ARTIFICIAL INSEMINATION —

an alternative to Adoption

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In this paper she outlines a new and exciting program which is seen as an alternative to adoption.

We are well aware of the changing scene in adoption, and the long wait for children which childless couples face. Today, artificial insemination with donor semen (AID) is an alternative to which many such couples are turning. It is becoming an acceptable means to establishing a family, and the Royal Women's Hospital recently commenced work in a clinic set up for couples seeking AID.

The first successful artificial insemination using a donor was performed in 1864 and it has been quite an accepted practice in Europe and the U.S for many years now. Although it has actually been in use in Australia for about 30 years it is only in the last decade that AID has been more widely practiced. This is partly due to changing social attitudes, and the acceptance of AID as an alternative method of producing a family, and also because medical and technical knowledge in this area have improved, thereby obtaining better results.

It was 2 years ago that the idea of setting up an AID clinic within the Royal Women's Hospital was discussed, and the program began on the first of May. There are many facets to AID, there being the obvious ones of the selection of candidates and selection of donors, the techniques used with regard to collecting and storing of the semen, and the actual insemination process. Then, there are the equally important issues which can be classified under legal, religious and psychological.

Let me begin with the selection of couples, this being an area where social workers are actively involved in this hospital. Initially, the couples are referred publicly or privately to the gynaecologist in charge of the program who makes the necessary medical assessment. The couple is then referred to the Social Work Department where they are interviewed jointly and separately. What we look for in the couple is a secure and stable marriage with a mutually satisfying relationship, a desire for children, and good parenting experience of their own. Individually, we seek a husband who is accepting of his infertility and feels that he can cope with his wife bearing a child of whom he is not the biological father. We seek a wife who is accepting of her husband's infertility and the consequent anxieties, and who is prepared to participate in the involved procedure required for artificial insemination. Following these interviews, if the couple are seen as good candidates for AID, they are asked to sign a form consenting to artificial insemination of the wife with the understanding that there is no guarantee that pregnancy will result and if there does, of the possible risks involved (as with any pregnancy) thus absolving the doctor and hospital from any possible blame. The signing of the form also ensures confidentiality of both the couple involved and the donor. It also required the husband to recognise any children by AI as his own, with full inheritance and support rights.

Grey Areas

There are many grey areas of thought on AID as there are in adoption. One of these is whether a child should be told. It is an idea which is subject to change as community attitudes change. We are well aware of such changes in the adoption field over the years, and of the possible changes to come. At this stage our feeling is that it is the couples' choice whether they tell a child of the artificial insemination and we are finding that the majority of couples do not feel that there is a need to tell the child or anyone else for that matter. Unlike adoption, once the wife has become pregnant there is no need for any explanation to the outside world.

Donors

Next we come to the selection of donors. As this is a purely medical process, it is not something I will spend time on other than to give a brief outline. The clinic here intends to use two sources of donors:— Medical students, and the husbands of women who have previously had treatment for infertility and have then achieved a successful pregnan-

cy. Every donor is vetted medically, with attention to genetic and hereditary factors, and the sperm count. A donor is also asked to sign a form disclaiming any legal rights and responsibilities to any child born of his sperm and agreeing not to seek the identity of the couple; again the matter of mutual confidentiality. A furthur precaution on **this** aspect is the coding of all donated material. Of legal importance is the matching of the donor's blood group to that of the husband. The actual matching of donor to candidates is made so that there are similiarities of race, physical appearance, and as mentioned before, blood grouping. Because of the potential risk of consanguinous marriages between the progeny of the donor via AID and any natural children of his, a limit is placed on the number of times a donor can be used.

Storing

The technique of storing the donated semen is a fascinating but out-of-my-area subject. Basically, the clinic in this hospital will operate with what is know as a bank for frozen semen where material can be stored indefinitely at -196°C. The actual insemination will be intrauterine and will of course occur when the recipient is ovulating. The biggest single factor in unsuccessful inseminations in the past has been the timing of ovulation. With the advent of banks for frozen sperm this does not present the problem it previously did, in that the material for insemination is available at all times. It is intended to inseminate each woman every month for 5 cycles, unless of course pregnancy occurs. Once a pregnancy does occur the woman will return to her own GP, specialist or clinic for the duration of the pregnancy, with no mention of artificial insemination having occurred, thus preserving once again the confidentiality of the matter.

With regard to the legality of AID the courts have chosen for the most part to ignore the issue. However, it is easy to envisage potential problems. Five people, real or potential, are involved — husband, wife, doctor, donor and child — and each has rights. All sorts of queries arise, and as a result of these, the forms to which I have already referred, have become an important part of the procedure. The form signed by the couple offers the hospital and doctor protection, places responsibility on the husband, and provides for the rights of the child. The form signed by the donor releases him from rights or responsibilities with regard to the child. Since such documents could probably be successfully challenged in a court of law, there are steps to be taken that help avoid the problems:— The referring of the patient, who has had successful insemination, back to a doctor who is unaware of the AI. It is therefore this doctor who is named on the birth certificate. There is always the possibility that the husband may be the father of the child unless he is azoospermic, as the couple are encouraged to lead a normal sexual life throughout the procedure. The matching of blood groups of donor and husband is another safeguard.

In general, the hierarchy of a number of religious groups (Catholic, Orthodox Jewish, and some Anglican) are opposed to the practice of AID. However, there are many working members of these religions who take a more liberal view. Once again, we feel this is the couple's decision as to whether their own religious views are a barrier to AID or not.

Psychological

Artificial insemination has many psychological implications, which is why in our clinic each couple is assessed by the doctor and then by a social worker. To avoid any potential problems, both husband and wife must understand completely all aspects of AI and the couple are given every opportunity to discuss any queries they have. The husband must initially come to terms with his infertility; secondly, be able to accept the insemination of his wife by the semen of another man; and thirdly if the insemination is successful, parent a child not born to him. The success of such an undertaking will rest on the acceptance by the father, of the philosophy of parenthood in its widest sense, rather than in the restricted view of biological fatherhood. Encouragingly, studies have shown a remarkable acceptance by and marriage stability among these couples participating in AI. The divorce rate is significantly lower than that within the general community.

Attentive

Established clinics have also found that once the wife becomes pregnant, the husband tends to be very attentive throughout the pregnancy and at the birth, and are often back on the doorstep of the Specialist very quickly to enquire about a second try! Part of the work with the clinic being established here will be research, and it is hoped that discreet follow-up of the families established by AI will give some indication of problems which could arise in future. (Such as acceptance of the child, particularly by the father.)

Confidential

Confidential identifying information is not accessible to the staff involved in this program, as records are kept separately and securely.

One thing about this program is very clear, that it is a new and exciting project for those of us involved, and one where there is still much learning to be done.

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