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# Making families: Organizational boundary work in US egg and sperm donation

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ABSTRACT

Egg and sperm donation can create distinct issues for designating family boundaries. These issues come to the forefront as relations between donors, recipients, and donor-conceived children have been shifting from anonymous to more open arrangements in the US and other western countries. In this study, I address US organizational practices and family boundary construction. Fertility clinics, egg donation agencies, and sperm banks are central providers of US gamete donation services. Given the disruptive potential of gamete donation, how do they manage relationships between parties? Through a content analysis of materials from twenty fertility clinics, twenty egg donation agencies, and thirty-one sperm banks, I address three major strategies of organizational boundary work: 1) creating identity categories, 2) managing information, and 3) managing interaction. I ultimately argue that even as many organizations offer opportunities for connections between parties, they exercise social control over donation arrangements through *bounded relationships*.



## Introduction

Gamete donation—the donation of eggs or sperm to help conceive a child—frequently has been framed as socially disruptive technology (Michelle, 2006), especially for designating family boundaries (Cohen, 1996). Surrogacy raises similar issues, but it is arguably more complex than gamete donation, so it is excluded in this analysis. Historically, US gamete donation has been under medical jurisdiction, characterized by strict professional control over the process and anonymity of all parties, although boundaries between donors and recipients were differentially enforced for egg versus sperm donation (Becker, 2000; Braverman, 2010). Since the early 1980s, however, growing international attention has been paid to more open arrangements (Greenfeld, 2002), including disclosure to children about their conception and use of donors willing to release their identities. Various countries have enacted policies, such as legislation that makes all donor identities available for donor-conceived children upon reaching adulthood, a 'double-track' model where both anonymous and identity-release options coexist, and explicit legislation that all donations are anonymous, or that anonymous options are outlawed (Frith, 2001; Greenfeld, 2002; Pennings, 1997). There are no official US policies, although the American Society for Reproductive Medicine (ASRM)—the major professional association in the industry—has typically advocated for anonymity (Greenfeld, 2002) until recently (ASRM, 2008, 2009). In the US, donor-shared sibling families have started connecting through online registries, potentially creating alternative kinship arrangements (Hertz & Mattes, 2011). Additionally, newer considerations for donors' rights, obligations, and interests (ASRM, 2009) make donor personhood more difficult to ignore. Such transformations raise questions about how US donation arrangements are currently managed. More broadly, this offers a site to explore issues in constructing family boundaries that are taken for granted when reproduction occurs 'normally.'

Although gamete recipients can independently search for donors, they are encouraged to use fertility clinics, egg donation agencies, and sperm banks to minimize medical, psychological, and legal risks (ASRM, 2006). Yet there has been little sociological analysis of how these organizations shape donation arrangements (although see Almeling (2010)). A recent theoretical article (Rauscher & Fine, 2012) called for more sociological research on family privacy in assisted reproduction, but focused primarily on disclosure between parents, children, and others such as extended family. The current study focuses specifically on organizations providing donation services. Given the disruptive potential of gamete donation, how do these organizations manage relationships between donors, recipients, and children? How do they demarcate families out of these different parties?

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## Conceptual framework

The growing calls for openness in gamete donation are situated within the context of a changing fertility industry as well as gendered expectations and technological differences for egg versus sperm donation. I address each of these briefly below. Then I conceptualize openness more broadly as a question of family boundary construction.

### *Patient to consumer?*

Like other US healthcare services, gamete donation has largely transformed from a medical service to a commercial product (Holster, 2008). Beginning in the late 19th century, the traditional medical model, at least for sperm donation, relied on secrecy and anonymity between donors, recipients, and donor-conceived children (Marsh & Ronner, 1996). This reflected professional anxiety about medical, legal, and moral boundaries between parties. Addressing potential legal controversies, Hager (1960, p. 223) described how physicians controlled sperm donation, by making sure the donor was "anonymous to everyone except the doctor" and that he "racially and physically resembles the husband." Hager further acknowledged that although the infertile couple's "fancies and wishes" would be considered, "in the end it will probably be necessary for [the doctor] to use his own best judgment" to select a donor.

US egg donation has a different story. First successfully used in the early 1980s, initially many recipients identified their own donors, such as a friend or family member (Thompson, 2005) or received eggs from another woman in the clinic's patient population (Sauer & Paulson, 1995). As such, donor options were quite limited, and the procedure was not subject to the same norms of anonymity as sperm donation. Donor choice increased as clinics began to offer pools of anonymous dedicated donors (Sauer & Paulson, 1995) and egg donation agencies came onto the scene (Spar, 2006), promoting a movement toward anonymous arrangements (Cohen, 1996).

In the early 21st century, US gamete donation looks quite different. Donors are advertised online, their gametes available at the click of a button (Holster, 2008; Schmidt & Moore, 1998). Egg donation has particularly become a high-demand, high-priced sector in the fertility industry (Spar, 2006). Patients have become "patient-consumers" and the market in reproductive medicine has broadened to include not only the medically-defined infertile couple, but also "parents-in-waiting" such as single, gay, and lesbian prospective parents (Mamo, 2013).

These changes in the patient-consumer population have also impacted donor, recipient, and child relationships, particularly for sperm donation. The traditional medical model reinforced the hetero-patriarchal family by appearing as if reproduction had occurred 'naturally' within the family unit. 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 (Scheib, Riordan, & Rubin, 2003), but disclosure to children also became more relevant as peers, family members, and others inevitably commented that "everybody's got a dad" (Haimes & Weiner, 2000). Many requests for identity-release sperm donors came initially from lesbian and single women; although, heterosexual couples are also increasingly using identity-release donors as part of growing concern that donor-conceived children have a right to know about their genetic origins, among other factors (Scheib et al., 2003).

A more consumer-oriented model of gamete donation has also produced different types of organizations specializing in different products and services (Spar, 2006). Here I focus on fertility clinics, egg donation agencies, and sperm banks. Fertility clinics are staffed and directed by medical professionals such as reproductive endocrinologists and andrologists. Egg donation is one of many infertility services they offer. Clinics conduct the medical aspects of the donation: screening donors; training them to inject fertility drugs; providing informed consent consultations; and conducting the egg retrieval and embryo transfer for in-vitro fertilization. Clinics may also run in-house donation programs, recruiting and matching donors with recipients. Egg donation agencies are staffed and directed by various personnel, including previous donors/recipients, nurses, and even former modeling agency CEOs (author's data collection). They act as "intimate intermediaries" (Spar, 2006) – their primary purpose is to recruit donors, match donors and recipients, and connect parties with other services (e.g., reproductive lawyers). They partner with fertility clinics for medical services. Because agencies are solely focused on creating arrangements between donors and recipients, they are considered more responsive to client desires than clinics (Treiser, n.d.). Sperm donor recruiting, screening, and donations all occur through sperm banks. The sperm donation sector is significantly smaller and more consolidated than egg donation because federal regulations to quarantine and freeze sperm for six months are costly. However, cryo-preservation creates the capacity to ship sperm across the country, so a smaller number of large sperm banks dominate this sector (Spar, 2006).

### *Gender, biology, and donation*

Gender norms and biological aspects of donating interact to produce different expectations for egg versus sperm donation. Egg donation is often framed as a 'gift', emphasizing emotional labor that egg donors are expected to engage in, whereas sperm donation is often framed as a 'job' (Almeling, 2010; Ragone, 1999). Egg donation is also noted for being a more open process between donors and recipients, the acceptability of which is reinforced by cultural norms of femininity (Becker, 2000). Rather paradoxically, there are also reasons to view open egg donation as more threatening to family boundaries because women are perceived as more invested in their gametes as potential children than men (Almeling, 2010). There are also technological differences that create closer connections between parties in egg donation compared to sperm donation: donor sperm is cryopreserved and quarantined for six months (ASRM, n.d.), but egg donation is usually "fresh" because of the lagging capability to freeze and thaw human eggs without damage (Rodriguez-Wallberg & Oktay, 2012). The two women's cycles are coordinated, prepping the donor for egg retrieval and the recipient for embryo transfer within a few days from each other (ASRM, 2006).

### *Family boundaries and boundary work*

Questions about openness in gamete donation explicitly invoke family boundaries. Gamete donation involves disclosure of personal information and the transfer of bodily products symbolizing highly intimate aspects of human relationships—sexuality and reproduction (Becker, 2000). During the exchange there is both a need and a desire to permeate boundaries through disclosing relevant health and social information, coupled with maintaining boundaries to protect each party from unwanted intrusion by the other (Burr, 2009; Cohen, 1996).

Symbolic boundaries, which refer to conceptual distinctions that separate "people into groups and generate feelings of similarity and group membership" (Lamont & Molnar, 2002, p. 168), are particularly crucial to understanding family creation processes. Symbolic boundaries serve important social, legal, and political functions by acknowledging "who, when, and how, members participate in family life" and distinguishing "members of a family from one