How best to protect the vital interests of donor-conceived individuals: prohibiting or mandating anonymity in gamete donations?

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Abstract  Anonymous gamete donation continues to be practised in most jurisdictions around the world, but this practice has come under increased scrutiny. Thus, several countries now mandate that donors be identifiable to their genetic offspring. Critics contend that anonymous gamete donation harms the interests of donor-conceived individuals and that protection of these interests calls for legal prohibition of anonymous donations. Among the vital interests that critics claim are thwarted by anonymous donation are an interest in having a strong family relationship, health interests, and an interest in forming a healthy identity. This article discusses each of these interests and examines what they could involve. The legislation in two countries is considered: Spain, which mandates anonymous gamete donation, and the UK, which prohibits such practice, to assess how these different legislations might or might not protect these vital interests.

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KEYWORDS: anonymity, gamete donation, regulations, right-to-know, Spain, UK

☆ This paper was presented at the Brocher Symposium "Between Policy and Practice: Interdisciplinary Perspectives on Assisted Reproductive Technologies and Equitable Access to Health Care," held at the Brocher Foundation, Hermance, Switzerland in July 2015. The Brocher Foundation’s mission is to encourage research on the ethical, legal and social implications of new medical technologies. Its main activities are to host visiting researchers and to organize symposia, workshops and summer academies. More information on the Brocher foundation programme is available at www.brocher.ch.
Introduction

The practice of gamete donation has increased steadily in the last decade. For instance, from 2003 to 2013 egg donor cycles in the USA rose almost 40% (Centers for Disease Control and Prevention et al., 2014) and in Europe donor cycles more than tripled between 2003 and 2010 (from 7548 to 25,187, respectively; Kupka et al., 2014). Like other practices in assisted reproduction, gamete donation, and particularly egg donation, has received a considerable amount of attention for a variety of reasons. For some, gamete donation is morally objectionable because genetic parenthood involves parental obligations and such obligations are non-transferable (Moschella, 2014); others have raised concerns about the establishment of a market for gametes (Almeling, 2011); and still others have called attention to the paucity of research on the long-term effects of the drugs used in egg donation protocols (Woodriff et al., 2014). Recently, the anonymity usually associated with gamete donation has come under increased scrutiny and criticism (Cahn, 2009; Cowden, 2012; Ravitsky, 2012; Somerville, 2011). Although anonymous egg donation continues to be practised in most jurisdictions around the world, and some countries, such as Spain, France and Denmark, explicitly protect the anonymity of donors by legislation, an increasing number of countries, including Sweden, the Netherlands, Norway, and the UK, now mandate that donors be identifiable to their genetic offspring (Allan, 2012; Blyth and Frith, 2009). Critics of anonymity practices often argue that they frustrate several fundamental and uncontroversial (and, as such, termed ‘vital’) interests of donor-conceived individuals and that protection of these interests calls for legal prohibition of anonymous donation (Cahn, 2009; Cowden, 2012; Velleman, 2005). Among the vital interests that critics argue are thwarted by anonymous donation are an interest in having strong family relationships, health interests, and interest in forming a healthy identity (Cahn, 2009; Cowden, 2012; Ravitsky, 2012; Somerville, 2011; Velleman, 2005).

In this paper, each of these interests is discussed and what they could involve is examined. The situation in Spain and in the UK is considered to assess how their differing policies with respect to donor anonymity might or might not protect these vital interests. Before proceeding, a brief description of the gamete donation policies in these two countries is offered.

Gamete donation policies in Spain and the UK

Spain

Assisted reproductive technologies, including gamete donation, are regulated in Spain under Law 14/2006—Human Assisted Reproduction Techniques, which came into effect in May 2006 (Jefatura del Estado, 2006). It superseded Law 45/2003, which in turn had amended Law 35 of 1988. The current law establishes procedures for the utilization of assisted reproductive technology to overcome infertility (whether in heterosexual couples, same-sex couples, or single women) and in the prevention and treatment of genetic diseases. It also establishes requirements for gamete and embryo donation. According to this law, donors must be appropriately informed, in general terms, about the destination and consequences of the donation. It stipulates that no more than six children can be born in Spain with gametes from the same donor, that donors must inform the centre about other donations they have performed, and that the donation must be altruistic. Thus, the law prohibits payment for gamete and embryo donation, except to compensate the donor for time, effort and discomfort. Based on a recommendation from the National Committee of Human Assisted Reproduction, the Health Ministry has set the compensation for egg donation at 900 euros, under the assumption that this amount does not constitute an economic incentive to donate. Moreover, the law establishes that gamete and embryo donation must be anonymous, and that centres must maintain the confidentiality of the information they gather. Donor-conceived individuals are legally entitled to access general (non-identifying) information about the donor. Only in exceptional cases, where a donor-conceived individual’s life or health might depend on it, does the law allow disclosure of donor identity.

The law also indicates that egg donors should be between 18 and 35 years-of-age and that sperm donors should be no more than 50 years old. According to the law, gamete donors must undergo specific medical and psychological tests, including blood and serological tests for infectious diseases and karyotype and genetic history to rule out the most common hereditary illnesses, before they are assigned to a recipient. It prohibits the selection of donors by recipients and charges the medical team with selecting the most suitable donor according to phenotypic and immunological characteristics. It also includes registration requirements to record information about the number of children born from each donor, the identity of those using donated gametes or embryos, and the location of donation and use. Although the requirement for a donor registry was established in 1996, as of yet no registry has been created in Spain.

UK

In the UK, The Human Fertilization and Embryology Act of 2008, which updated the original law of 1990, forms the basis for all UK legislation in relation to reproductive technologies and embryo research (HFE Act, 2008). The Human Fertilization and Embryology Authority (HFEA), established in 1991, is responsible for applying these regulations and for licensing IVF clinics. The law does not impose restrictions on the number of times a donor can donate, but it establishes that in UK-licensed centres no more than 10 families be created from the same donor. Egg donors must be between 18 and 36 years-of-age and sperm donors are eligible up to 41 years-of-age. The health and medical history of the donors and the donated gametes and embryos must be screened for certain medical conditions. The HFEA also regulates donor compensation and in recent changes it has stipulated a compensation of £35 per visit for sperm donors, and £750 per cycle for egg donors.

Until 2005, gamete donation in the UK was anonymous, but the Human Fertilization and Embryology Authority (Disclosure of Donor Information) Regulations of 2004 established the prohibition of anonymity. Donor-conceived individuals aged over 16 can access non-identifiable information about their donors such as physical description, ethnicity, year and country
of birth, whether they have any children, their medical history and if available, a goodwill message and ‘pen portrait’ from the donor. It also allows donor-conceived adults (18 and older) who were conceived after April 2005 to request the donor’s name, date of birth, and last known address from the HFEA. Though not required by law, the HFEA can also provide information about donor siblings. At age 16, donor-conceived individuals can receive non-identifying information about any donor-conceived, genetically-related siblings they may have, including the number, their sex, and their year of birth. At age 18, they can also request identifying information about any donor-conceived genetic siblings and can receive it if both sides consent. Similarly, though not a statutory right, parents of donor-conceived individuals can access, until their child reaches age 18, any non-identifiable information held by the HFEA, including a physical description of the donor, the donor’s year and country of birth, ethnicity, marital status, medical history, as well as a goodwill message and a ‘pen portrait’ if the donor has provided one. Parents can also receive information about the number, sex and year of birth of their child’s donor-conceived genetic siblings. Similarly, those who donated after 1 August 1991 can request information from the HFEA about the number, sex and year of birth of any person born as a result of their donation. Donors who provided gametes before April 2005 and who wish to be identifiable to their donor-conceived children, can also re-register so that they can give more information to the clinic, which will then be passed on to the HFEA to be accessible to donor-conceived individuals.

These two countries, with very different approaches to anonymity practices, but with many similarities in their attitudes to gamete donation, constitute good case studies to evaluate the effect of legislation on the protection of vital interests of donor-conceived individuals. The comparison can give some insight into whether anonymity in gamete donation does indeed frustrate important interests of donor-conceived people.

Protecting vital interests of donor-conceived individuals

Supporters of gamete-donor anonymity usually argue that anonymity practices best respect the donor’s interest in privacy (Sauer, 2009) as well as the desires of would-be parents in determining what they believe is in the interest of their offspring (Murphy and Turkmendag, 2014; Sauer, 2009). On the other hand, critics of anonymity policies in gamete donation contend that anonymity practices harm at least three vital interests of donor-conceived people: flourishing family relationships, health and the forging of a strong identity, and that regulations prohibiting such practices are required in order to protect these interests1 (Cahn, 2009; Cowden, 2012; Ravitsky, 2012; Somerville, 2011; Velleman, 2005). These vital interests are presumably set back by the practice of anonymity in gamete donation in different ways (de Melo-Martin, 2014). This section examines how such interests could be understood and evaluates how their protection fares in Spain and the UK given the different policies on gamete-donor anonymity in these two countries.

Strong family relationships

That people have a vital interest in strong family relationships seems uncontroversial. Arguably, the kind of family life one has shapes the kind of person one becomes. It is, after all, in families where children begin their moral development, where their talents and abilities can be promoted or inhibited, and where they initially acquire a sense of identity. Strong family relationships characterized by love and affection, understanding and trust, are certainly important for the wellbeing of individuals. Policies and behaviours that endanger this interest, including those relating to gamete donation, are then prima facie problematic.

Critics of anonymity policies claim that a vital interest in strong family relationships is thwarted by the contribution of such policies to the secrecy that often accompanies donor conception (Baccino, 2008; McGee et al., 2001). Indeed, despite a shift in professional attitudes toward openness in the last decade, evidence shows that rates of disclosure in families that conceive a child via gamete donation are relatively low in heterosexual couples (Readings et al., 2011). They are, however, higher for single and lesbian mothers because of the need to explain the absence of a father in the home (Maccallum and Golombok, 2004). According to critics, withholding the truth about donor-conceived individuals’ mode of conception leads to a situation in which parents have to keep secrets, which is likely to have negative consequences on family relationships (McGee et al., 2001). Non-disclosure, it is argued, ‘creates family tension (which children pick up very readily) by creating an environment where an uncomfortable and fundamental lie must be concealed’ (McGee et al., 2001, p 2034). Those who oppose anonymous donations claim that nondisclosure can also create anxiety, loneliness, stress-related symptoms and self-doubt in parents because of the need to conceal the truth of their child’s origin. Critics also argue that nondisclosure is likely to impede appropriate parental-child communication, can undermine trust and promote distance and suspicion in families (Imber-Black, 1998). Even in those families where disclosure occurs, opponents claim that anonymous donation can also harm peoples’ interests in strong family relationships. Evidence shows that donor-conceived people are likely to want to know the identity of the donor (Beeson et al., 2011; Clark, 2006; Goldberg and Allen, 2013; Harmon, 2005; Jdva et al., 2011) whereas anonymity policies create barriers to accessing this information that might lead donor-conceived individuals to resent their parents for utilizing this practice.

However, evidence about the impact on family relationships resulting from non-disclosure is mixed. Some studies have found differences in the level of parent-child conflict between families that have disclosed and those that have not, with families who had disclosed showing lower levels of conflict overall (Golombok et al., 2002). It should be noted, however, that this overall difference was the result of particularly positive ratings in the disclosing group, rather than dysfunctional relationships in the non-disclosing families (Golombok et al., 2002; Lycett et al., 2004). Other researchers have found that secrecy can affect family

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1 Other interests that have been cited include an interest in avoiding consanguineous sexual relationships (Cowden, 2012) and an interest in freely choosing what meaning to assign to the genetic components of one’s identity (Ravitsky, 2014). The interests discussed here are, however, those most often cited in the literature.
relationships in a variety of ways, such as conflict, cohesion and emotional expressiveness (Paul and Berger, 2007), and that accidental disclosure correlates with strained relationships and mistrust (Turner and Coyle, 2000). But, even in studies that found that secrecy created by non-disclosure negatively affected family relationships, donor-conceived children rated family functioning as moderately high (Paul and Berger, 2007). Other studies have shown that non-disclosure does not seem to have negative effects on children’s psychological wellbeing or on family relationships in general (Golombok et al., 2013). Some of these studies also show that, possibly contrary to the expectations of those promoting openness, children who are aware of the circumstances of their birth show greater adjustment difficulties than those who do not have knowledge of their mode of conception, although again, in general, children born through reproductive donation did not differ overall from naturally conceived children (Golombok et al., 2013).

Although the research results about the effects of disclosure on family relationships are mixed, let us grant, for the purpose of this discussion, that not disclosing the mode of conception to donor-conceived individuals negatively affects family relationships. How do the Spanish and UK policies fare in protecting this vital interest? Neither country mandates or prohibits disclosure. Indeed, no country where anonymous donation is illegal mandates that parents disclose donor status to their children (Blyth and Frith, 2009). Furthermore, in spite of the differences in anonymity requirements, clinical practice in Spain recommends that parents disclose the mode of conception to their children (Baccino, 2008; Fitó, 2010). Moreover, although studies about disclosure rates in Spain are scarce, some evidence indicates that single women who use gamete donation are likely to disclose mode of conception to their children (Jociles-Rubio et al., 2014), while those in heterosexual couples express resistance to doing so (Fitó, 2010). Studies also show that there is no difference in intent to inform a child based on the use of a known or an anonymous donor (Greenfeld and Klock, 2004), and the rates of disclosure seem to be similar in countries with and without anonymity (Araya et al., 2011; Isaksson et al., 2012). However, difficulties collecting disclosure information makes this data hard to assess, so the reality may be different. Obviously, disclosure of mode of conception could be required independently of whether anonymity is mandatory or prohibited, although as indicated, no country currently does so. If this is so then, whether or not one believes that non-disclosure and secrecy negatively affect family relationships, there does not seem to be any difference between anonymous and non-anonymous gamete donation policies as to their ability to protect the interest of donor-conceived individuals in strong family relationships. So despite critics’ contention, the exiting evidence does not support claims that anonymity policies thwart people’s interest in flourishing family relationships by contributing to lack of disclosure, or insofar as they do so, they do not appear to fare any differently than non-anonymity policies do in this respect.

Given these findings, if one believes that disclosing mode of conception is important for family relationships, then focusing on prohibiting anonymity might not be the best strategy to protect the interests of donor-conceived individuals in strong family relationships. Interestingly, evidence suggests that fears about disruption to, and negative effects on, the parent–child relationship and family structures are often given as reasons not to disclose the mode of conception to donor-conceived people (Becker et al., 2005; Daniels et al., 2011; Hershberger et al., 2007; Indekeu et al., 2013; Shehab et al., 2008; Stuart-Smith et al., 2012). To the extent that those using donor conception do not disclose because of concerns about the legitimacy of their family, effecting cultural and social changes that contribute to ensuring the equal status of all families, and moving towards a debunking of the normative force of the biogenetic family might go a long way towards increasing the rate of disclosure following both anonymous and non-anonymous donation. It might be the case, however, that policies prohibiting anonymity contribute towards a culture of openness that makes parents using gamete donation more comfortable with disclosing this information to their children. As indicated earlier, disclosure rates do not seem to be affected by anonymity requirements, although as also mentioned, data about disclosure rates is difficult to assess. Nonetheless, it might also be the case that the emphasis on genetic relatedness inherent in these policies might actually contribute to enshrining the biogenetic family and thus make disclosure less likely.

Health

A second interest that opponents contend is hampered by anonymous donations is an interest in one’s health. As some critics of anonymous donation contend: ‘When it comes to your genetic origins, what you do not know can indeed hurt you’ (Ravitsky, 2012, 19). Donor-conceived individuals who are unaware of their genetic origins lack information about at least one of their genetic parents. Thus, they cannot reap the benefits of a more complete medical family history and are prevented from accessing information necessary to make informed decisions about their health. Access to one’s genetic origins, critics argue, is important to protect one’s health interest in a variety of ways (Cowden, 2012; Ravitsky, 2012). Medical family history offers crucial information related to genetic factors. For instance, it can play an important role in identifying patients who may benefit from predictive genetic testing (Rich et al., 2004), and information about highly penetrant genetic mutations, such as those responsible for Huntington disease or even breast cancer associated with BRCA1 and BRCA2 gene mutations, can be critical to those who might be at risk for these diseases. Knowledge of medical family history can also be central to determining how to properly interpret genetic test results. Studies have shown the clinical utility of family history for identifying persons with a variety of genetic syndromes, such as hereditary breast and ovarian cancers (Metcalf et al., 2010). Some studies also suggest that information about medical family history can be useful for the assessment of risk for some common diseases such as diabetes, cardiovascular disease and mental health disorders, in which genetic factors play a less clear role (Yoon et al., 2002). Furthermore, to the extent that donor-conceived children have erroneous ideas about their own medical history because they are unaware that they are not genetically related to both of their parents, they might be misdiagnosed and can fail to seek needed treatments at appropriate times. Critics of anonymous donations charge that, insofar as genetic
factors play a role in the development of disease and the improvement of health, donor-conceived individuals’ health interests would be best protected by policies that prohibit anonymity (Ravitsky, 2012).

As with the case of an interest in strong family relationships, it seems uncontroversial that health constitutes a vital interest for human beings. I believe that there are, however, reasons to question claims that lack of access to a donor’s medical history thwarts the health interest of donor-conceived children when they are unaware of their mode of conception. First, genetic screening for heritable diseases is routinely performed in potential gamete donors, and those carrying known mutations associated with disease are usually ineligible for participation (Dondorp et al., 2014). Although possible (Maron et al., 2009), donor-conceived children are unlikely to be negatively affected by the lack of specific information about highly penetrant mutations transmitted by the gamete donors.

Second, it is not clear that knowledge about heritable factors plays as important a role as might be assumed in promoting people’s health. Evidence shows that access to family history fails to improve risk prediction, change people’s risk perceptions, or lead to better health outcomes (Berg et al., 2009; Wilson et al., 2009). People’s risk perceptions appear to be relatively resistant to change even when they have detailed information about elevated disease risk based on family history (Spain et al., 2008; Wang et al., 2012). In some cases, knowledge of genetic risk, even when such knowledge is the result of genetic testing and not just acquired via knowledge of family history, seems to have little effect on people’s health-related behaviours (Heshka et al., 2008). But, even if knowledge of genetic risks were important for health outcomes, progress in personalized or precision medicine now gives individuals the ability to have their own genome sequenced and analysed, thus providing information about relevant genetic risks without any need for family history (Collins, 2010; Novelli, 2010). Personal genetic testing also means that donor-conceived individuals who have not been informed of their status may discover inadvertently that they are donor-conceived. However, as indicated in the previous section, gamete donation policies – whether supporting anonymity or not – do not mandate disclosure and thus both types of policies would fail to address this possibility.

Third, many parents either lack or fail to disclose relevant health information to their genetically related children. In fact, although people in general believe that their own family history is important, few actively collect health information from their relatives to develop a family history (Centers for Disease Control and Prevention, 2004). People often lack relevant details about their relatives’ health history or fail to recall pertinent information. Moreover, because some diseases have stigmatizing consequences, parents might choose not to disclose such information to their genetic children. And, according to some evidence from physician practices, a thorough exploration of the family history may be far from the norm in adult primary care, even when primary care providers often report high rates of collecting general family medical history information (Murff et al., 2007).

Of course, that the value of family history in improving peoples’ health might be overstated is not to claim that it has not value at all. Similarly, that many people in the general population might be misinformed about their family history does not mean that it is morally appropriate to prevent donor-conceived individuals access to such information. But both of these facts seem to indicate that access to a complete family history is not obviously necessary to protect one’s health interests. These might be the result of inadequate collection practices or insufficient scientific knowledge. If at some point the evidence indicates that having accurate information about one’s family history significantly improves health outcomes, then this would count as an important reason to disclose such information to donor-conceived children.

Nonetheless, even if access to family history is not necessary, it might still be the case that such information might be crucial in some cases, and thus that insofar as donor-conceived individuals are prevented from access to it, this might negatively affect their legitimate health interest. Is legislation in the UK better able to address this problem than legislation in Spain? It might indeed be better, but if so, it need not be because of differences in anonymity requirements. As critics of anonymity practices also recognize (Cowden, 2012), anonymity policies need not prevent donor-conceived individuals’ access to genetic medical history. Indeed, both the Spanish and the UK policies are consistent with donor-conceived individuals having access to the medical history of the donors. As indicated, both legislations require that gamete donors undergo genetic screening for a significant number of heritable diseases. Both also require the gathering of extensive information about donors’ medical family history. Clinics in both countries are required to collect this information and to use it in making decisions about eligibility. In the UK, although not required by law, clinics often collect significant information about donors, including a handwritten personal note and good wishes. The Spanish law, in spite of its requirement of anonymity, explicitly indicates that donor-conceived individuals should have access to non-identifiable information about the donor, including medical information. Clinics in Spain are required to provide this information to parents of donor-conceived children if they request it. In the UK clinics are not prohibited from giving such information, and actually prospective parents use such information when making decisions about donor selection, for instance. Parents can also request this information from the HFEA after the children are born. Nothing in the law prevents parents from passing the information about their donors on to their children. Indeed, in the UK this was done even before anonymity was prohibited in 2005. It is true that access to this information is more limited in Spain than it is in the UK, but this is at least in part the result of the law’s prohibition of donor selection by the prospective parents rather than on the mandatory anonymity policy. The medical team however has access to medical information and, as mentioned, it is charged with using it when making decisions both about donor eligibility and donor matching. Nothing in the Spanish law, however, prohibits parents from accessing whatever non-identifiable medical data the clinic has once the procedure has been done. Indeed, the law explicitly grants parents the right to access non-identifiable information about donors.

It is true that better methods need to be implemented to ensure updated donor medical information that might be relevant to donor-conceived children. Establishing a donor registry required by law might go a long way towards achieving this goal. But such strategies can be implemented independently of whether or not anonymous donations exist.
Granted, insofar as parents have chosen not to disclose donor status to their children, they are unlikely to provide them with whatever information they have on the donor. But, as we saw earlier, this is an issue for policies that require or prohibit anonymity, as neither mandates disclosure. It is also the case that the UK legislation explicitly allows donor-conceived individuals who have not been informed about their status by their parents, but who suspect they are donor-conceived, to request information, including medical history, about their possible donors. Although the Spanish law does not have this provision, no provision in the law forecloses this option and thus possible donors. Although the Spanish law does not have this request information, including medical history, about their individuals who have not been informed about their status by their lack of access to the identity of the donor (Ravitsky, 2012).

Finally, those who oppose anonymous gamete donations have also argued that donor-conceived children have a vital interest in forging a healthy identity and that such interest is set back by their lack of access to the identity of the donor (Ravitsky, 2012). These critics take the position that, although we can alter other factors of our lives while remaining the same person, knowledge of our genetic origins is necessary to appropriately understand who we are. Some of those who are critical of anonymous gamete donations also argue that access to the identity of one’s genetic progenitors is necessary to help make sense of one’s physical characteristics, talents, or interests (Velleman, 2005). It gives context to questions about family resemblance. It also can help foster a sense of belonging and a connection with the past, a sense of continuity. Thus lacking information about where such traits come from, lacking access to a context that makes family resemblance of certain traits understandable, is said to hinder donor-conceived children’s project of self-understanding (Ravitsky, 2012). For critics then, “providing identifying information will allow donor-conceived individuals [...] to fulfill their own sense of identity” (Cowden, 2012, 111).

Assessing whether this interest might or might not be set back by mandatory anonymity policies is a difficult task, primarily because opponents of anonymous gamete donations do not, in general, offer arguments about what a healthy identity entails or what contribution information about one’s genetic origins makes in forging such an identity. Given the existence of different theories of identity formation, many of which do not privilege genetic relatedness (Haslanger, 2009; Mackenzie and Stojjar, 1999; Meyers, 2004), this is a serious oversight. After all, the claim is that anonymity policies thwart donor-conceived individuals’ interest in forging a healthy identity. If what it means to have a healthy identity is not clear, then it is difficult to assess not just whether anonymity policies harm this interest, but also whether non-anonymity ones protect this interest.

Critics often use reports by donor-conceived, or adopted individuals, who lack information about their genetic progenitors and who express a sense of loss and incompleteness because of this (Cowden, 2012; Ravitsky, 2012; Somerville, 2011). But it is hard to know how to assess this evidence for both methodological and substantive reasons (de Melo-Martín, 2014). For instance, it is difficult to determine whether the identity problems are the result of people lacking access to the identity of their genetic progenitors or the result of living in a social context where having access to such information is thought to be necessary for forging healthy identities (Leighton, 2012). Indeed, it seems quite plausible to believe that in Western nations, for example, where there is so much emphasis on having access to information about one’s genetic progenitors and where high regard is still granted to the biogenetic family, individuals who lack access to this information might feel they are lacking something essential to their identity (Haslanger, 2009).

Some other evidence suggests that one of the main motivations for donor-conceived individuals’ desire to meet their donors is curiosity about what the donor looks like so that they can make sense of some of their own physical characteristics or personality traits, rather than because they want a relationship with them (Jadva et al., 2011; Ravelingien et al., 2014). In this regard the Spanish policy of mandated anonymity does indeed prevent donor-conceived people from having information that could lead to meeting their donors while the UK law makes this option not just available but relatively easy. However, if the desire to meet one’s genetic progenitors is indeed the result of simple curiosity about physical appearance, then it is difficult to see how this could be thought to be a vital interest that requires legislation in order to protect it. Clearly, human beings are curious about many things that we would be reluctant to legislate for. For instance, people might be curious about whether their parents were in love when they were conceived, how many sexual partners their parents had, whether their parents considered an abortion, or whether they were conceived accidentally or intentionally. It is hard to see how the fact that people might be curious about these things is sufficient to enact legislation protecting the interest in such curiosity. Thus, although it might well be the case that donor-conceived individuals are curious about their donors, and while the Spanish policy of anonymity prevents access to this type of information (but the UK policy does not), it is not clear that anonymity policies set back a vital interest in need of protection. Moreover, and as indicated earlier, given our society’s emphasis on genetic relatedness and focus on familial resemblance, it is perhaps not surprising that people feel such curiosity. Thus challenging the ideologies of the biogenetic family and those that naturalize the value of genetic ties might arguably be at least as good a strategy as prohibiting anonymous gamete donation to address these issues. Granted, changing these ideologies is likely to take

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2 Note that for some people, being able to access such information might be very significant, but nonetheless we do not have legislation requiring it. Importantly, I am not comparing the relevance of information about one’s genetic origins with these other types of information. The point being made here is simply that curiosity – even if perfectly understandable – is not sufficient to require legislation.
longer than changing policies. Nonetheless, we should not disregard the effects that these ideologies have on policy-making decisions.

It might be, however, that the interest in a healthy identity should be understood not simply as involving the satisfaction of curiosity but rather highlighting the importance of personal contact with the gamete donor. Such contact would permit the development of relationships that would ultimately help donor-conceived individuals make sense of their own self. It is true that at least some donor-conceived individuals seem to want to have a close relationship with their donor, but this does not seem to be the norm for most donor-conceived people. In fact, the evidence that exists, although still limited, indicates that an extensive relationship with their donor is not what most donor-conceived individuals want – even those who actively search for their gamete donor (Besson et al., 2011).

In any case, insofar as the interest in forging a healthy identity is understood in this way it seems clear that neither the Spanish nor the UK legislation can protect it. No reasonable policy can mandate that donors have a close relationship with those conceived using their donated gametes. Granted, because the UK policy gives donor-conceived individuals access to identifying information, it does not hinder the possibility of such a relationship while the Spanish law does. Nonetheless, this understanding of identity is not uncontested given its privileging of genetic relatedness over other types of relationships and thus it is not obvious that it constitutes a vital interest to be protected. Clearly, many people develop healthy identities even when they lack access to contact with their genetic progenitors. This is not to say that genetic relatedness plays no role at all in the construction of the self, but undoubtedly the role that it plays can be different for different people and at different times. In societies where genetic relatedness has a high value, these relationships are likely to be thought particularly important in identity formation. As indicated earlier however, disrupting and challenging this ideology rather than strengthening it further, might be a good way to protect the legitimate interests of donor-conceived individuals.

Conclusion

If the arguments presented here are correct, it is not obvious that policies that mandate anonymity, such as those in Spain, set back vital interests of donor-conceived people or that policies prohibiting anonymity, such as those in the UK, protect such interests in more robust ways. Insofar as the interests are arguably vital and uncontested – such as strong family relationships and health – both types of policies appear to fare similarly in protecting these interests. To be sure, the Spanish law might offer insufficient protection regarding access to health information about donors, but as discussed, regulations can be implemented under an anonymous policy that could give donor-conceived individuals better access to such information. Thus in this respect, the problem is not with the requirement of anonymity but with policies and practices that make collecting and accessing medical information from gamete donors difficult. Similarly, although having a healthy identity is also reasonably thought of as a vital interest, how such an interest is interpreted matters greatly when assessing anonymity policies and their ability to offer protection. Insofar as the interest in question is understood as a need to satisfy donor-conceived individuals’ curiosity, it is true that mandating anonymity frustrates such interest, but it is not at all obvious that, so understood, it constitutes a vital interest in need of legal protection. Similarly, if an interest in developing a healthy identity is conceptualized as one involving a need to make sense of one’s self in relation to one’s genetic progenitors, policies such as the UK one prohibiting anonymity are better able to protect this interest. However, that this interest so conceptualized is vital is not uncontested.

Note that the arguments presented here are not intended to support the position that policies mandating anonymity are better, all things considered, than those prohibiting it. There might be legitimate reasons to prefer non-anonymity policies to anonymity ones (see, for example, de Melo-Martín, 2013), but that the former better protect fundamental and uncontroversial interests of donor-conceived individuals than the latter does not appear to be one of them. Similarly, none of these arguments support a practice of secrecy regarding people’s mode of conception. Even if secrets are not always wrong, moral reasons exist that would encourage parents of donor-conceived individuals to not hide, or lie to them about their origins (Bok, 1984). What these arguments defend is that anonymity policies need not be an obstacle to openness. Finally, none of the arguments I have offered should be taken as denying that the state has an important role to play in regulating reproductive technologies, including gamete donation practices. What they do highlight, however, is the need to ensure that such regulations appropriately accomplish what they were originally set up to achieve.

Acknowledgements

This work was originally presented at the Brocher Foundation Symposium ‘Between Policy and Practice: Interdisciplinary Perspectives on Assisted Reproductive Technologies and Equitable Access to Health Care.’

The Brocher foundation mission is to encourage research on the ethical, legal and social implications of new medical technologies. Its main activities are to host visiting researchers and to organize symposia, workshops and summer academies. More information on the Brocher foundation programme is available at www.brocher.ch

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Declaration: The author reports no financial or commercial conflicts of interest.

Received 29 November 2015; refereed 2 November 2016; accepted 30 January 2017; Available online 28 April 2017.