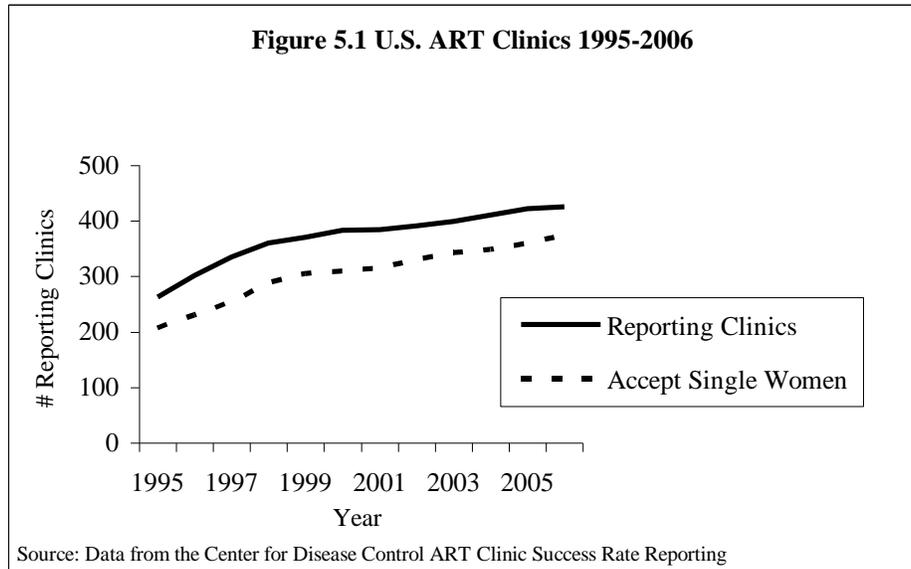
The increased use of AI by lesbian women during the 1980s was labeled the “lesbian baby boom” (Agigian, 2004; Amato & Jacob, 2004). Growing demand from lesbian and single women created intense controversy that women would intentionally seek to have children outside of traditional family structures. Stereotypes and distrust of these women appeared in public media and among legal and medical professionals. For example, in a *New York Times* article, Dullea (1979: A18) identified three types of unmarried women who might use donor insemination: the career woman with “no marital prospects in sight,” the disturbed woman “traumatized by rape or abortion,” and the lesbian who “may try to hide her sexual preference, or she may be quite outspoken, demanding her “biological right to motherhood”.”

Physicians frequently acted as gatekeepers by denying services to single and lesbian women (Wikler & Wikler, 1991). A 1987 survey of physicians (OTA 1988) found that 52% would reject women for artificial insemination if they were unmarried and 15% would reject a woman if she was a lesbian (presumably many physicians incorporated lesbian women in the “unmarried” category). In 1994, the Ethics Committee of the American Fertility Society—a major professional association for reproductive medicine and precursor to the American Society for Reproductive Medicine (ASRM)—discussed alternative family arrangements and new reproductive technologies. They acknowledged such arrangements were viable options, but openly privileged families formed by heterosexual, married couples and supported physician gatekeeping. These are explicit acts of gatekeeping, but Wikler and Wikler (1991) also identified implicit forms

of gate-keeping. For example, potential lesbian or single clients could be discursively excluded if clinics described and advertised AI or other procedures as medical solutions only for male factor or couple factor infertility. Such descriptions would characterize infertility and its treatment as implicitly partnered and heterosexual.

Changing or Persistent Attitudes in the Industry?

Prompted by the inability to ignore social change, particularly the increasing visibility of gay and lesbian family building and single parents by choice, the Ethics Committee of the ASRM altered their stance in 2006. In a new report, they concluded: “there is no persuasive evidence [in the social science literature] that children raised by single parents or by gays and lesbians are harmed or disadvantaged by that fact alone” (The Ethics Committee, 2006: 1333) and urged practitioners to accept patients “without regard to marital status or sexual orientation.” Based on ethnographic observation in U.S. fertility clinics over two decades, Thompson (2005) likewise reported a shift in practitioner attitudes. Practitioners had moved away from deploying the ‘best interests of the child’ model, which frequently denied access to lesbian and single women, toward a model of ‘reproductive choice and privacy,’ where power was more firmly placed in the hands of the patient as consumer. Thompson (2005: 2) also pointed to data from the Society for Assisted Reproductive Technology (SART) that, in 2001, 84% of clinics in the U.S. reported willingness to accept single women, “effectively remov[ing] marital status and sexual orientation from being barriers to treatment.” Taken together, the evidence suggests that the industry has undergone vast changes in the last few decades. SART reports between 1995 and 2006 show that clinics accepting single women has increased proportionate to the total number of clinics in the U.S. (Figure 5.1).



Yet, other evidence suggests persistent mechanisms that undermine or discourage access by lesbian and single women, such as the terms of insurance coverage for assisted reproduction. Although infertility insurance mandates have been passed in fifteen states (ASRM, 2005; NCSL, 2010), they are largely silent on coverage of artificial insemination or donor sperm (Agigian, 2004), which places the full economic burden on women using these procedures. While donor insemination is less expensive than other procedures – Amato and Jacob (2004) estimated \$1130-\$1340 per attempt—it may require several attempts to get pregnant (Gartrell et al., 1999). Lesbian and single women may also need other, more expensive, services if they have problems conceiving. Some lesbian couples seek “co-maternity,” to solidify the biological, parental connection that both women have to the child(ren): one partner donates the egg, which is fertilized by donor sperm and the embryo transferred to the second partner, who undergoes gestation and labor (Amato & Jacob, 2004; McManus et al., 2006). Explicit or implicit criteria pertaining to marital status and sexual orientation can exempt lesbian and single women from insurance coverage. Mandates for Arkansas, Hawaii, Maryland, and Texas grant coverage of IVF

only when a woman's egg is fertilized by her spouse's sperm (ASRM, 2005). Policy in Rhode Island defines infertility specifically as a condition of married individuals (ASRM, 2005). Mandates in several states define infertility solely in medical terms (ASRM, 2005) which precludes social factors such as lack of an opposite-sex partner. The majority were passed before 1991, suggesting they reflect earlier attitudes about alternative reproduction. Yet, a recent motion in 2007 to remove the marriage requirement from Rhode Island's mandate was vetoed by the governor, who commented that "the state should be encouraging the birth of children to two-parent families, not the reverse" (ASRM, 2007). This explicitly denies the legitimacy of single motherhood by choice and ignores lesbian partners seeking services with intentions to co-parent, reinforcing a heteronormative view of family.

Given that the majority of clinics now officially accept single women, according to SART data, explicit gate-keeping appears to be a thing of the past. Yet, both Agigian (2004) and Barney (2005) concluded that reproduction is still overwhelmingly framed as a partnered, heterosexual prerogative. Several scholars suggest the persistence of more subtle forms of gate-keeping in reproductive services (Steinberg, 1997; Wikler & Wikler, 1991), producing differential experiences and access for lesbians, single women, and partnered, heterosexual women. I now turn to an analysis of fertility clinic websites to assess current receptivity in the industry to serving lesbian and single women. Although official reports from SART seem to tell one story (i.e. increased access), (how) do clinics actually present services to clients looking to create alternative families?

Method

The main analytic strategy in this chapter was a summative content analysis (Hsieh & Shannon, 2005) of clinic websites. Website content is an indirect way to gauge clinic practices and some clinics may not provide all relevant information on their websites. In the last decade, however, there has been ongoing discussion within reproductive medicine journals that practitioners should be aware of and actively involved in Internet use by patients and prospective clients (Abusief, Hornstein, & Jain, 2004; Cousineau et al., 2008; Weissman et al., 2000). Given this definite awareness within the professional community, it seems reasonable to assume that clinics looking to bring in clients would actively promote relevant services and information on their websites. Additionally, with the growing amount of health information on the Internet, prospective patients may use it as a first step toward seeking services. Websites can provide cues of clinic receptivity and support, which recent studies have found to be salient in the process of creating alternative families (Ross, Steele, & Epstein, 2006; Chabot & Ames, 2004).

Sample Selection

Fertility clinics—staffed by specialists in reproductive medicine—are one of several options for women seeking infertility and assisted reproduction services. I focused on clinics because their population is clearly defined, they are linked under the same major professional organization(s) that have consistently presented guidelines for behavior, and there is available data on clinics' official acceptance policies for single women. My intent is not to diminish the diverse and often non-medicalized ways that lesbian and single women become mothers (Bock, 2000; Mamo, 2007), but to examine access to at least one of the medicalized options for assisted reproduction. It is also worth

noting that for those women with a medical problem conceiving, a fertility clinic may indeed be their primary option for services.

The 1992 *Fertility Clinic Success Rate and Certification Act* (CDC, n.d.) requires all fertility clinics to report annually to the Center for Disease Control (CDC) and SART. These reports are publicly available, with a lag between reporting and dissemination to the public. I pooled together the most recent years available (2005-2007) to capture any clinics unreported during one of those years. After removing duplicates and clinics that had merged or changed names between years, the list included 516 clinics. I used two additional criteria for the final sample. First, clinics had to be in current operation and have a working website. Only thirty clinics presumed to be operating did not have a web presence, so this criterion excluded less than 6% of the initial list. The second criterion for exclusion was for networked clinics: I identified the main clinic and excluded ancillary branches that shared the same main webpage because this was duplicate information. My final analytic sample contained 402 clinics.

Coding

All website coding and analysis for this chapter was done by the author. To assist with coding and analysis, I used a qualitative software program. All qualitative analysis is to some extent subjective (Hsieh & Shannon, 2005). Although some methodological discussions emphasize the need for multiple coders to assess inter-rater reliability, others focus on how the single researcher is the sufficient “instrument” in coding and analysis (Bradley, Curry, & Devers, 2007). In this chapter, I adopted the latter strategy, but to bolster data reliability, I revisited my coding decisions at a later date and revised any discrepancies.

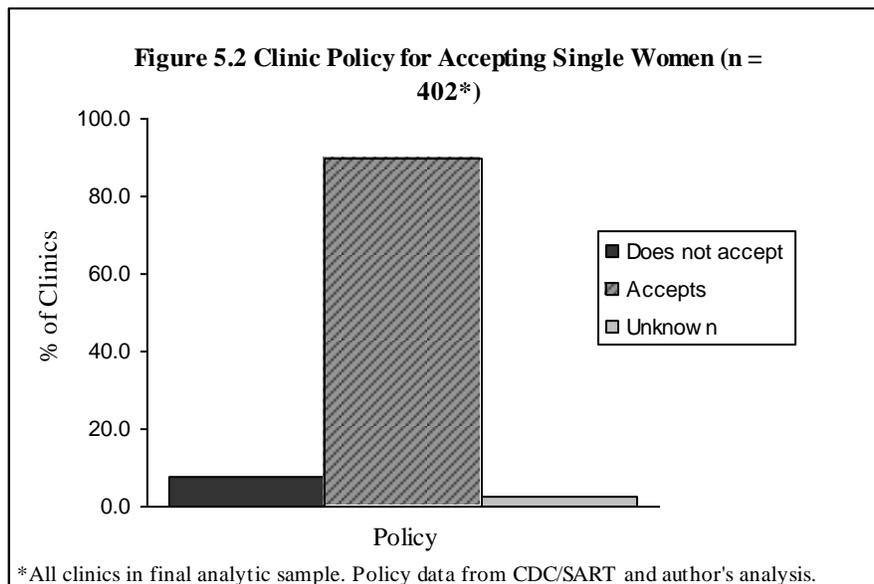
Due to the lag between the SART reports (2005-2007) and data collection (2009), I used two strategies to identify a clinic’s policy on serving single women. First, I categorized clinics based on their policy from the most current report year available. Then I examined websites of non-accepting clinics to gauge whether their policy had changed between the last reporting and 2009. I also looked for any mention of this policy on their website. For accepting clinics, I focused on three main aspects of website content: 1) whether the website contained any *reference* to lesbian/single women or alternative families (explicit, ambiguous, or none); 2) if references were made, the *tone* of the discussion (supportive, neutral, or restrictive); and 3) whether the references were *inclusive* of both lesbian and single women. For text-heavy websites, I used keywords to facilitate searching, such as “lesbian,” “same sex,” “single,” “married,” “husband,” “partner,” and “donor.” Although my major coding categories were directed from themes in the prior literature, I also allowed for themes to emerge after I examined the data (Bradley et al., 2007) and refined initial categories to reflect this. Table 5.1 describes the main themes that organize the findings.

5.1 Major Thematic Codes

Code	Description	Notes
Acceptance Policy	Whether a clinic officially accepts single women	Drawn from SART data, but also coded from website descriptions to check most recent policy (2009)
Reference	Whether a clinic website contained a reference to lesbian/single women or alternative family creation	Refined in three subcategories: explicit reference, ambiguous reference, no reference
Tone	Implicit or explicit attitudes, conveyed by the website reference, about lesbian/single women or alternative families	Refined into three subcategories: supportive, neutral, restrictive
Inclusive	Whether a website reference applied to both lesbian and single women or only one	

Acceptance Policies

Figure 5.2 shows clinic policies on accepting single women. Of the 402 clinics in my sample, thirty-one (7.7%) reported non-acceptance to SART. Two additional clinics had reported non-acceptance in 2007, but their websites referred to single women using AI, suggesting that they had changed their policy. I was unable to discern policies for 10 clinics (2.5%), even after reviewing their websites, because they did not have complete information in the 2007 reports and had either not reported to SART in 2005 or 2006, or were not yet open for business in either of those years. All clinics in California were coded as accepting single women regardless of the 2007 SART data because a recent California Supreme Court decision (ASRM, 2008) has made it illegal to discriminate against fertility patients based on their sexual orientation, and implicitly, marital status. Overall then, a clear majority of fertility clinics in the U.S. accepted single women (89.8%).



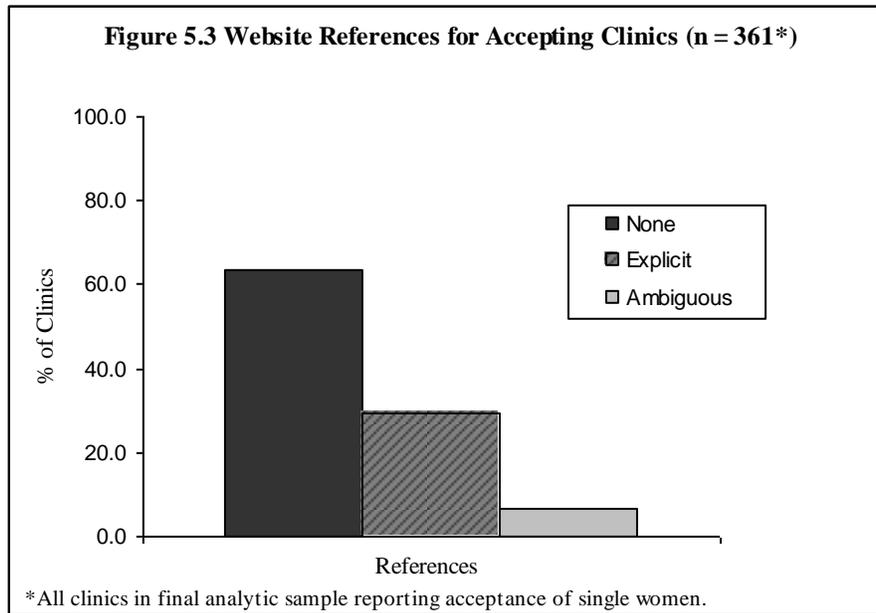
I examined websites for the non-accepting clinics, but did not find any mention of why they chose not to serve single women. Many used implicit gatekeeping (Wikler &

Wikler, 1991) by defining infertility as a heterosexual couple's issue. For example, some websites displayed slogans such as "We're here for one reason...to help couples give birth to a healthy baby" [id # 107] or "Helping couples achieve their dreams of children" [id# 148]. Discussions of AI also frequently referred to using the husband's sperm or donor sperm in situations of male infertility, and services were often described in terms of diagnosing and treating both male and female partners. A few websites explicitly referred to married couples as their intended patient population. One description of AI referred only to AIH, which was literally spelled out as "Artificial Insemination with Husband's Sperm" [id # 183, underline my emphasis]. This reinforced that the procedure was only applicable to married, heterosexual couples. As such, there was no outright indication from these websites that the clinics did not serve single women, but more subtle cues were provided through how services were conveyed to potential clients (Stevens, 1995).

Acknowledging Alternative Family-Building

To be cognizant of and counteract heterosexist assumptions in health services, researchers have suggested that providers can use strategies such as nonsexist, gender neutral, or inclusive language when referring to significant others; visually display a variety of family structures in waiting rooms, and have materials adapted for different patient populations (Amato & Jacob, 2004; Jacob, 2000; Stevens, 1995). A simple way to cue potential clients is to mention relevant services or describe services in relevant terms. As such, clinics looking to extend services to lesbian and single women should acknowledge that they serve these women or help to create alternative family structures. Figure 5.3 shows whether websites of accepting clinics contained any explicit references to lesbian or single women or alternative families. Less than one-third (29.6%) explicitly

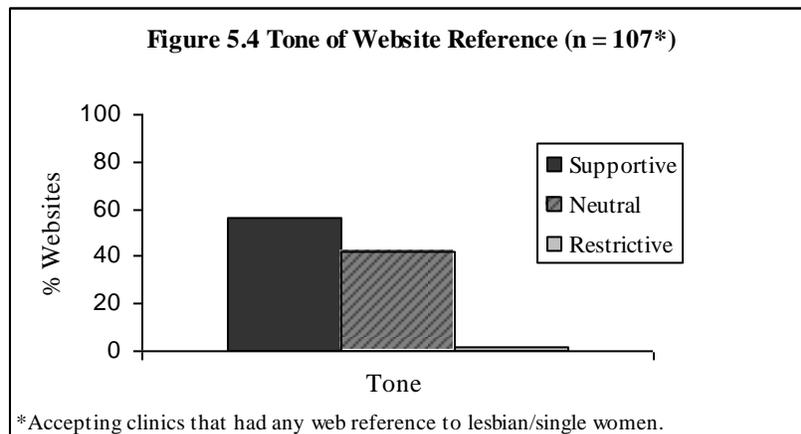
acknowledged alternative family building, and 6.6% had ambiguous wording. Ambiguous statements could be interpreted as referring to women seeking services without the knowledge or support of a (male) partner or seeking services as an unpartnered woman. For example, some descriptions referred to treating both individuals and couples, but then described services for heterosexual couples.



Accepting clinics that did not explicitly acknowledge alternative family building were essentially indistinguishable from non-accepting clinics because they made no indication that they served patients other than heterosexual couples. Such cues have been shown to be important for lesbian women seeking reproductive services (Ross et al., 2006) and their absence may deter potential clients if they think that the environment may prove hostile (Stevens, 1995). Additionally, although the SART data show increasing acceptance of single women, the relatively low rates of explicit references on clinic websites suggest that more subtle, exclusionary practices may continue in the place of open discrimination (Wikler & Wikler, 1991).

Additional Cues, Implicit Meanings

While the presence or absence of references to alternative family building provides an initial gauge of clinic receptivity, it is also important to address the tone of descriptions. These can provide additional cues to women seeking services regarding whether they will be met with a supportive environment. For example, Wilton and Kaufmann (2000) found that some lesbian women who sought maternity care services were met with unsupportive attitudes and judgments of lesbian motherhood that created negative patient-provider interactions. I identified three main tones from websites with explicit or ambiguous references to alternative families: supportive, neutral, and restrictive. I describe each of these in more detail below. Most of the references were either supportive or neutral (see Figure 5.4); only two clinics portrayed overtly restrictive policies toward single women, even as they reported officially accepting them.



Supportive

Slightly more than half of the website references construed support for alternative family building. Supportive references indicated that clinics welcomed diverse patients and were able to assist them in their different family building needs. References conveyed support in various ways, such as containing openly non-discriminatory

language, and posting relevant resources (e.g., books about lesbian or single motherhood). While these were more overt indications of the clinics' environment, some websites contained less explicit support, but still used positive language to describe diverse family forms or paths to parenthood, implying that they served more diverse patients.

Approximately 10% of clinics displayed non-discriminatory statements on their websites. Explicitly non-discriminatory statements were often on the main website page, in a mission statement or clinic philosophy, or on a separate page geared toward alternative lifestyles or non-traditional family building. These statements conveyed unambiguous support and non-judgmental service. For example, the following websites referred to 'embracing' and 'welcoming' diverse clientele:

The Clinic embraces all patients, regardless of age, marital status or gender preference [id# 259].

Our Practice welcomes the most challenging patients without regard to diagnosis, marital status and sexual orientation. Our goal is to help loving couples and individuals create a healthy family [id# 243].

[W]e understand that families come in all shapes and sizes. That is why we would be more than happy to explore fertility treatment options with same-sex couples or individuals without an accompanying partner [id # 152].

Most statements referenced both marital status and sexual orientation, but several were more exclusive. For example, the first clinic below mentioned "marital status" and "relationship arrangement," which implied that single, heterosexual women were welcome, but did not necessarily refer to lesbian women. The second clinic implicitly juxtaposed married (heterosexual) women with single (heterosexual) women, thereby excluding lesbian women and same-sex couples:

We will not stand in judgment of your marital status, relationship arrangement, age, or financial status. We simply want to help you bring your baby home in the least expensive, least invasive way possible [id# 247].

Some clinics accept only married women, but it has been the practice of [...] for many years not to discriminate against single women [id# 218].

Clinics did not always appear to favor serving single, heterosexual women over lesbian women and couples. For example, one clinic offered services to *committed lesbian couples*, but did not mention anything about serving single women [id# 219].

A second, overt way to cue potential clients was through the presence of support resources for alternative family building. In the websites I analyzed, this included reading and educational materials, links to online communities, information about in-house or local support groups, and relevant legal resources. However, less than 5% of clinics had these resources visible on their websites, and the majority was for lesbian and gay family building. One website did advertise a discount program for single women using donor insemination [id # 325]. Some websites did not include any other acknowledgment of alternative families, but the presence of these resources suggested that practitioners were at least considering the different needs and situations of these patient populations (Jacob & Amato, 2004; Ross et al., 2006).

Several websites contained supportive language referencing diverse patients or family structures; however these statements were not explicitly non-discriminatory. Language was typically inclusive of both individuals and couples and implied that infertility services could help with various family situations:

We understand that every individual and every couple is unique and that your road to parenthood requires guidance, support and caring [id# 233].

Values

- * To respect the diversity of family and the uniqueness of each individual.
- * To treat all patients with dignity and respect [id# 255].

Our goal is to help couples and individuals achieve their family building goals in a supportive and compassionate environment [id# 324].

These references indicated that a variety of patients would likely be accepted at the clinics. Other statements suggested that different situational factors made conception difficult, such as the absence of a male partner, but parenting desires in those situations were still legitimate:

Natural conception is not always able to provide children to those *who very much want them*. You cannot always overcome male factor infertility issues. *Sometimes, a healthy fertile male is not available* [id# 10, italics my emphasis].

Thanks to [...]’s Egg Donation Program, there are *hundreds of grateful individuals and couples* who, under normal circumstances could not have conceived by themselves, *now have a child to call their own* [id# 267, italics my emphasis].

Similar to the non-discriminatory statements, some of these references were more exclusive. For instance, the clinic below referred to the childbearing desires of “individuals” and “single women,” followed by the clause, “and who has no male partner,” inferring that the imagined patient was an unpartnered, heterosexual woman:

For some individuals and couples, using donor sperm is the first answer to the question of how to make a baby. Whether to assist *a single women [sic] who longs for a child and who has no male partner*, or for couples who’ve been through testing and arrived at diagnostic conclusions, the use of donated sperm can result in success at last [id# 30, italics my emphasis].

Another website did not openly indicate who might use the clinic’s donor sperm services, but the donor program page contained a picture of two women leaning on one another in a manner suggestive of a lesbian couple [id# 171]. Although these may generally signal support for alternative family building, only providing cues to single, heterosexual women or to lesbian women may still lead to exclusions of other women seeking services. Even though the phrase “single women” may apply to both unpartnered heterosexual women and lesbian women in various relationship arrangements, it does not necessarily include all of these women. For example, a survey of SART-affiliated clinics showed that a slightly higher percentage were willing to accept single, heterosexual women than lesbian couples (Stern et al., 2001).

Neutral

Slightly less than half of the website references were decidedly neutral in the way they conveyed services for lesbian and/or single women. For example, several websites briefly mentioned that services could be used by both married and single women or otherwise inferred that they were not restricted to married couples:

Who is a candidate for IVF using donated eggs? *Married or single women* with premature ovarian failure, malfunction of the reproductive organs, chromosomal abnormalities, genetic disorders, removal of the ovaries or radiation to the ovaries are candidates for IVF with donated eggs [id#142, italics my emphasis].

Donor sperm has been utilized for many years for couples in which the man does not have sperm, or his sperm does not fertilize eggs. *It is also an option for single women who want to have a child without a partner* [id#196, italics my emphasis].

Sperm can be from the husband, or from frozen donor sperm, *depending upon your situation and needs* [id#195, italics my emphasis].

The language used in the first two references suggests single women would be accepted at the clinics. The third reference possibly extends to lesbian women if the phrase “situation and needs” can be broadly interpreted to mean various social reasons for infertility or involuntary childlessness. None of these references, though, provide additional cues for gauging clinic environment or how practitioners might treat these women in person. As such, potential clients may have had reservations about seeking services at these clinics because they did not necessarily indicate a supportive environment for alternative family building.

Restrictive

Only two clinics mentioned restrictive policies for single women on their websites. Because they officially accepted single women, this was not an outright refusal of service; however, both clinics had additional requirements specifically for these women, which implied that they were less supportive of single parenthood relative to

two-parent families. Additionally, although single, heterosexual women might be accepted after meeting the requirements, it seemed unlikely that lesbian women would.

One clinic was based out of a military hospital. Their requirements for IVF candidates noted that single, active duty women had to bring a “letter from their command in reference to their participation in the program” [id# 322]. There was no indication that married couples had to inform any supervisors about their intentions to have a child through assisted reproduction. Because this was a requirement with “no exceptions,” single women who did not provide the letter would not be treated. The clinic’s setting also suggested that lesbian women would either not attempt to seek services or not disclose their sexual orientation given the U.S. military’s “Don’t Ask, Don’t Tell” policy (Belkin, 2008).

The second clinic was a private practice. Clinic protocol, as stated on the website, required a criminal background check for all *single individuals* wishing to receive donor insemination services. Again, such screening was not required for married couples. The language used overtly invoked what Thompson (2005) described as the ‘best interests of the child’ model:

While it is not uncommon for a single individual to raise a child alone in our society, it is understood that single parents are at a higher risk of inflicting child abuse and/or neglect. [...] It is our intent to do whatever possible to protect the child [id# 134].

There was no reference to sexual orientation, but because the statement openly contradicts the ASRM Ethics Committee’s stance (The Ethics Committee, 2006), one infers that lesbian clients would not be any more welcome, even if they were intending to have a co-mothering arrangement with a partner. Although only two clinics had restrictive policies, these were otherwise indistinguishable from other accepting clinics if one only relied on official reporting to SART. This provides support for needing a more

in-depth analysis of actual clinic environment and reception of diverse clientele, as official indicators can only provide one piece of the picture.

Discussion and Conclusion

As is evident from the above discussion, official clinic acceptance policies potentially mask a variety of clinic dispositions toward serving lesbian and single, heterosexual women. From my original sample of 402 clinics, 89.8% accepted single women. Yet, less than one-third made explicit reference on their websites to alternative family building, and approximately 10% displayed openly non-discriminatory statements. Although explicit gate-keeping has substantially decreased over the years, as is evidenced by the SART data (Thompson, 2005; also see Figure 5.1), it appears that more subtle gate-keeping practices may persist in how services are portrayed.

With the current data in this study, I cannot make conclusions as to whether this gatekeeping is intentional (with the exception of the two clinics with restrictive policies), but it may result in similar outcomes regardless of intent. If clinics only report acceptance of single women through official channels, but then do not offer any supportive indications, this may reduce women's perceived options in the medical marketplace. These official data are publicly available, but again, there is a lag between reporting and public dissemination. Granted these women may have other resources available, such as private referrals through personal physicians, and patient advocacy and support groups (e.g., The American Fertility Association, n.d.), but the onus should be on clinics to present their services in a more welcoming and supportive manner (Stevens, 1995). A recent report from a focus group of lesbian and bisexual women who had used infertility services recommended that clinics provide adequate indicators of clinic receptivity (Ross

et al., 2006). These women also expressed desires for resources relevant to alternative family building. In their study of lesbian couples becoming parents via donor insemination, Chabot and Ames (2004) observed that finding trustworthy and supportive medical personnel was a key issue in couples' decision-making processes. Researchers have suggested that providers can use strategies such as nonsexist, gender neutral or inclusive language when referring to significant others; visually display a variety of family structures in waiting rooms, and have materials adapted for different patient populations (Stevens, 1995; Amato & Jacob, 2004; Jacob, 2000). Conveying relevant and patient-sensitive information through in-house and electronic materials, are simple steps that clinics can take to provide a more welcoming environment if they are indeed seeking to serve these patient populations.

An important finding to reiterate is that not all references were inclusive of both lesbian and single, heterosexual women. The lack of a clear interpretation of "single woman," makes it difficult to tell how inclusive a clinic's policy might actually be. Although it seems feasible that clinics openly supporting gay and lesbian family building would also support single motherhood for heterosexual women, and vice versa, this is not necessarily the case. For example, one clinic that reported serving *committed lesbian couples* appeared to be less supportive of single parenthood even though they officially accepted single women. Previously, Stern and colleagues (2001) found that SART-affiliated clinics were less willing to serve lesbian women than single, heterosexual women. This suggests that we need to be cognizant of different cues and resources for each of these groups of women.

Although I can only draw indirect conclusions from website content, the results of the current analysis suggest that these clinics continue to operate primarily through a partnered, heterosexual framework of reproduction and parenthood. Heteronormative assumptions (Ingraham, 1994; Oswald et al., 2005) infuse the definitions and portrayals of infertility services, making invisible the reproductive needs and desires of lesbian and single women. This supports what Agigian (2004) referred to as the “discursive erasure of lesbian conception,” but I suggest that this should be expanded to include unpartnered, heterosexual women as well. These findings suggest persistent barriers to infertility services, which can lead to concrete repercussions, producing differential experiences and access for lesbian and single women compared to heterosexual couples. Although official policies appear on the surface to show a vast cultural change in acceptance of alternative families, these findings suggest that the lesbian and single woman question still lingers.

Chapter 6

My Gametes, My Right?

The Politics of Partner Involvement in Egg and Sperm Donation

Abstract

Gamete donation offers a unique opportunity to compare men and women's relationships to reproductive decision-making, unlike other reproductive processes, which typically involve women's bodies much more asymmetrically. In this chapter, I address issues of medical and reproductive decision-making by examining how a gamete donor's partner may be involved in the donation process. Some countries explicitly involve a donor's partner by legally requiring spousal consent for donation, but this is not the case for the U.S. In the absence of any formal regulation, what are the expectations for involving a donor's partner? Through a content analysis of materials from donation programs across the U.S., I examine how donation programs conceive of the partner's role; how this differs for egg and sperm donation; and the broader implications for men and women's medical and reproductive decision-making. Overall, I find that there are quite different expectations for partner involvement in egg versus sperm donation. Such differences, I argue, both stem from and reinforce existing issues navigating boundaries between intimate relationships and women's medical and reproductive autonomy.

Introduction

Gamete (i.e., egg and sperm) donation offers a unique opportunity to compare men and women's relationships to reproductive decision-making, unlike other reproductive processes, which typically involve women's bodies much more asymmetrically. Although this lends itself well to comparative analysis, feminist scholarship, and the social sciences more generally, has often overlooked gamete donors (Almeling 2007). Theoretically, egg and sperm donation have been described as equivalent procedures (Englert et al. 2004): they both result in a child with gametes from a third party who is not intending to be a social parent. However, scholars have shown how gender norms affect their interpretation and enactment (Almeling 2007; Haimes 1993; Spilker and Lie 2007). For instance, there are greater expectations for egg donors to be altruistically motivated, whereas it is considered quite acceptable for sperm donors

to treat donating as a “job.” As such, although both egg and sperm donation are routinely discussed under the umbrella term “gamete donation,” it is fruitful to draw comparisons between the two procedures with an eye toward how gender norms may influence donation practices.

In this chapter, I use the comparative aspect of gamete donation to explore issues of medical and reproductive decision-making and donors’ autonomy. Although donors’ medical autonomy has been frequently addressed, most discussions focus on threats to egg donors’ autonomy such as emotional or financial coercion (Gurmankin 2001; White 2001). I expand previous analyses to address the complex entanglement of medical and reproductive autonomy and look at both egg and sperm donation. Because medical and reproductive autonomy are quite broad issues, I examine these through the role of the donor’s partner. Some countries, such as France and Australia, explicitly involve a donor’s partner by legally requiring spousal consent to donation (Pennings 1996; Robertson 1988). This is not the case for the U.S., which is characterized more by a lack of overarching regulation for the new reproductive technologies (NRTs) (Spar 2006). A few states have passed their own policies, but any sort of comprehensive or overarching legislation has been slow to come (2007). Yet, in the absence of explicit regulation, fertility clinics and practitioners may develop their own informal policies to guide clinical practices (Annas 1980; Gurmankin et al. 2005). As such, what are donation programs’ expectations for partner involvement in the U.S.? Do these differ for egg and sperm donation? What are the justifications for and implications of involving a donor’s partner?

Medical and Reproductive Autonomy

Both medical and reproductive autonomy are inherently intertwined with gamete donation as a legal, medical, and social act. Autonomy, as a bioethical principle, is defined as “personal rule of the self” or being “free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding” (Beauchamp and Childress 1994: 121). In the medical context, patient autonomy is enacted through *informed consent*, which theoretically consists of five elements: competence, disclosure, understanding, voluntariness, and consent (Beauchamp and Childress 1994: 145). Respect for patient autonomy and the doctrine of informed consent have been viewed as critical moves away from physician paternalism—though not without controversy²² (Meisel and Kuczewski 1996). Informed consent has conventionally been theorized as a private dialogue between an individual patient and a doctor; patient autonomy was often regarded to be at risk when family members weighed in on medical decisions (Ho 2008; Kuczewski 1996). However, critiques of informed consent and patient autonomy, particularly from feminist scholars, have focused on the over-emphasis of individualism and ignoring that an individual is embedded in significant social relationships (Verkerk 2001). I acknowledge that these critiques are particularly important and relevant for the current study. My aim, however, is to address gamete donation practices in light of the conventional model of informed consent, which continues to be the reigning paradigm in practice. If patient autonomy is viewed as a primary goal in donation consent, then we need to understand how donors are treated in relation to this model. Medical autonomy and consent apply to gamete donation because procedures take place in a medicalized context; however, *informed consent* is only

²² Informed consent has been also critiqued for over-emphasizing the physician’s role of neutrality and for the fact that it has been used more often as a safeguard against future patient litigation as opposed to an indication of physician responsibility to patients (Meisel and Kuczewski 1996).

relevant to egg donation because it requires fertility drugs and a more invasive medical procedure. In contrast, sperm donation only requires simple consent (Whitney et al. 2003). These are important procedural distinctions that I address later on.

Medical autonomy and reproductive autonomy frequently intersect because of the increasing medicalization of reproduction in the contemporary U.S.; however reproductive autonomy has been defined less clearly. It is typically discussed in terms of personal choices about reproductive bodies and lives. As Shanley (1993: 621) noted, the classic feminist statement on reproductive autonomy, “My Body, My Right,” portrays “the notion that a woman herself—not a husband, not a doctor, not the state—must make those procreative decisions that affect her.” Recently, Purdy (2006) defined reproductive autonomy as “the power to decide when, if at all, to have children; also, many—but not all—of the choices relevant to reproduction” (p. 287). The NRTs, such as gamete donation and surrogacy, necessarily broaden the discussion to whether women should also be able to use their reproductive faculties to help others have children.

Although feminist scholarship has attended to reproductive autonomy in the context of surrogacy (Rothman 1990), abortion (Ryan and Plutzer 1989), and infertility treatment (Thompson 2002), gamete donors have often been overlooked. As such, most discussions of reproductive autonomy have focused on reproductive processes that asymmetrically involve women’s bodies. In contrast, gamete donation offers a unique opportunity to compare both men and women’s involvement in reproductive decision-making. Gamete donation and surrogacy do share some issues, particularly centered on commercial reproduction and reproductive contracts; however, I suggest that commercialized gamete donation arrangements are viewed as less controversial than

surrogacy contracts. In an early discussion of surrogacy contracts, Mahoney (1988) commented that prohibitions against such contracts unequally restricted women relative to men, but that women “would presumably remain free to sell their genetic material [i.e. donate eggs] just as men do” (p. 82). My analysis seeks a more developed understanding of whether men and women have comparable decision-making control over disposal of their reproductive cells and how partner involvement may impact this control.

The Donor’s Partner: Legal and Ethical Considerations

The donor’s partner is frequently an invisible or marginalized actor in discussions of gamete donation, but when he or she does appear it is typically in the context of a presumed heterosexual relationship, and most often a serious, committed relationship, such as a marriage or long-term partnership. In this section, I address the brief and different appearances that partners have made in the discussions of both sperm and egg donation, and the issues raised for and against partner involvement in the donation decision and process.

The Sperm Donor’s Wife

Early discussions of donor insemination struggled with defining medical, legal, and moral boundaries between donors, recipients, and spouses (Bartholomew 1958; Seymour and Koerner 1936). In a 1936 article in the *Journal of the American Medical Association*, Drs. Seymour and Koerner identified various “legal entanglements” that might ensue if proper measures were not taken to secure consent from all parties involved. The child’s legitimacy could be at stake if there was not adequate evidence that the recipient’s husband had consented to the procedure. Furthermore, the marriages of both the donor and recipient might be put in danger by any presumptions of adultery.

Seymour and Koerner noted that it was essential to have written consent from the recipient's husband and "notarized permission from the legal wife [of the donor], stating that her husband may participate" (p. 1533). Consent from all involved parties continued to surface as a major issue throughout the first few decades of the 20th century as courts in the United States, Canada, and Europe weighed in on the controversial nature of donor insemination (Bartholomew 1958; Bernstein 2002).

During the latter half of the 20th century, some physicians and scholars began to question the basis for spousal consent in sperm donation. Annas (1980) commented that the convention of having a donor's wife sign a consent form appeared to be largely based in "fear of legal liability rather than any social or medical rationale" (p. 9). He noted that although medical professionals (i.e., the American Medical Association, British Medical Society and "authorities in Australia") agreed about the practice, none gave any satisfactory explanation. Annas put forth two potential grounds on which a donor's wife might hold a physician or clinic liable. First, she might seek to "recover a portion of the money received" from the donation based on a vested property interest in the sperm. Second, she might hold the physician responsible if her husband ended up preferring "masturbation for pay to intercourse with her, or some other fantasy" (p. 9-10). Annas concluded, however, that a wife who might bring these claims against the physician or clinic was unlikely to be dissuaded by simply signing a consent form. Additionally, Annas noted that requiring spousal consent went against a recent U.S. Supreme Court

decision²³ “that refuse[s] to permit one spouse to have veto power over procreation decisions made by the other” (p. 10).

Pennings (1996) similarly commented on the vague justifications for spousal consent in sperm donation. Analyzing the possible ethical reasoning behind the practice, he identified three marital interests involved in sperm donation: sexual exclusivity, family composition (i.e., dealing with the possibility of having unknown biological relatives), and procreational exclusivity. He noted that decisions about one’s reproductive powers ideally should be made jointly if the donor was in a relationship that involved any current or future interest in procreation. Yet, Pennings ultimately concluded that informing one’s spouse or partner should not be made a legally enforceable requirement, nor should the partner be able to veto or otherwise control the decision. In the end, this should be left up to the donor, and any interference by the physician was viewed as a “paternalistic” and “unacceptable intrusion” into the donor’s personal life (p. 1136).

During the course of the 20th century, the legal status of donor insemination in the U.S. also became somewhat more solidified, which likely quelled some of the earlier concerns. Currently, thirty-six states plus the District of Columbia have statutes regarding donor insemination (Seibel 1996; Human Rights Campaign n.d.). Many of these explicitly remove the parental rights and responsibilities of the donor. Sperm donors’ spouses do not appear in any legal statutes in the United States. The only spouse mentioned is the recipient’s husband, who must grant consent to the procedure in thirty-four of the states.

The Egg Donor’s Husband/Partner

²³ Here he was referring to the decision that requiring third party consent for abortion placed an undue burden on women and was therefore unconstitutional (*Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 1976).

In contrast to the sperm donor's wife, the egg donor's husband has not appeared much in the relatively vast literature on legal and ethical issues of egg donation. In an early legal discussion, Robertson (1988) noted that the "assignment of rearing rights and duties" in egg donation would likely follow the sperm donation model. A child born of a married woman was legally the child of her husband—provided the husband consented to the insemination. This model would similarly strip the egg donor's spouse of paternal responsibilities. In the interest of "prevent[ing] disputes" over parental rights, "written consent of the donor's spouse may be requested, though it should not be obligatory" (p. 19-20). Similar to Annas (1980), Robertson pointed to the Supreme Court decision that a husband does not have the power to "prevent [his wife] from aborting or going to term" (p. 19), so he should not be able to interfere with her decision to donate eggs.

Only passing references to the egg donor's spouse/partner appear in the literature. Laying out the pros and cons of donor anonymity, Schenker (1992) noted that anonymity protected donors who feared being "legally liable for the maintenance of [any resulting] children" (p. 413). Given this potential liability, "the husband of a married donor would have a material interest in refusing consent to his wife's donation" (p. 413). Schenker, however, did not address whether a husband should actually *have* the power to veto his wife's decision. Discussing elements of donor consent forms, Stoddard and Fox (1996) commented that clinics should decide whether to require a spouse's signature although it was not legally required. Requiring a signature could "hinder someone from serving as a donor," but it could also reduce "the possibility of any claims by the husband" (p. 169). Like Annas' (1980) conclusion for sperm donation, these references indicate that the basis for spousal consent was largely a protection against litigation.

Professional Practices and Guidelines

Although egg donor's spouses were not particularly discussed in the professional literature, they appear to have been much more involved in practice. Surveying initial egg donation practices in the U.S., Braverman and colleagues (1993) found that spouses were frequently involved in donor screening. In a majority of cases, they directly impacted a donor's acceptance. More recent studies of donor screening practices are largely silent on the donor's spouse or partner (Gorrill et al. 2001; Lindheim et al. 1998), but clinical guidelines by the American Society for Reproductive Medicine (ASRM) have consistently recommended that intimate partners participate in psychological evaluations²⁴—even for anonymous egg donations (ASRM 1998, 2002, 2008). This same recommendation has not been made for anonymous sperm donors.

In 2009 the ASRM Ethics Committee released a report on interests, rights and obligations of gamete donors stating that both egg and sperm donors “should be made aware that they are not necessarily acting alone” (The Ethics Committee 2009: 24). Donors should be advised to consider that their own children and “present or future spouse(s) or partner(s) may have an interest in the consequences of the donation” (p. 25). The Committee, however, did not provide any specific recommendations or guidelines regarding how spouses' interests should factor in to the donation decision or process.

Both egg and sperm donation lack comprehensive regulatory frameworks in the U.S., but egg donation still exists in a particularly uncertain medico-legal terrain

²⁴ This appears to have developed from initial differences in recruiting donors. Early on, many programs in the U.S. required recipients to identify their own egg donors, while sperm donors have traditionally been anonymous (AFS 1993). As such, early guidelines from the American Fertility Society recommended psychological counseling “be offered to all parties involved” (1993 6S) in egg donation, including partners. It is unclear, however, why this would remain for the use of anonymous donors, which became more prevalent later on.

(Bercovici 2008). Compared to the thirty-six states (plus D.C.) that have enacted statutes for sperm donation, only eight states have done this for egg donors (Crockin and Jones 2010). Although Robertson (1988) suggested that egg donation norms and practices would follow sperm donation precedent, insights from earlier professional practices and guidelines suggest that it has not necessarily followed suit. An important point to consider here is that egg and sperm donation require markedly different procedures which disrupts any true equivalence between the two types of donations. In the next section, I address these in more detail and their implications for partner involvement.

Medical and Procedural Differences: Is a Partner Required?

Egg donation is more medically invasive than sperm donation, but does this necessarily require involving a donor's partner? To begin a cycle, donors inject medication to stop normal ovary functioning ("down regulation") and then switch to fertility drugs that stimulate egg production (New York State Task Force on Life and the Law n.d.). Clinics often suggest that a partner or friend can help give these injections. Eggs are retrieved via transvaginal ultrasound aspiration (i.e. an ultrasound guided needle). A donor needs someone to drive her to and from the procedure because she is given sedatives or put under twilight anesthesia (New York State Task Force on Life and the Law n.d.). The medical requirements of egg donation necessarily invite other people into the process, but this does not need to be a partner. Friends or other family members can also assist with injections or transportation.

Egg donation also involves some risk of complications from the drugs and retrieval (Maxwell et al. 2007). Because of these potential risks, egg donation involves an *informed consent* consultation, whereas sperm donation has typically required only

simple consent. Simple consent requires a patient to receive information about a procedure and then either consent or refuse (Whitney et al. 2004). Informed consent, described previously, assumes that a patient is competent, informed, and voluntarily entering into a decision; she decides whether or not to pursue a particular treatment after a physician counsels her on the risks and benefits. Because informed consent has conventionally been conceptualized as a dialogue between an individual patient and a doctor (Ho 2008; Kuczewski 1996), theoretically a partner can not be required to take part in the consultation.

The medical risks and requirements of egg donation provide a definite contrast to sperm donation, where the donor produces a specimen through masturbation. However, both egg and sperm donors have to carefully monitor their sexual activity. Sperm donors typically sign on for a 6 month to 1 year commitment²⁵ and donate on a weekly or bi-weekly basis. To achieve the desired specimen quality, they are instructed to abstain from sexual activity for usually 2-3 days prior to each donation. As a negative incentive, many banks have a policy that donors are paid less for sub-par samples.²⁶ Egg donors are instructed to abstain or use condoms during their cycle because the fertility drugs they inject make them very fertile (Cohen 1996, Part A). For any donor in a regular sexual relationship, these requirements imply that a partner would most likely be informed about such restrictions. Because sperm donors commit to multiple cycles, the more frequent restrictions to their sexual activity suggest that an intimate partner might be more likely to know.

²⁵ In the banks that I analyzed, the average commitment was 9 months. Only 1 bank requested a commitment as low as 4 months; the remaining required 6 months or more.

²⁶ Sixteen banks (52%) in my sample had this policy.

In sum, although egg and sperm donation exist in different medical contexts, these differences do not necessarily require greater partner involvement in egg donation. Friends or family members can assist with injections and transportation. Informed consent consultations can include, but theoretically cannot mandate, partner participation. Both egg and sperm donors have restrictions placed on their sexual activity, but, given the requirements of sperm donation, an intimate partner might be even more likely to know because of the longer donation commitment.

Legal and ethical discussions, early practices, and professional guidelines provide some insight into how partners might be involved in egg and sperm donation, but how does this translate into current on-the-ground practices? What policies and expectations do programs have? Do these differ for egg and sperm donation? What are the justifications for and implications of involving a partner? In the remainder of this chapter, I analyze current donation practices across the U.S. Drawing on data from the content of donation program materials, I address the ways and frequency with which partners are expected to be involved; the different roles they are perceived to have in the donation; and the implications of such involvement.

Method

Data

Three main types of organizations provide gamete donation services in the U.S.: fertility clinics, egg agencies, and sperm banks. Both clinics and agencies provide egg donation services. Clinics conduct the medical aspects of the donation procedures: screening donors, training them how to inject fertility drugs, providing informed consent consultations, and conducting the egg retrieval. Clinics may also run in-house programs,

where they recruit and help to match donors with recipients. Egg agencies recruit donors, match donors and recipients, and often connect parties with lawyers and other ancillary services to carry out the donation arrangement. They then refer donors to the recipient's clinic for the medical aspects of the donation. Agencies can often provide different services, such as semi-open or open donations (degrees of contact between a donor and recipient during the donation) and donors with particular characteristics, such as race, educational status, or physical appearance (Treiser n.d.). In contrast, commercial sperm donation is more consolidated. Recruiting and medical screening both occur through sperm banks. Based on the sample of organizations with onsite donation programs, described chapter three and Appendix A, there were 227 clinic-based programs, 101 egg donation agencies, and 31 commercial sperm banks²⁷ currently operating across the U.S.

Analytic Strategy

My main analytic strategy was a summative content analysis (Hsieh and Shannon 2005) which combines quantitative counts of categories with more in-depth qualitative interpretation of the data. With the help of an assistant coder, I coded the content of all available organizational materials. We began with a broad, but directed coding scheme, looking for any references to a donor's partner. After analyzing materials from several programs, I identified three primary emerging categories (Charmaz 2006) for how partners were involved in the donation process: support, screening, and formal

²⁷ Differences in the capacity to freeze and store gametes as well as FDA requirements to quarantine donor sperm have impacted the size and organization of the egg and sperm donation sectors. In the 1980s, new FDA requirements to quarantine and freeze sperm for six months (to test for HIV) caused many smaller banks to go out of business (Barney 2005), but cryo-preservation also provided the capability to ship sperm, so a handful of banks could serve the country. Egg donation has been more locally based because of the lagging capability to freeze and thaw eggs without damage (Akin et al. 2007); egg donation cycles are typically "fresh" transfers between donors and recipients. As such, the sperm donation sector is significantly smaller, but also more consolidated into larger corporations compared to the egg donation sector.

involvement. We coded categorical responses, indicating the presence or absence of a specific practice at each donation program, as well as creating text-based variables with brief contextual excerpts situate coding decisions. I relied primarily on these contextual excerpts when revisiting coding decisions to check for consistency and agreement between myself and the assistant coder.

I then revisited the initial codes describing partner involvement in order to make sense of the ways in which partners were being called on to participate in the donation process across the original three modes of involvement. From this perspective, I created higher order codes (Crabtree and Miller 1999) for how programs appeared to justify partner involvement in the donation process. Partners acted in at least in at least three different roles: partners were sources of social support for donors, partners were safeguards for various actors in the donation (program, donor, recipient), and partners were viewed as potential stakeholders in the donor's reproductive decision-making, including donating his/her gametes. I first address the frequency of specific modes of partner involvement, and then I move into a more extended discussion and analysis of the different roles that partners fulfilled in the donation process.

Modes of Partner Involvement

Donors' partners were involved in three major capacities during the donation process. First, programs inquired about partner *support*, often in the form of questions about whether a potential donor's partner knew of and/or supported their decision to donate. Second, programs involved partners in *screening* such as STD testing or taking part in psychological evaluations or counseling. Finally, partners were also *formally*

involved by some program requirements that they sign paperwork for the donation process. Table 6.1 shows the frequency of these types of involvement.

6.1 Spouse/Partner Involvement by Donor Type and Program Type

	Egg		Sperm
	<i>Clinic</i> (n = 126)	<i>Agency</i> (n = 77)	<i>Bank</i> (n = 18)
	%	%	%
<i>Any involvement from spouse/partner</i>	90	100	61
Support	56	70	56
Screening	40	75	6
Formal involvement	52	58	17

Note: Involvement categories listed here are not mutually exclusive.

Egg donor programs had more frequent, explicit expectations for this than sperm banks. Overall, 90% of clinics and 100% of agencies in my sample mentioned a donor’s partner in some capacity relevant to the donation compared to 61% of sperm banks. Clinics and sperm banks had similar rates of gauging partner support (56%), but egg donation agencies were significantly higher than both (70%). Egg donors’ partners were much more likely to be involved in medical or psychological screening than sperm donors’ partners (only one sperm bank involved partners in screening) and to be formally involved through signing consent forms, contracts, and other donation paperwork.

While these numbers give us some insight into patterns of practices across different organizations and type of donation (egg versus sperm), the second major aim of this analysis is to explore the justifications for and implications of partner involvement. Why are partners being called on to participate and what are the different understandings being created within egg and sperm donation practices? In the next section, I address the justifications for involving partners in donation programs. I argue that partners participate in at least three different roles: as sources of social support, as safeguards, and as stakeholders in reproductive decision-making.

Partner as Social Support

Social support is one issue that consistently arises in gamete donation. ASRM guidelines recommend that when programs psychologically evaluate donors, they should take a psychosocial history that addresses, among other issues, the donor's interpersonal relationships and any signs of marital instability when applicable (ASRM 2008). Social support from partners, family, or friends can help ensure that a donor carries out a cycle rather than dropping out early and disappointing potential recipients (Rosenberg and Epstein 1995). Patient literature for potential egg donors suggests that finding a good source of social support can be crucial as donors are confronted with "complex ethical, emotional, and social issues" (New York State Task Force n.d.). Like other protective mechanisms in medicine and gamete donation, however, encouraging social support, potentially walks a fine line between protecting a potential donor's emotional and social well-being and paternalism (Tong 2009).

Many of the programs in my analysis perceived partners to be a major and natural source of social support for both egg and sperm donors. Programs often assessed support indirectly by asking potential donors if they planned to or had already told a partner about their intentions to donate. This typically occurred during social-psychological evaluations. Donors were also frequently asked about partner and more general social support on their applications to donate:

If you are in a relationship at this time, have you discussed donorship with your spouse/partner? If so, what was their reaction? [id #90030, sperm]

Have you informed your family, husband or significant other of your desire/intention to become an egg donor? Yes No Please explain [id # 11, egg].

Although assessment of support was often indirect by asking the donor rather than the source(s) of support, a few programs made more direct efforts to gauge support. These efforts were only made by egg donation programs in my sample. One staff member noted that an in-house psychologist who interviewed all potential egg donors preferred to “touch base” with husbands to make sure that the donation would not lead to any marital disruption [id # 43]. Nineteen programs either requested or recommended that both the donor and her partner attend an initial orientation session so that the partner was aware of the donor’s intentions and could be informed about the procedure. Two programs included forms in donor packets for husbands to fill out, indicating whether they supported their spouse’s participation and detailing any objections they had [id#’s 5, 37]. Finally, a staff member from one program noted that potential donors typically would not pass the initial evaluation if they had not been open with their partners about their decision to donate [id # 20050440]. The sentiment expressed by many programs was that they wanted to ensure that potential egg donors had a good support network because of the relatively stressful demands of the donation cycle, the need to have someone drive them to and from the retrieval, and the psychological impact that the donation might have on them.

Although sperm banks also emphasized the importance of partner support, they did not appear to do any direct assessments of a donor’s support system. One program would consider rejecting a donor if he did not have partner support, but no sperm banks asked partners to attend orientation sessions or fill out forms expressing their attitudes about the donation. When the issue of partner support was explicitly addressed, it was phrased more in terms of donors’ decisions to seek/not seek support. One donor

coordinator noted that donors were “strongly urged” to inform their wives [id #90037]. A staff member from another program mentioned that they “encouraged” donors to talk to their partners and did “offer to speak with partners if the partner wishes” [id# 90033]. Personnel from two sperm banks mentioned that donors were explicitly not asked about their partners; one noted that a spouse might not even know about a donation if it was anonymous [id# 90041]. A staff member from the second bank expressed that the program did not want to “get involved” in the donor’s personal life by asking about partners because it was “outside of the business” [id # 90023].

The role of the partner as a source of social support was emphasized on the surface for both egg and sperm donation programs, but program policies and comments from staff suggested that assessing partner support was more crucial for egg donation procedures. Additionally, the issue of family and general social support was much more likely to come up for egg donors (48% of clinics and 58% of agencies compared to 28% of sperm banks). As such, I suggest that egg donation was more often construed as a decision requiring active social support and approval. In contrast, sperm donation appeared to be more of an individual decision where social support and social approval might be sought if the donor chose, but was not necessary to the process. These differences reflect earlier feminist critiques that women are perceived as more relational and embedded within family systems, whereas men were more likely to be viewed as independent from such systems (Thorne 1992; Rothman 1990). Such differences, however, may be doubly problematic if men who donate sperm do not receive or are not encouraged to receive social support to make such a weighty decision.

Partner as Safeguard

The ‘partner as safeguard’ was a second major way that programs seemed to conceive of partner involvement. This theme appears in the professional literature on gamete donation (e.g. Annas’ (1980); Seymour and Koerner (1936)) in terms of protecting the practitioner or program from liability and legitimating the transfer of gametes between donors and recipients. In my analysis of program materials, the ‘partner as safeguard’ role was variously enacted through involving partners in screening; involving partners in informed consent consultations; and having partners verify the content of a potential donor’s application.

Screening. Partners were regularly called upon by egg donation programs to be involved in either medical or psychological screening. Nearly 41% of clinics had policies for any type of partner screening and three-quarters of agencies set donor’s expectations for such screening. These rates may even underestimate the extent that partners are screened because one agency stated on their website that “9 out of 10 clinics will require your partner to get tested” [id# 47]. Psychological screening was less prevalent than medical screening, but there were also a few programs that requested *both* medical and psychological screening of donors’ partners. Only one sperm banks requested screening for sperm donors’ partners.

Medically screening donors’ partners potentially safeguards both the donation program and the gamete recipient. Although the FDA regulates donor screening, there are no requirements to screen sexual partners (ASRM n.d.). Donor sperm is STD tested, cryo-preserved, quarantined for six months, and re-tested. This is not required for donor eggs because of the lagging capability to freeze and thaw eggs without damage (ASRM n.d., Akin et al. 2007). Donors fill out detailed health histories, but screening their sexual

partner provides an extra layer of security in case a donor omitted or was unaware of having an STD or other transmittable disease. As such, there are some health justifications for medically screening partners in egg donation, but there is no apparent rationale for psychological screening. The ASRM currently recommends evaluation by a licensed mental health professional for all gamete donors (ASRM 2008) and has consistently recommended that egg donors' partners be involved, though not sperm donors' partners. The rationale for psychologically screening anonymous egg donors' partners is unclear and programs typically did not state why a partner would need to participate.²⁸

By including partners in medical and psychological screening potential egg donors do have to notify and *effectively* gain consent from a partner to agree to participate in the process. Although there are some legitimate health reasons for medically screening a donor's sexual partner, these may be largely based on fear that a donor is not fully disclosing personal health information (German et al. 2001). Psychologically screening a partner has no apparent rationale other than an additional layer of protection, perhaps by assessing that a partner is truly supportive of the donor's decision to donate. Overall though, requiring or strongly recommending that a donor's partner be involved in any type of screening is reminiscent of the paternalistic interference between a donor and her significant other that Pennings (1996) was decidedly critical of for sperm donation.

Informed Consent. Partners also acted as safeguards by participating in informed consent consultations. For example, the program below asked spouses to sign the

²⁸ This may be mentioned during face to face meetings, but it was not apparent in the materials I examined, including informational packets for donors.

informed consent form and encouraged both partners and spouses to be present at the consultation:

You will also meet with the ART physician to thoroughly discuss the risks and the benefits to you as an egg donor [...]. You will also sign an informed consent at this visit. If you are married or have a significant other, your husband or partner is encouraged to attend this visit. The spouse of a married egg donor is required to sign the informed consent [...] [id #20050003].

A typical consent form included a spousal signature statement such as the following:

I acknowledge by my signature below that I have read the foregoing and that all questions have been answered to my satisfaction, and acknowledge receipt of a copy of this consent form [id # 20050121].

In these instances, spouses were present to acknowledge that they and the donor had been fully informed of procedural risks and benefits. Often programs distinguished between legal and non-legal partners when requesting signatures. Here the partner is presumably safeguarding the donor from misunderstanding or not being fully informed about the procedure. He (since the reigning assumption is that the donor is heterosexual) is also likely acting as a safeguard to the program because informed consent consultations are increasingly viewed as a means for physicians to protect against future litigation (Meisel and Kuczewski 1996). Encouraging partners to be involved in these consultations may help to support potential donors in their decision-making, but requiring partner signatures and attendance places program interests ahead of donors' individual desires and undermines their ability to make these decisions on their own terms.

Verify Donor Information. A third, if less frequent, way that partners acted as safeguards was by verifying the content of a potential donor's application. Potential donors fill out applications containing various questions about their physical appearance, personal and family health, and social characteristics such as religious denomination and educational status. These are then translated into donor profiles for recipients to view. In

my sample, six clinics and six agencies had partners sign paperwork verifying what a potential donor reported in her application. This practice did not come up for sperm donation. One program required the potential donor and her husband to sign an “Egg Donor Investigation Agreement” [id# 20050408], which authorized a background check, if deemed necessary, and “investigation of all statements” in the application. Two programs included an acknowledgement at the end of the application for the donor and her partner to sign that the donor had “answered the above questions honestly” and did not “knowingly nor intentionally give[n] false or misleading information” [id #'s 20050415, 20050416]. Another program had the husband or boyfriend sign indicating that he was supportive and “believe[d] her answers on this questionnaire are true” [id# 90].

In light of escalating compensation as a major incentive for women to donate eggs, there has been some concern that potential donors would omit important medical information because it might eliminate them from the program (German et al. 2001). Additionally, some programs offer higher compensation to “exceptional donors” who have particularly desirable traits in terms of talents, or educational achievements (Holster 2008), which may provide an incentive for a donor to falsify her application. Here the partner is protecting the recipient and the program from any false claims the donor might be making about herself. Yet, none of the applications requiring partner verification indicated that an unpartnered egg donor needed someone to verify that she had accurately presented herself. This suggests that, in addition to protecting the program and recipient from a donor’s misrepresentation of herself, programs were also making sure the partner was informed about the donor’s intentions to donate.

Partner as Stakeholder

The third major way that programs conceived of the partner's role in the donation was by viewing the partner as a stakeholder in the donor's reproductive decision-making. This perspective echoes some of the ethical reasoning that Pennings (1996) pointed to in his discussion of sperm donors' moral obligations to their partners. The 'partner as stakeholder' role was apparent in how programs asked partners to participate in informed consent consultations and to sign as parties to various contracts. As stakeholders, partners acknowledged their own consent to the donation and were sometimes called on to relinquish any legal or parental claim to the donor's eggs, embryos, and any resulting children.

Although partners appeared to primarily act as safeguards in informed consent consultations, there were a few instances where programs seemed to acknowledge that partners were more integral to the donation decision. The content of the consent forms implied that the partner's signature held more weight than simply being informed of the procedure or bolstering the donor's understanding of risks and benefits:

I am the spouse of the donor. I have had explained to me, to my satisfaction, the various risks attendant to the donation of eggs and hereby signify *my agreement to my spouse's participation* in the procedure [Clinics 20050180, 20050186, 20050323, my italics].

I, (Donor's spouse) hereby certify that *I have no objection to my wife's donation* of eggs for use in the ART Program [Clinic 20050274, my italics].

These statements implied that programs were asking a spouse to provide his own consent to his wife's participation; he was not simply acting as a witness to her consent. There are no requirements in the U.S. that a woman must consult with her spouse prior to donating eggs (Stoddard and Fox 1996); however, the signature statements above suggest that some programs give the spouse the opportunity to veto or raise objections to his wife's participation. Furthermore, this policy seems directly contrary to the conventional notions

of informed consent and patient autonomy (Kuczewski 1996) because it actively requires partner involvement in the decision as opposed to ultimately leaving this decision to the potential donor.

Beyond providing consent, another key aspect of the ‘partner as stakeholder’ was to have them relinquish parental claims to the eggs, embryos, or resulting children. As the excerpt from one donation contract indicates, both husbands and partners were implied to have a recognizable interest in any children resulting from the donation, so their involvement was needed to protect the terms of the donation agreement:

Whereas, the Egg Donor and her Husband/Partner *do not desire to have a parental relationship* with any child born pursuant to this Agreement and believe the child is morally and legally that of the Prospective Parent(s) [id # 20050144, italics my emphasis].

As the excerpt below shows, in some instances, the partner’s involvement was predicated on the assumption that he had both a recognizable interest in and *claim to* the donor’s eggs as well as any children made possible by her eggs:

Donor and Donor’s Husband, if any, hereby agree that once the eggs are removed from the Donor, *they shall have no rights to said eggs* and further acknowledge that any and all embryos resulting from the use of Donor’s eggs and any children resulting there from shall belong to the Intended Parents. *Donor and Donor’s Husband*, if any, specifically agree that any child(ren) born pursuant to this Agreement are morally, legally, and contractually those of the Intended Parents and *they will not seek nor attempt to seek to form a parent/child relationship* with any child(ren) born to the Intended Parents [...] [italics my emphasis] [id # 117, 13].

Here both the donor and her husband are presumed to have *rights* to the donor’s eggs, which they agree to relinquish once the eggs are “removed from the Donor.” The wording of this contract implies that a married donor does not have sole control over the disposal of her body or its products; a marital relationship effectively alters the terms of her bodily control.

From another program, a staff member commented that husbands were included in donation contracts because they technically “owned” their wives’ eggs in the state

where her program operated.²⁹ Here the spouse moves from being a stakeholder in the donation decision to a proprietor of the woman's eggs. Although I found no legal statutes that this rested upon, this suggests informal professional understandings that may be more widely held. The assumptions in these contracts and agreements have also clearly evolved in different directions than Annas' (1980) and Robertson's (1988) understandings that gamete donation, as a procreative decision of one spouse, was legally protected from being vetoed or controlled by another spouse.

Discussion and Conclusion

The donor's spouse has been an often overlooked party in many of the dilemmas created by the NRTs. Although early medical and legal discussions about sperm donation stressed the need for spousal consent (Seymour and Kerning 1936), later on, scholars questioned the basis for this practice and whether it violated the privacy of the sperm donor (Annas 1980; Pennings 1996). Egg donation has taken a different trajectory. The egg donor's spouse or partner, though largely absent in the professional literature, has been more involved in both practice (Braverman et al. 1993; Cohen 1996) and professional guidelines (ASRM 1998, 2002, 2008). In current donation practices, partners appear to be much more extensively involved in egg donation than sperm donation. Programs had varying policies to include partners as sources of support, screening, and in more formal ways such as signing donation paperwork. Partner support was assessed at a similar rate by clinics and sperm banks—though it was mentioned much more frequently by agencies. Programs also tended to make more direct contact with egg donors' partners to gauge their support. Partner inclusion through screening and signing paperwork was much more likely to occur in egg donation programs than at sperm banks. I also

²⁹ For confidentiality reasons, I am not disclosing the state.

suggested that programs justified partner involvement through three major roles: as a source of social support, as a safeguard to the various parties in the donation arrangement, and as a stakeholder in the donor's reproductive decision-making. Egg donor's partners were also more likely to be cast in these roles, than sperm donor's partners.

Many of these informal policies appear to be linked to fears of “potential legal pitfalls” (Annas 1980: 1) anticipated by the medico-legal uncertainty of egg donation. Involving the partner protects various interests in the donation arrangement. Given the differences in egg and sperm cryopreservation (Akin et al. 2007), screening sexual partners bolsters the guarantee that egg donors are free from communicable diseases that might be transferred to the recipient. Having a partner verify the content of a donor application protects the recipient and the program from any false claims a donor might be making about herself. Involving partners in informed consent discussions and program agreements theoretically protects the program from liability and, perhaps, the potential donor from making an unwise decision. Having the partner formally relinquish parental rights provides evidence that neither the donor nor her partner had any parental intentions with those particular eggs, embryos, or any resulting children. While each of these practices may be professionally justified in terms of procedural risks and the relative uncertainty of egg donation, they also create controversy regarding how much a program can involve a donor's personal life and whether such practices overstep professional-client boundaries.

Intersections of personal relationships and medical and reproductive autonomy are complex boundaries to draw. For example, balancing women's reproductive

autonomy with personal relationships has been a controversial element of spousal consent for abortion (Ryan and Plutzer 1989) and mandatory parental notification for young women obtaining sexual health services (Reddy et al. 2002). Proponents of spousal consent and parental notification argue that the individual is embedded in significant social relationships, which are implicated in the decision(s) at hand. Yet, as Ryan and Plutzer (1989) observed, it is quite a different matter to assume that “the state has a rightful interest in regulating” (p. 42) how such relationships should figure in. In the context of gamete donation, this translates to whether or not practitioners should formally or informally regulate the involvement of donors’ significant others.

Although decisions to donate eggs should not be equated with decisions about abortion or contraception, egg donation practices may reach over into other reproductive decisions. Effectively requiring a partner to participate through screening and veracity checks on applications creates an understanding that practitioners can readily involve sexual partners at their discretion rather than a donor/patient’s discretion. Creating space for a spouse to veto a potential donor’s participation recalls earlier practices of gendered physician paternalism (Castel 1979; Ehrenreich and English 1973). Finally, if husbands (and partners in some instances) are thought to have legal rights to or ownership of their wives’ eggs, what does this mean for embryos, fetuses, and women’s bodily integrity?

Although gamete donation theoretically places men and women in more equal positions as donors (Englert et al. 2004), current practices analyzed in this study suggest that women do not have the same control to dispose of their eggs as men do with donating sperm. Furthermore, the double standards suggested by these local, practice-

based policies of partner involvement may have far reaching consequences more generally for women's reproductive and bodily control.

Chapter 7

Problematic Practices? Compensation and Selection in the Egg Donation Market

“\$50,000 Offered to Tall, Smart Egg Donor.” *New York Times*, March 3, 1999.

“A Baby, Please; Blond, Freckles -- Hold the Colic --- Laboratory Techniques That Screen for Diseases in Embryos Are Now Being Offered to Create Designer Children.” *Wall Street Journal*. Feb 12, 2009.

Abstract

Market-based health services have arisen out of major transformations in U.S. healthcare in the last several decades, with the increasing merger of business and medicine. This study contributes to the literature on private medical markets by focusing on a particular, under-explored market—human egg donation—and empirically addressing ethical concerns raised by the merger of business and *reproductive* medicine. Two major ethical concerns have emerged in egg donation: financial coercion of donors from dramatically increasing donor compensation and commodification through payment for the “donation” —especially payment for particular characteristics (e.g. race or education level). Drawing on data from fertility clinics and egg donation agencies across the U.S., I provide an overall assessment of how widespread ethically problematic practices are in the industry and I analyze how organizational, market, and other contextual characteristics impact whether and how clinics and agencies engage in these practices. Results suggest that these practices are influenced by market and contextual characteristics, as well as other factors relevant to the increasing commercialization of gamete donation. Furthermore, industry self-regulation through professional organizations and guidelines does not appear to deter members from engaging in these ethically questionable practices.

Introduction

In the U.S., the new reproductive technologies (NRTs), such as egg donation and in-vitro fertilization, are concentrated in a private medical market (Conrad and Leiter 2004; Holster 2008; Spar 2006). Market-based health services have arisen out of major transformations in the U.S. healthcare system in the last several decades with the increasing merger of business and medicine—what some have dubbed the “medical-industrial complex” (Relman 1980). Although social scientists have been particularly interested in medical markets, much of the sociological work has been mainly theoretical as opposed to empirical (see e.g., Conrad and Leiter 2004). This study aims to contribute

to the literature on private medical markets by focusing on a particular market that has been relatively under-explored systematically—human egg donation—and empirically addressing ethical concerns raised by the merger of business and *reproductive* medicine.

For human egg donation, two major ethical concerns have emerged in the potential for financially coercing donors to donate and the commodification of human bodies through payment for egg donation. Although egg donation is labeled as such, it frequently involves some form of donor compensation in the U.S. Egg donors are often depicted as potential victims of financial coercion especially since college students are popularly targeted to use donor compensation for college tuition (Gurmankin 2001; White 2001). Fears of commodification have mounted with the dramatic rise in egg donor compensation and payment for select traits, such as having a high IQ or a particular racial/ethnic background (Holster 2008; Almeling 2007; Pennings 2000). The Ethics Committee of the American Society for Reproductive Medicine (ASRM) has defended donor compensation but suggested that sums over \$5000 require justification and anything over \$10,000 is “inappropriate” (The Ethics Committee 2007). Among the ethical concerns expressed was that payments for particular traits implied that egg donation could be used for “positive eugenics” (p. 306) and the rising cost of donor eggs might create a market where only the very wealthy could afford egg donation.

The ASRM and the Society for Assisted Reproductive Technology (SART)—two major professional associations in reproductive medicine—provide industry and practice guidelines for many of the NRTs. Yet, much of the emphasis in these rising concerns has focused on consumer preferences, pointing to parents’ desires to select and enhance their future children as the driving force behind how NRTs will be used (King 1999; Silver

1999; Kolata 1999; Lemonick 1999). This emphasis overlooks how the industry constructs and offers options to consumers. Additionally, there has been little empirical research to address industry compliance with ethical guidelines. The research that does exist suggests that some programs decidedly operate outside of these guidelines for various reasons (Covington and Gibbons 2007; Levine 2010; Luk 2006).

In this chapter, I analyze trends for donor compensation levels and selective recruitment using data on fertility clinics and egg donation agencies across the U.S. I address two major questions: First, how widespread are ethically problematic practices in industry? Second, what organizational, market, and contextual characteristics are associated with such practices occurring? More broadly, I seek to address major ethical issues in the egg donation market with empirical, sociological insight. Having solid ethical guidelines, and ensuring that programs follow them, can provide important protection for both donors and recipients: they can protect women who are financially vulnerable from being unduly enticed to donate, and they can help ensure that intended parents do not have overly ambitious expectations for donor's socially valued traits to be passed on to donor-conceived children.

Background on the Issues

Donor Compensation

U.S.-based egg donation efforts initially began as a research project at the University of California, Los Angeles (Sauer 2001): donors were paid \$50 a day for participating. By the 1990s, donor eggs had escalated into a high demand, high price product in the medical marketplace (Spar 2006; Steinbock 2004). Compared to sperm donors, egg donors are currently given a much larger financial compensation. In 2007,

Covington and Gibbons noted a national average of \$4,217 for one egg donation cycle among SART-affiliated clinics. In contrast, sperm donors are typically paid \$50 to \$100 per sample (Almeling 2007; author's own data collection).

The much higher compensation for an egg donation cycle has been justified by the medical injections and procedures that a donor must undergo in order to donate (New York State Task Force on Life and the Law n.d.). Payment is for donors' "time, inconvenience, and discomfort," and is specifically not intended for the eggs themselves (The Ethics Committee 2007). Because of the relatively large sum, financial coercion of donors is a major ethical issue especially since younger donors, typically college aged women, are often targeted to donate because of their increased fecundity, which has been linked to more successful donation cycles (Cohen et al. 1999). ASRM guidelines recommend psychological screening for all donors to assess for possible coercion, among other mental health issues (ASRM 2008). Ethical guidelines also provide reasonable amounts for donor compensation (The Ethics Committee 2007), to explicitly minimize financial coercion. These guidelines, however, are not enforceable by any means other than professional authority and sanctioning. For example, agencies unwilling to comply with ethical donor compensation amounts are threatened with removal from an ASRM published list aimed toward consumers, but there are no other sanctions mentioned (Covington and Gibbons 2007). Without more effective sanctioning or regulation, what are current industry practices for donor compensation? Several recent studies suggest that compensation has not remained within the ethical limits (Covington and Gibbons; Levine 2010; Luk 2006). These studies, however, examine different subpopulations such as SART-affiliated clinics, egg donation and surrogacy agencies, or advertisements for

donors in school newspapers, making it difficult to assess overall patterns in the industry and what factors are relevant to donor compensation levels. In contrast, this study brings together the broader population of all known operating clinics and agencies in the U.S. that recruit egg donors.

Payment for Select Traits

Egg donation initially required many recipients to identify their own donors (Steinbock 2004). This limited patient choice as women often relied on a family member or friend who was both willing to donate and a good candidate, or received eggs from another woman in the patient population (Sauer and Paulson 1995). Donor choice increased as clinics began to offer pools of anonymous dedicated donors (i.e. women whose sole affiliation with the clinic was to donate their eggs) (Sauer and Paulson 1995) and egg donation agencies came onto the scene (Levine 2010). The issue of consumer choice in gamete donation is multifaceted. Arguments against choice have included creating “a child on command,” the perceived moral separation between medicine and markets (i.e. not opening up medical practices to supply and demand forces), and the slippery slope of choice leading into positive eugenics if prospective parents consistently preferred certain features over others (Pennings 2000; Schonfeld 2003). On the other hand, increased choice was a movement away from physician paternalism—if patients weren’t choosing their own donors, then physicians were, and patient autonomy should be respected in such major life decisions (Pennings 2000).

The troubling aspects of choice and commodification were apparent in the aftershock of a 1999 ad that appeared in newspapers at Ivy League and other top schools across the U.S. An infertile couple was willing to pay \$50,000 for a woman to donate her

eggs if she was 5 foot, 10 inches; athletic; scored at least 1400 on her SATs; and had no major medical problems (Kolata 1999). Other ads have offered anywhere from \$20,000 to \$80,000 to donors who meet certain criteria (Levine 2010; Steinbock 2004). These have raised questions about how selective prospective parents should be and how much or whether they should be allowed to compensate donors with certain characteristics. While some studies have analyzed prospective parents' interest in "designing" their children through various means available with NRTs (Hanson 2001; Dahl et al. 2006), there has been relatively little research examining the other side of the question: how frequently are such practices promoted by the industry?

Surveying SART-affiliated fertility clinics, Covington and Gibbons (2007) asked if all donors were paid the same compensation or if other characteristics factored in to the final amount. They gave examples such as prior donations, prior fertility history, and ethnicity. Eighty percent of clinics reported that these characteristics did not affect final donor compensation level. Of the 20% who replied in the affirmative, however, the authors did not request what specific characteristics increased compensation. Holster (2008) examined the content of 100 egg donation agency websites to explore the marketization of egg donation through the Internet. Eleven percent of the programs advertised "exceptional" or "extraordinary" donors who had a high GPA, high test scores (e.g. SAT), an Ivy League education, or a graduate or professional degree. These donors typically commanded higher compensation than other donors in the same pool, creating an explicit hierarchy. Additionally, in an analysis of practices at two egg donation agencies and two sperm banks, Almeling (2007) observed that non-white donors were considered scarcer and frequently commanded a higher compensation. These studies

suggest that programs explicitly place differential value on donor characteristics, but it is difficult to discern any systematic picture of overall trends or contributing factors. The egg donation market in the U.S. is decentralized, so it is also important to consider the impact of differing program, market, and contextual characteristics on donation practices.

Programs, Markets, and Contextual Characteristics

Literature on organizations and medical markets offer insight regarding program behaviors. I first address four major characteristics internal to the programs themselves: the organizational form, membership in professional associations, the length of time a program has been in business, and other relevant organizational routines. I follow this with external characteristics, which includes both the local market demographics and state and regional context that where programs are situated.

Internal Characteristics

The various organizations involved in egg donation constitute an organizational field “organized around a common substantive interest” (Aldrich and Ruef 2006: 40). Within such fields, there are often different organizational forms, based on “characteristics of an organization that identify it as a distinct entity and, at the same time, classify it as a member of a group of similar organizations” (Romanelli 1991:82). While there is no set classification scheme to identify these forms (Romanelli 1991), fertility clinics and egg donation agencies comprise two obviously distinct, but interrelated types of organizations. Clinics are staffed and directed by reproductive endocrinologists and other medical professionals such as nurses and andrologists; egg donation is just one service among many that they provide to infertility patients. Agencies are staffed and directed by a range of personnel, including previous donors, nurses,

reproductive lawyers, family practitioners, and former modeling agency CEOs (based on the author's own observations during data collection). They are solely focused on creating arrangements between donors and recipients and are considered to be more responsive to client desires than clinics (Treiser n.d.). Agencies are typically privately owned, stand alone businesses. Clinics can be private practices or based out of an institutional setting such as a university or hospital. Agencies and clinics provide different types of services to clients and they are accountable to different authority structures that may have differing organizational and institutional goals (Aldrich and Ruef 2006; Kralewski, Pitt, and Shatin 1985), so it is important to distinguish between these two organizational forms.

Most clinics and agencies are affiliated with either the ASRM or SART, which are two key professional associations in reproductive medicine. Scholars have addressed how organizations come to develop similar behaviors (Dimaggio and Powell 1983); one way is through membership in professional associations. Programs may develop similar practices out of the pressure to conform to professional norms provided either explicitly or implicitly by the ASRM or SART. These associations offer guidelines as well as (minimal) sanctions. As I noted previously, SART specifically lists egg donation agencies who have agreed to comply with their ethical guidelines on donor compensation and threatens removal if they do not comply (SART 2007; The Ethics Committee 2007). This list signals to consumers which agencies are acting in line with professional ethics and, presumably, are 'safe' choices for consumers to do business with.

Another important characteristic is how long a program has been in business. Demographic perspectives on organizations note the importance of cohort experiences for

organizational behavior (Aldrich and Ruef 2006: 164). Programs that have been around longer may be more steadfast about compliance with professional guidelines and more likely to follow the traditional medical model of gamete donation (Braverman 2010), which I describe in more detail below. In contrast, newer programs that are trying to succeed in an increasingly saturated market may use more aggressive tactics in recruiting and promoting donors, and take on a more consumer-oriented model of service to quickly gain customers.

A final major internal aspect to address is the combination of practices, procedures, and norms through which programs operate. These various formal and informal organizational behaviors are what Levitt and March (1988) labeled *organizational routines*. While the aim of this study is to examine two particular organizational routines (donor compensation and selective recruitment), there are other relevant practices to consider. I suggest three practices are particularly salient to the changing landscape of egg donation: anonymity versus openness between donors and recipients; the use of donor photographs; and the minimum age requirement for donors. Anonymous versus open donations and use of donor photographs both indicate underlying changes in egg donation as it is increasingly promoted in a medical marketplace (Braverman 2010; Holster 2008). The traditional medical model of egg donation preserved strict boundaries between donors and recipients and typically only allowed for discrete medical information relevant to the procedure (Braverman 2010). Options for semi-open or open donation arrangements and the ability to view photographs of donors are decided shifts away from this model toward more consumer-oriented practices. Donor minimum age is an important issue addressed in professional

guidelines from the ASRM and other patient literature. All donors need to be of legal age (18) to consent to the donation, but the ASRM further recommends that egg donors be at least 21 because of the more invasive medical requirements and the desire for donors to be mature enough to handle the emotional and physical aspects of the cycle (ASRM 2006, 2008). As such, setting the minimum donor age below 21 may be indicative of a program's willingness to more aggressively recruit young, college-aged donors or engage in other practices that do not entirely adhere to professional and ethical guidelines.

External Characteristics

Donation programs exist in various market and regulatory contexts across the U.S. In an economic analysis of fertility clinic markets, Hamilton and McManus (2005b) noted several market characteristics relevant to the growth of fertility clinics, including the total population and demographics such as median household income, and proportion of women who were employed and college educated. These market demographics were presumably linked to women's demand for and ability to access reproductive services. Higher educational attainment is frequently associated with delayed childbearing (Smock and Greenland 2010), possibly leading to age-related infertility (Maheshwari et al. 2008). Higher income and education are typically identified as key enabling factors for infertility helpseeking (Stephen and Chandra 2000; White et al. 2006).

Market structure is another important consideration. When organizations are competing for resources or clientele within the same environment, they may find niches of specialization to differentiate themselves from competition (Aldrich and Ruef 2006; Barman 2002). Programs faced with high levels of competition may recruit select donors

as a marketing strategy to differentiate their services from other programs,³⁰ whereas programs with low competition or a monopoly may have less impetus to create selective donor pools. There has also been some speculation that competition may influence programs to use NRTs more aggressively and disregard professional guidelines to bolster success rates and attract more clients (Henne and Bundorf 2008).

Beyond local market characteristics, programs may be differentially impacted by state and regional contexts. Particular areas of the U.S. have been prone to extreme growth for multiple or complex reasons; for instance, the fertility market in California, especially southern California, is known for being very “congested” (Spar 2006; personal communication, program staff members). Regulation can affect how the industry develops in certain states and can also affect consumer access and demand for specific services (Hamilton and McManus 2005a). Currently, fifteen states have passed insurance mandates for infertility coverage (ASRM 2005). These mandates differ in a variety of respects, but they theoretically mediate the relationship between consumer resources and the type or amount of reproductive goods and services consumers are able to acquire in the reproductive marketplace. Some research has shown that insurance mandates may increase the number of consumers seeking reproductive technologies (Hamilton and McManus 2005a; Schmidt 2007). Finally, my own communication with various program staff members across the U.S. has suggested there are different attitudes about gamete donation, particularly on the East and West coasts, which have resulted in different practices about information exchange and openness between donors and recipients. Other

³⁰ Some scholars of organizational behavior have theorized that competitiveness is not an extrinsic, market characteristic, but rather an intrinsic, organizational feature. For example, Barnett and McKendrick (2004) asked “Why are some organizations more competitive than others?” For this study, I did not have adequate measures of organizational competitiveness that they draw on (e.g. capacity, sales), although I do expect, based on differences addressed above, that agencies are more inherently competitive than clinics.

research has shown that donor compensation varies by region (Covington and Gibson 2007). As such, it is likely that there are other regional differences affecting donation program practices.

Method

Data

Data came primarily from a directed content analysis (Hsieh and Shannon 2005) of donor and recipient materials from programs across the U.S. See chapter three and Appendix A for more details on data collection. I also relied on some additional public data sources to create some of the measures in this chapter, which I report in more detail below. With help from three undergraduate assistants, I coded all program materials and records of communication for variables used here. This study relied on manifest content of program materials (i.e. explicit discussions of practices), so coder subjectivity was less of an issue. However, to bolster data reliability (Lombard, Snyder-Duch, and Bracken 2002), coding decisions were reviewed until absolute agreement was reached between the assistant coder(s) and the author.

Sample Selection

I used three criteria for the final sample of ART clinics: 1) clinics had to have in-house donor recruitment; 2) clinics could not solely work with known donors (i.e. when recipients use friends or family members as donors); and 3) for networked clinics, I selected only the main branch because others would have provided repeat information. 227 clinics met the selection criteria. I included all egg donations and commercial sperm banks currently operating in the US (n = 101 and 31, respectively). In total, there were

329 programs currently operating in the U.S. that recruited egg donors. After accounting for missing data, the final analytic sample contained 272 programs.

Missing Data

The main missing data strategy used in this analysis was listwise deletion, resulting in a reduction of 17.5% of the original cases. Below, in Table 7.1., I provide a comparison of possible differences between the full and the analytic sample. I also conducted additional analyses using multiple imputation. Although the ‘rule of thumb’ has been to impute 3-5 datasets (Allison n.d.), more recent work on imputation suggests that researchers need to impute many more datasets (Graham et al. 2007). Using this suggestion, I imputed 10, 50, and 100 data sets and conducted regression analysis on the pooled datasets each time. Overall, there were minimal differences among the imputed results for the 10, 50, and 100 datasets, and between the imputed results and the listwise results in each of the four regression models. As such, the models presented below use the listwise deletion strategy.

Measures

I addressed two major practices in this study: donor compensation and selective recruitment. I used two measures for donor compensation. *Compensation* indicated the dollar amount given for one donation cycle. *Ethical compensation* was a dichotomous variable indicating compensation less than or equal to \$5,000 (= 0) and greater than \$5,000 (= 1). This reflects the first major cutoff stated in the ethical guidelines: amounts above \$5,000 require justification (The Ethics Committee 2007). No programs in the sample indicated a starting compensation greater than \$10,000, so I left this as a dichotomous variable.

I also created two measures for selective donor recruitment. *Selective recruitment* included three practices: 1) requiring or preferring applicants to be college educated (achieved or in progress); 2) advertising “exceptional,” or “premier” donors available for a higher compensation level; and 3) specializing in donors with a particular racial or ethnic background, such as African American, Asian, Jewish, or Indian donors. If a program conducted any of these three practices, they were given a code of “1”; if they possessed none, they were given a code of “0.” The second measure for recruitment, *exceptional*, focused solely on the absence (=0) or presence (=1) of exceptional donor options, with higher compensation levels, at a given program. While the first measure tapped into a variety of practices that programs may engage in, the second measure addressed practices decidedly outside of ethical guidelines because exceptional donors are explicitly paid for possessing certain attributes.

I included three substantive blocks of variables to control for program characteristics, program practices, and market or contextual characteristics. Program characteristics assessed three major attributes: whether a program was an *agency* (=1) or *clinic* (=0); whether a program was *ASRM affiliated* (=1) or not (=0); and how many years a program had been in business. Data sources on ASRM affiliation differed for clinics and agencies. For clinics, I relied on documentation of the medical director on the current web-published ASRM membership list (www.asrm.org). For agencies, I relied on whether or not they were listed in the SART publication for ethical compensation compliance (SART 2007).

All program materials were scanned for indication of how long a program had been in business. If the exact year of founding was not apparent, I used the earliest year

mentioned, such as when a senior staff member had joined the program. If this information was not available, I used the first year that a clinic had reported their success rates to SART (reports run from 1995 to 2007). Because agencies do not report to SART, I used the year their website domain was first registered (utrace.org) if no other information was available. This measure is not ideal, but provides at least an approximate timeframe for when an organization started doing business.

I included measures of three other program practices: whether donation arrangements were *anonymous* only (= 1) or if non-anonymous options were available (=0); whether donor *photographs* were available (=1) or explicitly not used (=0); and whether the minimum age set for donors was less than twenty-one (=1) or twenty-one and older.

I used five measures to gauge characteristics of the local market area: relative income, proportion of college educated women, total population, whether a program had a monopoly (no other programs within a 20-mile radius), and whether a program was in a high competition locale (11 or more other programs within a 20-mile radius). I created the first three measures using data from the 2000 Census. Hamilton and McManus (2005b) defined fertility clinic market areas by Metropolitan Statistical Areas (MSAs); however, not all programs were located in MSAs. As an alternative geographic unit, I used Census places, which include towns, cities, and villages (U.S. Census Bureau n.d.). Census places are also potentially more meaningful units in terms of defining the areas where fertility consumers may be seeking services. I created *relative income* from a ratio of the median Census place income to the median state income in order to standardize across states with different standards of living. A higher value indicated a relatively

wealthier Census place within the state. I created an indicator for the proportion of college educated women by summing the number of women with any college degree (bachelor's and above) in a given Census place and dividing by the total female population. I used a logged measure for total Census place population after preliminary analysis showed a highly skewed distribution. To create the measures for monopoly and high competition locales, I geo-coded each of the programs in my sample and computed a distance matrix (Ersts n.d.). I created count variables of the number of clinics and agencies within twenty miles of all programs in my sample and then computed dummy variables using the categories from Henne and Bundorf (2008).

I included three additional contextual variables: whether a program was located in California (=1) versus all other states (=0); whether a program was located in a state with an infertility insurance mandate (=1) or not (=0); and whether a program was located in the Western census region (=1) versus all other Census regions (= 0).

Analytic Strategy

Donor compensation (in dollars) had eighteen categories, so I treated it as a continuous variable, using linear regression. The additional three outcome variables (*ethical_comp*, *selective recruitment*, *exceptional*) were all dichotomous, so I used logistic regression for these models.

Findings

Descriptives

Table 7.1 describes the analytic sample and provides a comparison with select data from all known, operating clinics and agencies in the U.S. that recruit egg donors. Most of the variables were quite similar across the two samples, suggesting that the

analytic sample for this study adequately represented the population of clinics and agencies across the U.S.

In the analytic sample, the clear majority of programs were ASRM affiliated. On average, programs had been in business for approximately 13.8 years, but this ranged considerably from just opening to having been in business for 45 years. Similar to the findings by Covington and Gibbons (2007), there was quite a range in donor compensation (\$2-\$10,000), but the sample average was close to \$5,000. Slightly more than one-third of the programs offered starting donor compensation greater than \$5000. This did not factor in programs with regular compensation below \$5000 who had additional compensation for exceptional donors. Nearly 22% had selective recruitment criteria, which included any of the following: 1) requiring or stating a preference for a college degree (achieved or in progress); 2) having exceptional donors; and 3) openly specializing in donors of a particular race or ethnicity. This is higher than the finding reported by Holster (2008), but I also used broader criteria. When the criteria are narrowed to only those programs with exceptional donor options, results are similar (8.8% compared to 11% in Holster's study). The majority of programs conducted only anonymous donations. However, most used donor photographs during the selection process, suggesting a partial movement away from the traditional medical model that restricted information sharing between donors and recipients (Braverman 2010).

On average, programs were situated in relatively higher income areas (1.2); however, relative income of a program's location also ranged from decidedly below the state median income (.6) to three times as much. The average proportion of college educated women was .3, but also ranged considerably from .03 to .90. These indicators

suggest that programs are situated in a range of contexts, which may impact both donor recruitment and criteria that clientele may have in looking for a donor.

Henne and Bundorf (2008) posited that different levels of competition, defined as the number of programs with a twenty-mile radius, might differentially affect program practices. They suggested that more than 11 nearby programs constituted high levels of competition. I explored the two extremes of competition here. Around 11% had a monopoly (no programs within 20 miles) and 16.2% had high competition from nearby programs. Twenty-two percent of the sample was located specifically in California, displaying the “congested” industry in that state (Spar 2006). An additional 14.3% were in the Western region of the country. More than half of the programs were located in a state with an infertility insurance mandate.

7.1 Descriptives for Full Versus Analytic Sample

	Full Sample ^a (n = 327)			Analytic Sample (n = 272)		
	M or %	SD	Min-Max	M or %	SD	Min-Max
<i>Program characteristics</i>						
Agency	30.6			34.6		
ASRM affiliate	78.9			78.7		
Years in business	13.9	8.0	1 to 45	13.8	8.0	1 to 45
<i>Program practices</i>						
Compensation (\$)	-	-	-	\$5,071.3	\$1,717.2	\$2 to \$10,000
Greater than \$5000	-	-	-	33.5		
Selective recruitment	-	-	-	21.7		
Exceptional donors	-	-	-	8.8		
Min age < 21	-	-	-	36.0		
Anonymous only	-	-	-	71.0		
Photos available	-	-	-	86.4		
<i>Market/contextual characteristics</i>						
Relative income (place/state)	1.2	0.5	.6 to 3.3	1.2	0.5	.6 to 3.3
Proportion college ed women	0.3	0.1	.03 to .9	0.3	0.1	.03 to .9
Total population (logged)	11.9	2.0	6.7 to 15.9	11.9	2	6.7 to 15.9
Monopoly	11.6			11.0		
High Competition (> 11 nearby)	17.4			16.2		
California location	19.6			22.1		
Insurance mandate	54.1			54.4		
Western region (exc. CA)	12.8			14.0		

^aOnly provides comparisons for variables with complete data.

Donor Compensation

Table 7.2 shows the linear and logistic regression results for donor compensation levels. There were similar characteristics associated with both the amount of compensation (in dollars) and compensation amounts greater than \$5000. These were primarily market and contextual characteristics. Compared to programs with low to medium levels of competition, those with a monopoly (no other programs within a 20-mile radius) had significantly lower compensation levels on average and were less likely to have compensation levels greater than \$5000. In contrast, programs in high competition areas (11 or more programs concentrated in a 20-mile radius) had significantly higher compensation levels and were significantly more likely to have compensation levels greater than \$5000 compared to those with low and medium levels of competition. Being in a state with an infertility insurance mandate was also strongly associated with higher average donor compensation levels. This is possibly indicative of the market responding to consumers' ability to pay (more) for reproductive services because costs are partially covered by health insurance and perhaps increase consumer demand as a result (Hamilton and McManus 2005a). An additional finding here was that programs with anonymous-only donations were less likely to have compensation levels over \$5000. This suggested that being able to meet a donor in person and learn more about them commanded a higher price in the industry. Taken together, these findings suggest the utility of incorporating both organizational as well as market and contextual characteristics into analyses of clinic and agency practices.

It is also worth noting here that ASRM affiliation was not a significant predictor of donor compensation level in either model. This indicated that professional guidelines were not necessarily deterring member-organizations from engaging in ethically

questionable practices. In the absence of more effective sanctioning, market-forces may have been more powerful in shaping organizational behavior, as Covington and Gibbons (2007) also noted.

7.2 Linear and Logistic Regression Results for Donor Compensation Levels (n = 272)

	Compensation (\$'s)		Greater than \$5000		
	B	S.E.	B	S.E.	Exp(B)
Program characteristics					
Agency	309.02	279.44	-0.63	0.46	0.53
ASRM affiliate	169.21	227.32	0.79	0.42	2.20
Years in business	18.64	12.63	0.02	0.02	1.02
Program practices					
Compensation (\$)					
Compensation greater than \$5000					
Selective recruitment	175.37	242.99	0.16	0.39	1.18
Exceptional donors	-388.71	365.78	-0.46	0.60	0.63
Min age < 21	-172.72	197.62	-0.23	0.33	0.79
Anonymous only	-149.41	258.51	-0.97 *	0.44	0.38
Photos	13.04	275.12	0.18	0.46	1.20
Market/contextual characteristics					
Relative income (Census place/sta	-160.22	322.19	0.19	0.52	1.21
Proportion college ed women	1428.73	1017.94	0.67	1.67	1.96
Total Census place population (log	10.69	59.54	0.07	0.10	1.08
Monopoly	-702.09 *	307.39	-2.45 *	1.06	0.09
High competition	831.27 **	276.17	0.81 *	0.41	2.24
California location	-504.33	275.02	-0.35	0.41	0.70
Insurance mandate	1370.27 ***	245.15	1.17 **	0.40	3.22
Western region	-303.51	293.09	-1.25	0.70	0.29
Constant	3661.88 ***	980.66	-2.70	1.64	0.07
R ² /Pseudo R ² (Nagelkerke)	0.32		0.30		

*p<.05. **p<.01. ***p<.001.

Donor Recruitment

Table 7.3 shows the logistic regression results for donor recruitment practices. Selective recruitment, as previously described, included any recruitment practices where programs specified or stated a preference for donors with particular characteristics, such as being college educated or having a particular racial/ethnic background. This measure also included programs that paid a higher compensation level to donors with specific characteristics (i.e., exceptional donors). The second model solely focused on the latter practice, which is decidedly against ethical guidelines (The Ethics Committee 2007). Agencies were significantly more likely than clinics to engage in selective recruitment in general and to offer exceptional donor options in their donor pools. This finding is intuitive, given that agencies are more likely to meet consumer demands by offering “hard-to-find” donors (Treiser n.d.) and provide recipients with their ideal “match.” No other variables were significant predictors of selective recruitment practices more broadly, but there were additional factors relevant to a program advertising “exceptional” donors. Programs offering anonymous-only donations were significantly less likely to advertise exceptional donors. It is possible that having options for more open donations and in-person meetings between donors and recipients may increase the pressure for donors to be construed as ideal and exceptional candidates. Surprisingly, competition from nearby programs was not a significant factor in donor recruitment practices, but programs located in California were significantly more likely to advertise exceptional donors than programs located in any other state. Because the industry in California is significantly more concentrated than in other areas across the country (Spar 2006), this

may have provided the impetus for programs to offer specialized services in a congested industry (Aldrich and Ruef 2006). Again, notably, ASRM affiliation apparently did not deter programs from engaging in these selective practices as affiliated programs were not significantly different from non-affiliates in their likelihood of selectively recruiting or advertising exceptional donors.

7.3 Logistic Regression Results for Donor Recruitment (n = 272)

	Selective Recruitment			Exceptional Donors				
	B	S.E.	Exp(B)	B	S.E.	Exp(B)		
Program characteristics								
Agency	1.68	***	0.48	5.37	2.11	*	0.94	8.27
ASRM affiliate	-0.45		0.38	0.63	0.39		0.63	1.48
Years in business	0.00		0.02	1.00	-0.03		0.05	0.97
Program practices								
Compensation (\$)	0.00		0.00	1.00	0.00		0.00	1.00
Compensation greater than \$5000	-0.12		0.60	0.89	0.55		0.91	1.73
Selective recruitment								
Execeptional donors								
Min age < 21	0.03		0.35	1.03	-0.48		0.59	0.62
Anonymous only	0.56		0.43	1.76	-1.87	**	0.74	0.15
Photos	0.19		0.60	1.21	-0.92		1.30	0.40
Market/contextual characteristics								
Relative income (Census place/state)	1.02		0.59	2.78	-0.38		1.04	0.68
Proportion college ed women	-0.52		1.90	0.60	-1.47		2.96	0.23
Total Census place population (logged)	0.18		0.11	1.19	-0.11		0.18	0.90
Monopoly	0.56		0.58	1.75	-1.53		1.34	0.22
High Competition	-0.05		0.47	0.95	-1.20		0.85	0.30
California location	0.59		0.46	1.80	1.99	**	0.78	7.29
Insurance mandate	-0.28		0.51	0.76	-0.51		0.82	0.60
Western region	0.38		0.53	1.47	-0.09		0.91	0.92
Constant	-6.30	**	2.00	0.00	2.75		3.04	15.70
Pseudo R ² (Nagelkerke)	0.20				0.42			

*p<.05. **p<.01. ***p<.001.

Discussion and Conclusion

This study aimed to empirically contribute to the growing literature on private medical markets and to focus on a particular market that has been relatively under-explored systematically in the U.S. I addressed two major questions, regarding key ethical issues raised by the market for human eggs. First, how widespread in the fertility industry are controversial practices such as high levels of donor compensation and recruitment of donors with select traits? Second, what organizational, market, and contextual characteristics are associated with these practices occurring? This analysis confirms that such practices are quite widespread in the industry—average compensation level was \$5000 and more than one-third of all programs had starting donor compensation over \$5000, excluding any additional boosts in compensation for those who may have fulfilled exceptional donor requirements. More than one-fifth of all programs engaged in selective donor recruitment (e.g., specifying a preference for race/ethnicity or education-level) and 8.8% specifically advertised exceptional or premier donors who were explicitly paid higher compensation for specific characteristics. The prevalence of these practices and the fact that ASRM affiliates were not significantly different from non-affiliates suggest that industry guidelines (The Ethics Committee 2007) are not being effectively considered on-the-ground, likely due to a number of factors, including the fact that this can be a fairly lucrative market (Covington and Gibbons 2007; Spar 2006). The latter is a particularly troubling finding because other than professional guidelines and sanctioning, there are no other regulatory mechanisms addressing these practices in the U.S. fertility industry (Levine 2010; Spar 2006).

The regression results give a more in-depth picture of what factors may be influencing these problematic practices. Overall there was not a consistent pattern of relationships for both compensation and recruitment practices. Yet, the general picture suggests that market-relevant factors drive both of these sets of practices in the industry, such as the level of competition from other programs; the presence of insurance coverage for consumers to afford more (costly) services; and whether a program is in the business of meeting consumers' desires either through offering more open options between donors and recipients or providing recipients with a "better" selection of donors (Treiser n.d.).

In *The Baby Business*, Spar (2006) urged us to seriously recognize the fertility industry as an industry and proceed with our analyses from there. Although she noted that her analysis did not "insist that this market is either good or evil" (p. xv), such questions have been taken up elsewhere, primarily from bioethical perspectives. The issues raised strike at the core of central social questions about the value we place on (different) human bodies (e.g. Schonfeld 2003). Although these are moral and philosophical questions, I suggest that any thorough analysis of these private medical markets has to be empirically informed by what actual on-the-ground practices are; whether these are consumer or industry-driven, or both; and their potential social impacts. Any move toward more effective regulation of this industry has to have some oversight of what is actually occurring, not just what should be occurring according to professionally sanctioned guidelines. Although previous scholars have focused primarily on consumer preferences in shaping how the NRTs will be used (King 1999; Silver 1999; Pennings 2000) this analysis suggests that we need to turn more attention to the industry itself and whether self-regulation is effective in private medical markets.

Chapter 8

Conclusion

I began this project largely on the premise that the NRTs—and particularly gamete donation—have produced a variety of issues and dilemmas receiving plenty of theoretical attention, but lacking empirical insight. My overarching aim was to contribute to the latter as our society continually experiences the need to respond to these technological developments. I addressed four major substantive questions:

- How do organizations in the fertility industry help to create and delineate families?
- Do they facilitate particular definitions of family?
- Do egg and sperm donors, as men and women involved in analogous reproductive decision-making, have similar control over donating their reproductive cells?
- What issues are posed by gamete donation in the context of a medical marketplace?

In focusing on these questions, my interests have been largely shaped by my commitments to feminist sociology and my desire to address the fertility industry and gamete donation as potential sites for reinforcing or altering social institutions and social inequality. Yet, I am also interested in conducting research that is relevant to the lives of those who are participating in these technologies: the doctors, donor coordinators, social workers, donors, recipients, and newly created families. I imagine that many people who are in the ‘baby business’ (Spar 2006) enjoy the thrill of helping people create families in

the face of medical and social barriers; but I also think that this industry has to reconcile its actions with public attitudes and issues of social justice. Feminist scholarship on *stratified reproduction* (Colen 1986; King and Meyer 1997) has shown that some people are empowered to reproduce, while others are discouraged and disempowered. Building on the work of prior feminist scholars (Agigian 2004; Barney 2005), my research suggests that this continues to exist, particularly for lesbian and single women. In a future project, I hope to address this for single and gay men as well and examine their personal experiences (and obstacles) becoming fathers with the help of the NRTs. These are important issues to address for postmodern family building: is the industry resistant to or supportive of different family structures? Can they facilitate models of family that stretch far away from the notion of the patriarchal, nuclear family? Some organizations in the industry seem to be open to this (see chapters four and five), but others appear more conservative, perhaps afraid of the social and legal repercussions if they transgress too far.

Actors in this industry also need to be well-versed in the bioethical issues that emerge in and through their work. Reproductive and medical autonomy are major issues in reproductive healthcare, but too often donors (and their partners) go unnoticed in these discussions, or the focus is only on particular issues, such as emotional or financial coercion. I am hoping that my discussion here can contribute to more extensive interdisciplinary dialogue on this issue. Along this same vein of ethical issues, the intense focus on the donor compensation-exploitation debate has created a lot of awareness within the industry, but not necessarily compliance with professionally endorsed ethical guidelines. This definitely deserves further exploration because it suggests that industry

self-regulation is not necessarily the best model. Spar's (2006) argument for recognizing the fertility industry as such is well-taken here, but this also needs to be an industry that is well-aware of the central social issues it deals in: definitions of conception, pregnancy, parenthood, and affiliation.

As I'm wrapping up this project, two new events are on the public radar: a recommended 5-year probation for the doctor who implanted the embryos into Nadya Suleman (AKA "Octo-mom") and the arrival of the "Twiblings" –twin siblings born with the assistance of two different gestational carriers. These events, like others that have preceded or followed them, raise numerous questions. Should Octo-mom's doctor have his license revoked? No, says the judge reviewing his case, that would be too extreme and "the public would be adequately protected" by the probation (NBC New York 2011). What about the fact that the doctor "asserted he might still deviate from the ASRM [...] guidelines" (NBC New York 2011)? Is public uproar enough to keep practitioners from stepping away from suggested ethical practices? Is he an unethical practitioner or a practitioner who stretched the boundaries because he didn't want to tell a patient she couldn't have a large family? Both suggest the limits and problems of "privacy" and "choice" in reproductive decision-making.

Then enter the 'twiblings,' the final outcome of one couple's long journey through five rounds of IVF, adoption applications, egg donors, and gestational carriers. Melanie Thernstrom is the main character here, writing about her quest for a child. She envisions herself finding carriers who are like "female relatives — women with whom it was fun to shop for baby things and who would give us advice on actually caring for the babies and make it all seem doable" (Thernstrom 2010). The doctor, who had to be

heavily persuaded to let her undergo a fifth round of IVF, is marginal; the surrogacy agency (that they decided not to work with) attempted to dissuade them from thinking they would want to form close bonds with their surrogate. How will this turn out in five years? Ten? Can new types of human bonds be forged without having socially sanctioned terminology and expectations for them? I think Thernstrom aptly captured the conundrums of this:

Third-party reproduction creates all kinds of relationships for which there are not yet terms. [...] there is no word to describe the relationship between our children and the carriers' children, but it feels to me that they are, somehow, related. [...] There is also no word to describe our children's relationship with each other. Our children were born five days apart — a fact that cannot be easily explained. When people press me about their status ("But are they really twins?"), the answer gets long. [...] If the person continues to quibble about whether they really qualify as twins (as, surprisingly, people often do), instead of asking why it matters, I announce airily that they are "twiblings" (Thernstrom 2010).

Like many others, I think the NRTs will continue to produce these ethical dilemmas and awkward social situations for users, practitioners and the public, because they strike at the core of how we attempt to socially and culturally define what it means to create and be families. Franklin (1995) offers a useful phrase, describing the impact of the NRTs as 'postmodern procreation' where "boundaries are breached, leading to a crisis of legitimacy [...] in traditional beliefs about parenthood, procreation, and kinship" (p. 335). So where do we go from here? I think this project and the matrix of social issues and relations that it is embedded in raises both theoretical and practical implications for some next steps. In the following sections, I address each of these aspects in more detail.

Theoretical Implications

One overarching theme here is that while existing sociological theory can provide a jumping off point to address many of the issues raised in this project, it is clear that it is not enough to adequately capture the new social forms and new social issues that are

created by the NRTs. While feminist sociologists have analyzed reproduction as a key entity in human society, they have been less successful than other disciplines (e.g. anthropology) at bringing critical analyses of reproduction from the margins to the center (Rapp 2001). The sociology of reproduction as a field of study (separate from the demographic analysis of human fertility) is still coalescing if we look at scholarly endeavors, such as publications and conference time allotted to such topics. The plus side to this is that there is plenty of work to do. The downside to this is that we are still in need of a better theoretical toolbox, especially as feminist theorizing on reproductive technologies moves into a more ambivalent, postmodern framework (Thompson 2002).

So what are some of the theoretical tools that we need? Based on the work in this project, I think we need to focus on three issues in particular: 1) more theory-building on postmodern families; 2) better understanding of the complex workings of medical markets; and 3) an increasing dialogue between bioethics and social sciences.

More Theory-Building on Postmodern Families

Feminist and family studies scholarship has created the concept of postmodern families to replace traditional sociological understandings of “the modern Family” as a monolithic institution (Thorne and Yalom 1992; Cheal 1993). We now have a host of theorizing on topics such as ‘families we choose’ (Weston 1991), blended families (Baxter, Braithwaite, and Nicholson 1999), and single parents by choice (Bock 2000), among others. Yet, we still have theoretical gaps when it comes to applying these tools to understanding gamete donation and other forms of third party reproduction. I described in chapter four how organizations actively manage donor, recipient, and child relationships, but this is only the beginning of the family process. There is a lot left to understand about

how these relationships survive, dissolve, and create tensions as the child grows. Some newer scholarship has begun to focus on how parents with donor-conceived children interact with their own extended family in legitimizing the child as a family member (Becker, Butler, and Nachtigall 2005) and attempts to disambiguate kinship when family members donate gametes (Thompson 2005). Recent work by Hertz and Mattes (2011) is also starting to ask questions about the relationships between donor-siblings (children who share the same donor) and their parents. Are they family? Is there another way to describe such social bonds? Other anecdotal stories have also appeared, focusing on the third parties' perspectives about their roles (e.g. Hennessy 2011). It is clear from this growing body of work that there is no simple understanding to these issues. It is also clear, as Melanie Thernstrom noted with her "twiblings," that we lack the language to be able to describe many of these newer forms of social relationships. These in a way are the epitome of truly postmodern relationships arising from and reinforcing postmodern family forms. As such, one of the tasks that lie ahead is to generate a better theoretical understanding of the variety of relationships that the NRTs can create and the taxonomy that the participants themselves use to talk about those relationships.

Better Understanding of Medical Markets

A second theoretical gap that became apparent as I worked on this project was that although social scientists have produced significant work on the topic of medical markets, there is 1) a need to further our understanding of the workings of these markets in general as well as addressing particular types of medical markets, and 2) a need for feminist scholars to pay more attention to this topic.

Regarding the former, sociologists have frequently drawn on the now-classic work of Richard Titmuss (1997) on economies of human blood to conceptualize different modes and consequences of markets in human bodily goods. Titmuss's analysis provides thought-provoking distinctions about altruistic models versus transaction-based models of distributing human blood. Many of these ideas can be imported into thinking about markets in reproductive cells and reproductive labor; however, in other ways these conceptualizations are not enough to address all of the issues raised by the fertility industry. Feminist scholars have helped to stretch our understanding here by pointing out that gender inequality is fundamental to understanding reproductive cells and reproductive labor. In particular, they have reminded us that altruism, which is the preferred model in Titmuss's work, is highly gendered and has more often than not been used to exploit women (Tong 1996) even as it may produce a more morally palatable system. But, as I addressed in greater detail in chapter seven, there are also significant problems with putting a monetary value on reproductive cells. When does this become coercive? We have some guidance here from the ASRM Ethics Committee (2007), but this topic needs more extensive empirical research. How does payment affect donor and recipient experiences and relationships? Recent work by Rene Almeling (2011) begins to address part of this question, but again there is much more empirical work needed to bolster the ethical and philosophical work that has been addressing these issues.

We also need to better address how medical markets are distinct from other types of markets. Some scholars have started this task (e.g. Conrad and Leiter 2004; Spar 2006), recognizing that medical markets are a "theoretical anomaly" (Light 2000: 395)

because they do not fit neatly into existing theories about competitive marketplaces. In this same vein, Spar (2006: xvi) observed:

[T]he baby market does not operate like other markets do. There are differential prices that make little sense; scale economies don't bring lower costs; and customers who will literally pay whatever they possibly can. [...] the fundamental rules of commerce [e.g., property rights, etc.] are conspicuously absent.

As such, we cannot solely rely on existing theories—we need to develop better understandings of how the concept of value in particular is differentially applied in this type of market and how it applies more broadly to other markets in human bodily goods. This would help to further contextualize some of my findings in chapter seven—especially the finding that clinics and agencies with geographic monopolies actually have lower rates of donor compensation than those in more saturated markets. This is a finding that is the opposite of how competitive markets *should* work as traditionally conceptualized.

The second point that I raised above is that feminist scholarship needs to pay more attention to medical markets. Of the existing feminist literature, commodified reproduction, often surrogacy contracts, has been the major focus (e.g., Mahoney 1988; Rothman 1990). But this over-emphasis on surrogacy does not adequately prepare us to analyze other forms of exchanges. Can these same theoretical perspectives be applied to gamete donation? Blood and organ donation? Human milk donation? In chapter six, I raised several issues about oversights in existing feminist theorizing, especially regarding the notion of reproductive autonomy in gamete donation. I think we need to (re)conceptualize gamete donation as a type of reproductive decision, not just a medical decision. Then we can start to think about the various ways that this particular decision is

interconnected with other reproductive decisions such as pregnancy, abortion, and adoption.

Dialogue between Bioethics and Social Sciences

The third major theoretical implication woven throughout this project is the notion that there should and can be a greater dialogue between sociology and bioethics when it comes to analyzing the various issues posed by the NRTs. As I noted in the introductory chapter, empirical work lags greatly behind theoretical and ethical discussions generated by the NRTs (Markens 2007; van Balen and Inhorn 2002). This theoretical work is largely produced by scholars in disciplines other than the social sciences, yet we have much to bring to the table. De Vries et al. (2007) acknowledge that bioethics and the social sciences have historically had a “troubled relationship”: lines have been drawn designating social science work as empirical and descriptive and bioethical work as focusing on the normative questions of human society (p. 1). Yet such distinctions are not so simple to make here. For one: this excludes the possibility of critical or feminist social science perspectives, which are explicitly normative in approach to empirical questions. A second issue is that, especially with feminist scholarship, disciplinary boundaries are often breached: feminists have historically drawn on a range of theorizing from different disciplines; concepts and orienting perspectives are regularly imported and exported to suit a variety of purposes. This should be quite clear from my analysis in chapter six, where I draw on the concepts of medical and reproductive autonomy: autonomy is a core concept in bioethics, but bioethicists do not lay sole claim to it. My theoretical use of it in this project deploys work from feminist legal scholars, bioethicists, sociologists, and science studies scholars.

In chapter five, I approach the issue of barriers to lesbian and single women as both an empirical and a normative problem. As I argued in the introductory chapter, to assess whether barriers exist in the first place, one must first acknowledge that lesbian and single women can and should become parents. In chapter seven, I orient the empirical problem of what drives donor compensation and selection with discussions largely drawn from the bioethics literature. These only become “problematic practices” if we define them as such. While other scholars may approach these practices from purely an economic standpoint, my interest in gender inequality and human relationships makes this a normative exploration.

So what can social scientists bring to the table here? I do think we bring the power of empirical research as a means to be able to further our understanding of how various parties are conceptualizing what is and isn’t ethically problematic, and understanding what practices *are* occurring as opposed to what *should be* occurring. I think the systematicity of large scale data analysis can be an incredibly useful tool when we are looking at an industry, like the U.S. fertility industry, that is largely decentralized. I also think the power of various qualitative methodological orientations, such as grounded theory (Charmaz 2006), can be a useful endeavor here for working from the data and generating new theoretical insights.

Practical Implications

This projects also points to some very practical implications. For starters, I think we need to have comprehensive, but flexible mechanisms in place to better help individuals, couples, and families define and protect their relationships with one another. In chapter four, I addressed how organizations aim to mediate and contain donor,

recipient, and child relationships. Much of this containment is due to fear that various parties will cross boundaries, that donors may attempt to gain custody of donor-conceived children, or that donors may find themselves with parental rights that they thought they had successfully transferred to other people. Unfortunately some of this fear is based on actual court cases (e.g., Raeburn 2010) and the rather infamous Baby M case in the 1980s, which pitted a traditional surrogate's claims to biological motherhood against the biological father's rights (Pollitt 1995). And, if we thought surrogacy was complicated, egg donation breaks motherhood down into even smaller fragments: the egg donor, the gestational carrier (i.e. the woman that provides the womb), and the intended social mother. Potentially up to three women can lay some sort of parental claim on a donor-conceived child with these new technologies. The current patchwork of regulation, which I described briefly in chapter one, varies extensively by state and may not cover or transfer to defining parental rights for all the various forms of third party reproduction. This can leave intended social parents in fear that they are not legitimately recognized by the state—a fear that is exacerbated if we are discussing alternative families, such as single parents by choice, and same sex couples who co-parent. Regulation, however, has not often been a feminist-friendly recommendation because too often it works to deny or reduce women's access to reproductive services (Lublin 1998). As such, we need to proceed cautiously and think about the interconnections of the NRTs with abortion politics, pregnancy politics, and the broader matrix of relations that contextualize reproduction.

The second major practical implication arising from this project is regulation of industry practices. I addressed this problem most explicitly in chapter seven. The fertility

industry in the U.S. has been described as the “Wild West” of the global fertility industry (Yoshino 2009) because we lack any cohesive, national regulation of the NRTs. While there is some oversight by the CDC and the FDA, much of the regulation is internal: the ASRM and SART—professional associations for practitioners—lay down best practice guidelines and ethical standards. They are also in charge of enforcing these standards when they see fit. Although these bodies do sanction clinics and agencies that do not abide by certain standards (e.g., ethical donor compensation levels), the sanctions have no teeth: organizations are told they will be removed from a published list (SART 2007), but there are no other penalties.

My findings in chapter seven suggest that membership in these professional associations does not deter clinics and agencies from engaging in unethical compensation and selective donor practices. This raises several questions: Why aren't these organizations abiding by their own professional standards? What are the inherent problems with industry self-regulation? Can we create a work-able framework for external regulation? Here is an area where it would be fruitful to explore cross-national differences in approaches to regulating the NRTs. What can we learn from other ways of organizing this industry? Some work is being done now on reproductive tourism—how restrictive policies in some countries lead intended parents to travel for reproductive services (Inhorn and Patrizio 2009), but we need to also include a more systematic comparison of benefits and disadvantages of different regulatory systems that are in place.

Through working on this project, it has become clear to me that these various debates and dilemmas are ultimately more complex the more that you learn and think

about them. For instance, I initially approached my analysis in chapter six, thinking that egg donors should be able to donate their gametes without any partner or family input as I found that sperm donors are typically treated. Yet as I became more entrenched in the literature and my analysis, I could understand why some of the organizations wanted partners or family members to be supportive—gamete donation after all is a life-creating/life-altering decision. In other words, throughout the process of my work, I realized that even the issues I initially thought were quite black and white (i.e. this is oppressive or not for women) turned out to be much more morally ambiguous. As such, I think the best approach for wrapping everything up is to raise additional questions, point to areas where the work is far from being done rather than create a list of specific policy recommendations or firm conclusions. One thing for sure is that professional guidelines, ethical approaches, and industry regulation cannot just be informed by top down theories and protocol: they have to involve analyses of on-the-ground practices and analyses of donor, recipient, and donor-conceived children's experiences. This is an endeavor where practitioners, bioethicists, social scientists, and policymakers have to work hand-in-hand. This cannot be anything other than a poly-vocal social project.

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Appendix A Response Rate and Missing Data Analysis

This appendix describes the final response rates and missing data. Because each chapter focused almost exclusively on a different set of variables, I address overall response from organizations and then focus on missing patterns more specific to each substantive analysis. Table A1.1 displays the initial sampling frame for each type of organization and the final sample sizes for those with onsite gamete donation programs recruited commercial (i.e. not family or friends) donors.

A1.1 Sampling Frame and Onsite Donation Programs

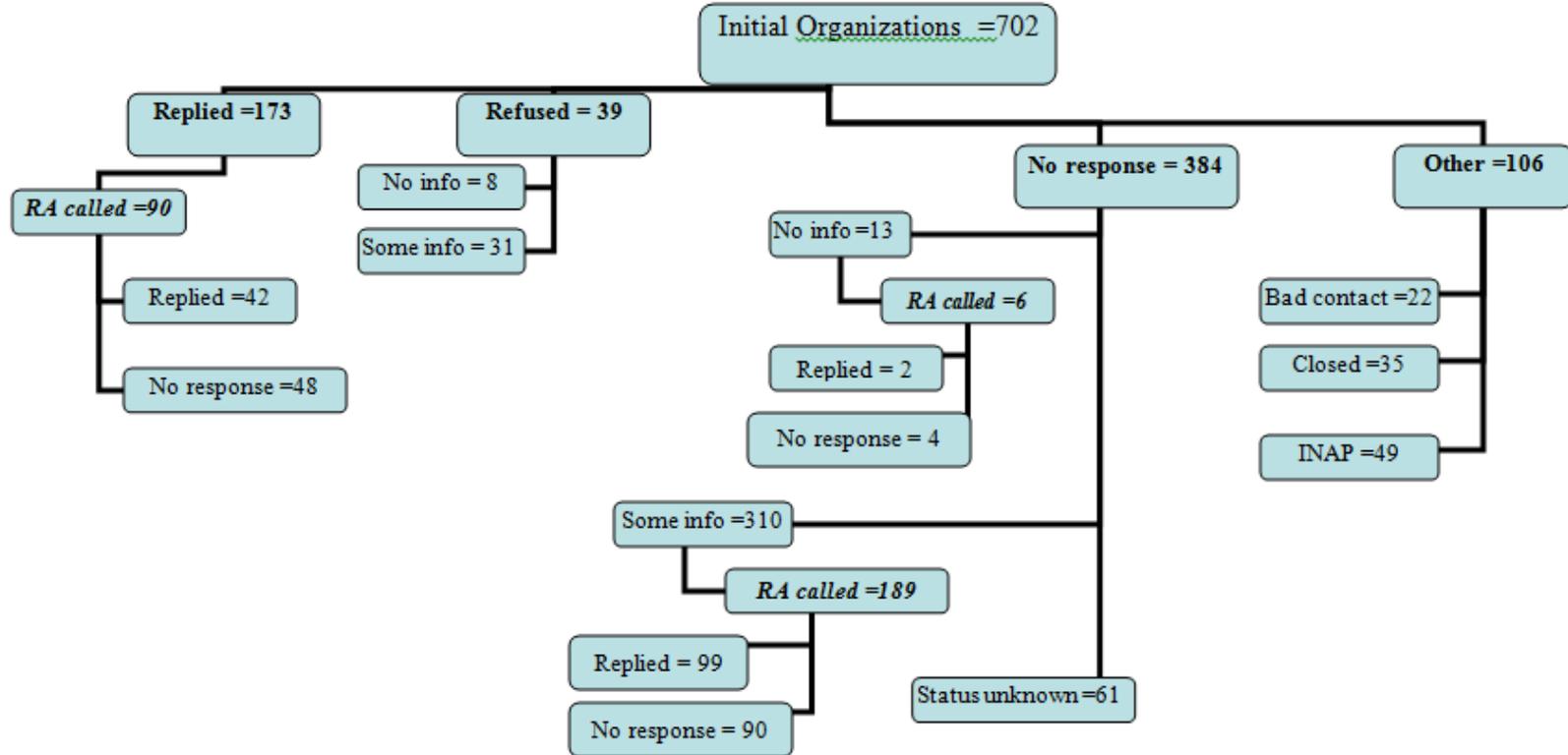
	ART Clinics	Egg Donation Agencies	Sperm Banks
Sampling Frame	516	130	55
Sampling Source	SART/CDC Data ASRM, clinic referrals, HRC, ACS, AATB Resolve, AFA		
Onsite Donation Program ^a	227	101	31

^aBased on analysis of websites (list of services), and mail, email, phone contact.

The majority of my analysis relied on data from organizations with these onsite donation programs. I attempted contact three times with a program, via, mail, email, or phone, before assigning a response disposition code. Later, a research assistant did follow up calls with some organizations that were still missing on key variables (see chapter three for more detail on her calls). Figure A1.1 shows the response tree in terms of the initial sampling frame, dispositions for three attempts at open contact, and responses to follow-up calls from the RA. The initial sampling frame of clinics, agencies, and sperm banks included 702 organizations. For the first round of open contact, I excluded any clinics that were networked or did not list egg donation as a service on their website (these fell mainly under the INAP category). Of the clinics that I did attempt to contact, 173 replied, 39 refused, 384 were non-responsive, and a few had outdated/no contact information, or had closed down. Of the non-responsive clinics, I was unable to gauge

whether sixty-one of these had any sort of egg donation services after attempting contact, so they were omitted from the sample. An RA conducted follow-up calls with 285 organizations that were presumed to have onsite donation programs (for sperm banks, she identified herself openly as my research assistant, given the nature of questions she was asking; for clinics and agencies, she identified as a potential donor). She was able to gain additional information from 50.2% of these. Table A1.2 shows the final response dispositions for each of the types of organizations. These three dispositions were created posthoc from tallying the available data across variables used in the four main substantive chapters: no information, partial information, complete information.

Figure A1.1 Organizational Response Tree



A1.2 Response Dispositions for Organizations with Onsite Donation Programs

	ART Clinics n = 227 %	Egg Donation Agencies n = 101 %	Sperm Banks n = 31 %
Complete	44.5	60.4	51.6
Partial	55.5	39.6	48.4
No info	0	0	0

I had more complete case data for both agencies and sperm banks compared to clinics. However, for all types of organizations I was able to gain some data. There were no cases with completely missing data in the final analyses (unless they had been removed from the sample because of unknown status).

Missing Data

Table A1.3 summarizes the overall patterns of missing data by organizational type. This shows how much data was available within the above mentioned category “partial information.” The majority of cases had less than five missing variables across all three types of organizations. No sperm banks had more than three missing variables. Around 10% of clinics and 2% of agencies were missing five or more variables, so overall, even cases with partial information had the majority of the data available for variables used in this project. In the next section I turn to each of the four main chapters to show available data for those particular variables as well.

A1.3 Amount of Available/Missing Data

# Missing	ART Clinics n = 227 %	Egg Donation Agencies n = 101 %	Sperm Banks n = 31 %
0	44.5	60.4	51.6
1 to 4	45.4	37.6	48.4
5 to 9	9.6	1.9	0
10+	0.4	0	0

Substantive Analyses. Chapter four was the first of the substantive chapters and focused on donor-recipient information exchange and maintaining family boundaries. As

part of the quantitative analysis, I coded four variables describing program policies: 1) photographs 2) anonymity 3) cycle outcome, and 4) post-cycle contact. Table A1.4 shows the available data on these four variables.

A1.4 Available Data on Chapter 4 Key Variables

	ART Clinics n = 227 %	Egg Donation Agencies n = 101 %	Sperm Banks n = 31 %
Photos	89	100	80.6
Anonymity	96	98	96.8
Cycle Outcome	58.9	69.3	51.6
Post-cycle Contact	59	74.3	51.6

Overall, data was most consistently available on whether donations were anonymous during the cycle, followed by whether donors provided photographs to the program. As such, findings on cycle outcome and post-cycle contact should be interpreted with caution because there was significantly less data available on these types of policies.

In chapter five I examined the differences in clinic website references and valence toward non-traditional families, specifically those created by lesbian and single women. In this chapter I relied entirely on the clinic sample and only used clinics with a web presence. Because of selection criteria detailed in the chapter, my final sample contained 402 clinics. A chi-squared test showed no significant association between region and non-working websites, suggesting that the remaining clinics, if selected for inclusion, were generally representative of the clinic population.

Chapter six focused on spouse and partner involvement in egg and sperm donation. From a content analysis of donation materials, I coded for three types of spouse or partner involvement: partner support, partner screening, and formal involvement.

Table A1.5 displays the breakdown by the type of program and data available. Overall, I had at least some information on modes of partner involvement for more than half of all clinics, agencies, and banks, but there was a significant amount of missing data across all three of these variables. The percent of available data was much lower for these variables relative to those in other chapters because many of these were only found in donor materials (as opposed to being readily available on websites) or through communicating with program staff. As such, additional analyses were conducted to address how representative this data was of the general sample of clinics, agencies, and sperm banks.

A1.5 Available Data on Chapter 6 Key Variables

	ART Clinics n = 227 %	Egg Donation Agencies n = 101 %	Sperm Banks n = 31 %
Partner Support	51.5	69.3	54.8
Partner Screening	56.8	72.3	51.6
Formal Involvement	61.7	66.3	54.8

Table A1.6 compares programs in the full sample with those in the analytic sample on key contextual variables for which I had data. Clinics and agencies in the northeastern region were somewhat underrepresented and both clinics and agencies from California were somewhat overrepresented in the analytic sample, but overall, characteristics were similar between the two samples.

A1.6 Comparison of Full Sample with Analytic Sample for Chapter 6

	Clinic		Agency		Bank	
	Full (n = 227) M or %	Analytic (n = 126) M or %	Full (n = 101) M or %	Analytic (n = 77) M or %	Full (n = 31) M or %	Analytic (n = 18) M or %
Northeast	26	19	19	15	29	33
Midwest	19	20	12	10	26	22
South	21	31	19	17	7	6
West	13	14	13	12	16	17
California	12	16	38	46	26	28
Years in business	16.2 years	15.7 years	8.7 years	8.8 years	23 years	23.6 years
ASRM member	81	82	75	74	-	-

In chapter seven I addressed donor compensation and whether egg donation programs selectively advertised or recruited their donors. I used several variables in these analyses both from primary data collection (see chapter seven for discussion of measures) and other data sources (see chapter three for this table). For a comparison of complete cases with the larger analytic sample, refer to Table 7.1 in chapter seven. I did conduct additional analyses using logistic regression analyses to predict whether I had no versus any information across various characteristics for which I had complete data for all clinics and agencies: region, years in business, ASRM membership, industry density; program in a state with an infertility insurance mandate (yes/no); total population of a program's Census place; percent of women with a college degree in a program's Census place; and the ratio of median income of a program's Census place to state median income. None of the variables were significant in the regression analysis, suggesting that there were not any major contextual differences for the complete case data relative to the full sample of clinics and agencies.

Appendix B

Sample Coding Task

This is an example of a coding task that one research assistant (RA) was asked to complete. The two variables created in the master data file were “compensation” and “compensation_notes.” Compensation refers to donor compensation amount in dollars for one donation cycle. Compensation notes is a linked notes variable that can give greater detail about whether there was a compensation range or whether some donors were paid more than others, or any other relevant information. Some compensation amounts had already been found in hard copies of applications being coded by other research assistants, so this RA was instructed to retrieve any missing data from websites. After the RA had finished coding, I went through and double-checked any cases that still had missing data to see if amounts could be found in any materials I had from the program. I also read through the compensation notes variable to check for agreement with the RA’s coding decisions. Overall, each coding decision was reviewed by at least two coders (an RA and myself). Most coding tasks handled by undergraduate research assistants had similar formats as this one—using directed coding of manifest data such as the presence or absence of given policies and practices.

Task (from Training Sheet)

You will be coding for donor compensation amounts for both egg and sperm donors. Some of the amounts have already been retrieved, so please fill in any missing information to the extent that you can find from websites.

Compensation. Put in the dollar amount of base compensation for one donation cycle (use the lowest amount if a range is given). If you can't find any donor compensation listed, put in a value of "99."

Compensation Notes. Please record any additional information you come across about donor compensation. Things to look out for include different amounts for donors, such as repeat donors, or paying more for donors with particular characteristics (race, education, IQ). Please also record any explicit statements that all donors are paid the same compensation. If a compensation range is given, report the full range here as well.

Appendix C

Industry Snapshot

This appendix provides a geographic snapshot of the US fertility industry. Based on the variables coded throughout this project, there are some key features of the industry that differ by location. Figures A3.1 through A3.3 display the density of the industry across the three main types of organizations: ART clinics, egg donation agencies, and sperm banks. One noticeable pattern across all three figures is that California is an industry hotspot. Indeed, this corroborates comments that I heard from some clinic staff that Southern California in particular was a “congested” location. Clinics are also concentrated in Texas, Florida, and throughout portions of the Midwest and Northeast. Egg agencies have a similar pattern, but do not have the same extent of coverage as clinics. There are also about four times as many clinics as there are egg donation agencies. Given the differences between the egg and sperm donation sectors, which I described briefly in chapter six, it is not surprising that only slightly more than one-third of the states have a sperm bank located in them.

I also mapped three additional variables (Figures A3.4-6) to show the spread across the country in terms of organizational characteristics: % of organizations within a state that had been in business for more than 15 years; % of organizations with donor compensation greater than \$5000, and % of organizations that allowed for non-anonymous donations. Looking at Figure A3.4, both the Northeast and Midwest have higher concentrations of older businesses (50% or more in some states in these regions have been open for greater than 15 years). Virginia is also a prime location for older businesses in the industry—this is also where some of the original IVF practitioners were

trained (e.g., at the Jones Institute). In Figure A3.5, there are a few states that have high concentrations of donor compensation amounts over \$5,000, including many states in the Northeast (donor compensation here tends to average \$8,000), select states in the Southeastern region, Indiana, and Wyoming. Although California is the most congested spot in the country for the industry, this did not, somewhat surprisingly, have the highest concentration of donor compensation above \$5,000. Finally, Figure A3.6 displays the percentage of agencies and clinics in each state that allow for non-anonymous options (semi-open or open). This map is quite intuitive given the comments I frequently heard from staff members that the East Coast and West Coast had rather different perspectives about open arrangements. The West Coast has a higher concentration of organizations providing non-anonymous options throughout the region.

A3.2 Eqq Donation Agency Density Across the US

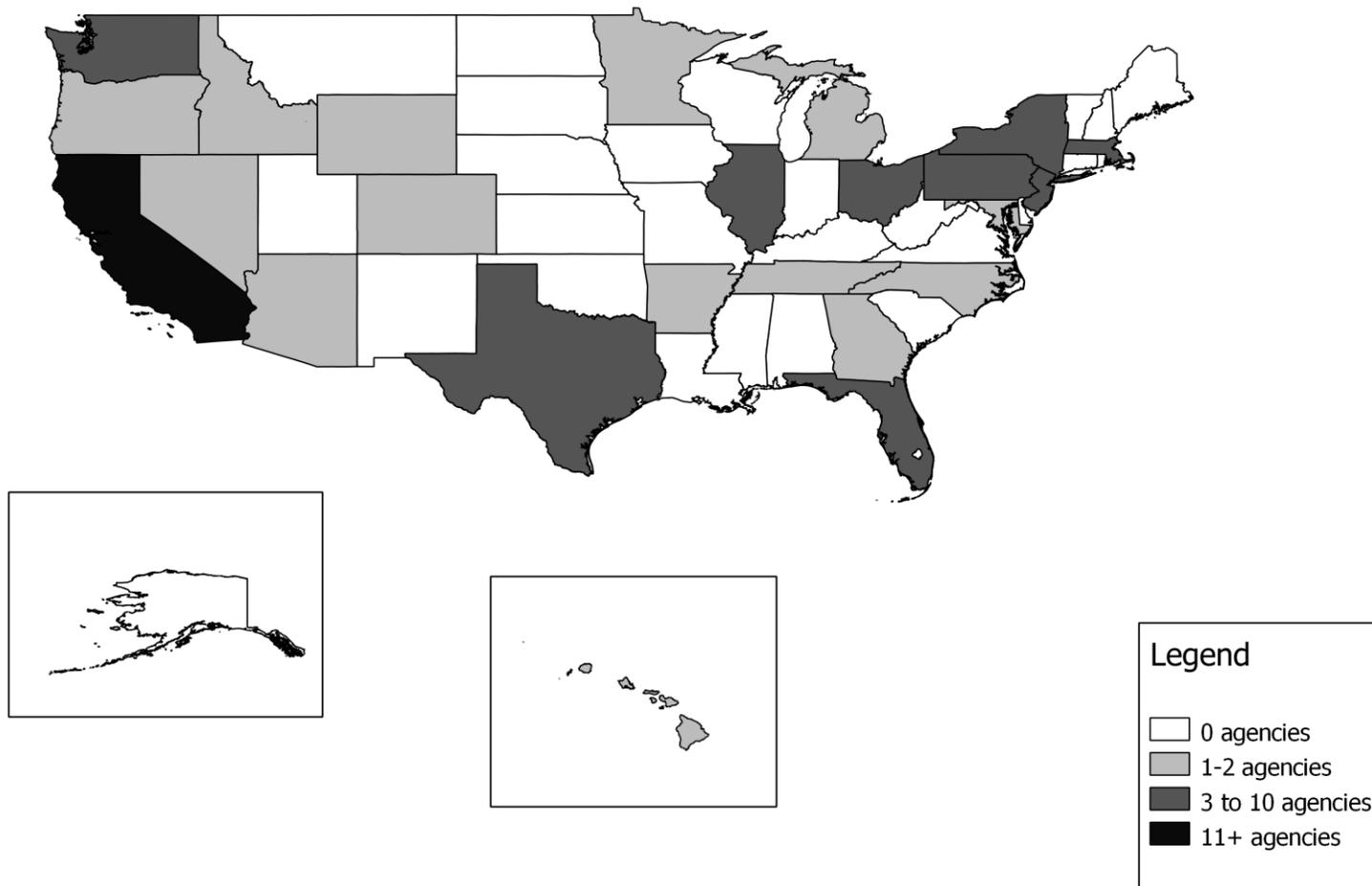


Figure A3.5 % of Clinics/Agencies with Donor Compensation Greater than \$5000

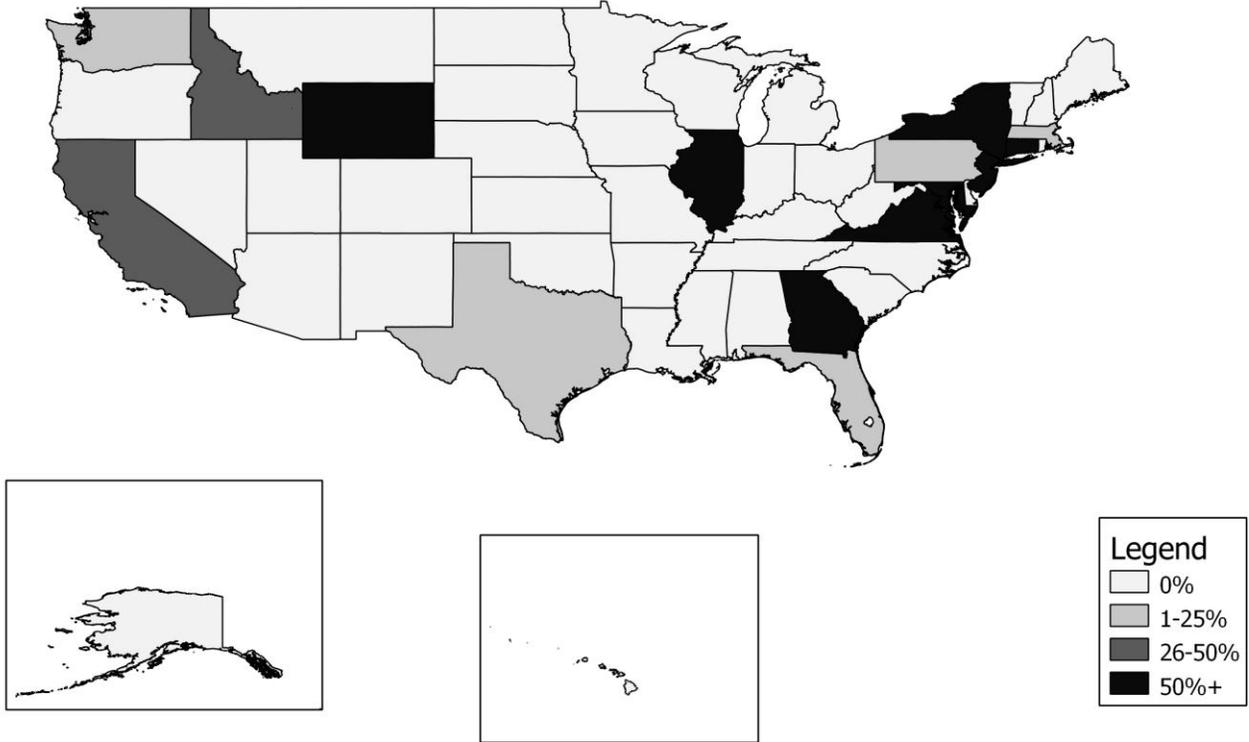
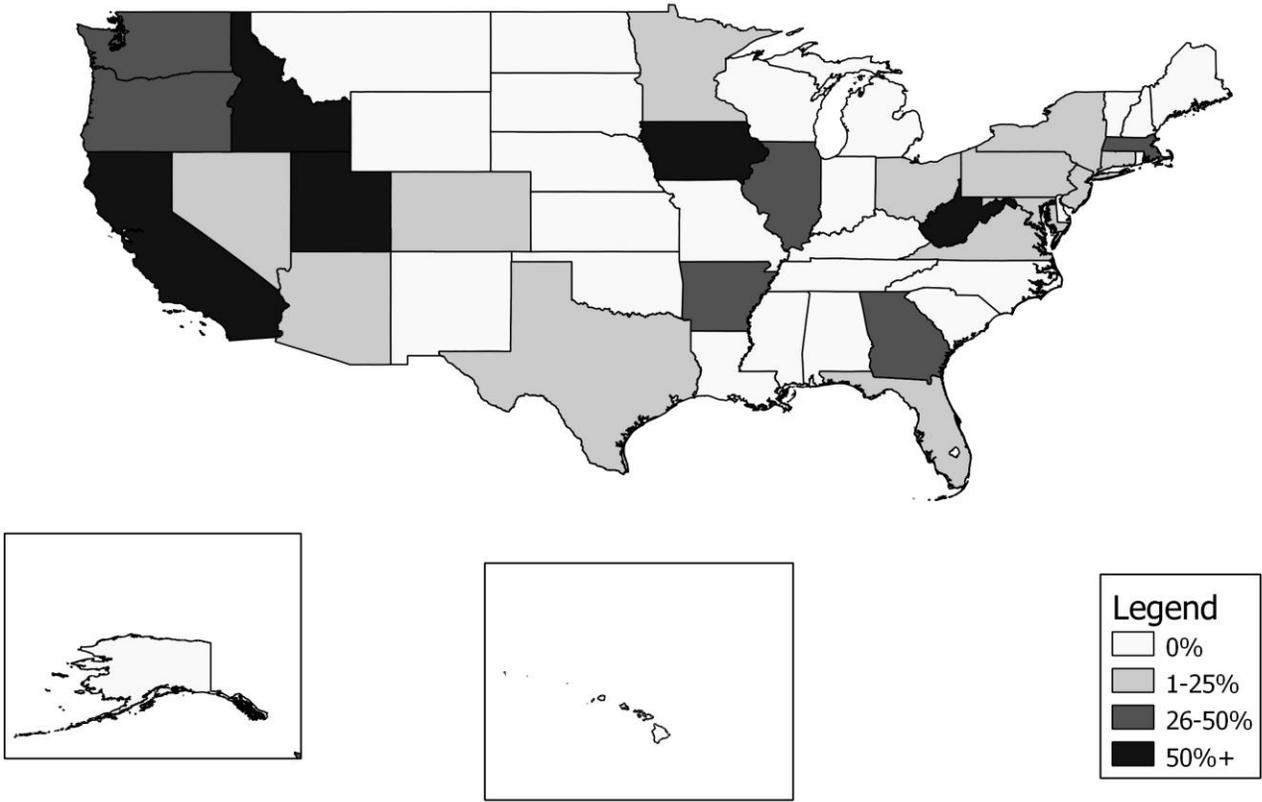


Figure A3.6 % of Clinic/Agencies with Non-Anonymous Options



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- Johnson, K.M. and R.M.Simon. Forthcoming. "Women's Attitudes toward Biomedical Technology for Infertility: The Case for Technological Salience." *Gender & Society*.
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- 2010-11 Competitive Graduate Teaching Assistantship, Women's Studies Department
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2005 Herbert Bailey Graduate Fellowship, \$5000