THE UNIVERSITY OF CHICAGO

# ASSISTED REPRODUCTION IN GERMANY AND THE UNITED STATES: REGULATING THE FAMILY AND NEGOTIATING CONCEPTIONS

A DISSERTATION SUBMITTED TO
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# DISSERTATION ABSTRACT

This project compares the reproductive experiences of lesbians and the related treatment decisions of fertility physicians in Germany and the United States, which provide notably different regulatory contexts for lesbian reproduction. In Germany, several facets of regulations serve to discourage lesbian use of fertility medicine, whereas in the United States, few regulations on fertility medicine exist. Drawing on a review of country regulations, content analysis of media coverage, and in-depth interviews with lesbians and physicians, I argue that the regulatory context (including legislation, medical professional guidelines, health insurance policies, and case law regarding families) both reflects and reinforces the reproductive cultural practices in these two countries. Overall, I find that the regulations have notable effects on physician treatment decisions and lesbian reproductive decisions regarding the logistics of conception and the choice of sperm donor. In particular, regulations in Germany discourage lesbian use of fertility medicine and inadvertently encourage novel kinship practices, while the regulatory context in the US encourages the medicalization of lesbian conception and the reproduction of the two-parent, tightly bounded family unit.

# CHAPTER 1: INTRODUCTION

In this dissertation, I explore the ways in which different regulatory contexts influence the reproductive decisions of lesbian couples, as well as the treatment decisions of fertility physicians in Germany and the United States. My initial interest in a comparison of these two countries stemmed from the surprise I felt when I learned that Germany, which is generally regarded as a progressive nation regarding gay and lesbian rights, had stricter and more discriminatory policies toward lesbian reproduction than the US. My surprise became academic curiosity, as I learned that Germany had successfully implemented civil union partnerships and prohibitions on employment discrimination with little political turmoil and that there were several prominent, openly gay politicians on the German political stage. In 2010, when I was designing this project, the US appeared considerably less tolerant, as gay marriage was highly controversial and expressly prohibited in a majority of the states, employment discrimination on the basis of sexual orientation was legal in many places, and openly gay American politicians were quite rare. Thus, I was confounded to learn that policies toward gay and lesbian reproduction in these two nations exhibited a different, arguably paradoxical pattern. Whereas the American Medical Association (AMA) expressly allowed for the treatment of lesbians with techniques of fertility medicine, the *Bundesärztekammer* (German Medical Association, hereafter BÄK) holds that lesbian couples and single women should not receive such treatments because their children would lack connection to a social father. Thus, I set out to examine how the different regulatory frameworks impacted lesbian reproduction in these two countries, both with regard to the physicians who provide access to treatment and for the women attempting to conceive outside of a heterosexual partnership.

My results are best illustrated by the following two case studies.

I met Alexandra[1], a 39-year-old, white lesbian, in her homey, spacious apartment in Berlin. She was dressed comfortably in jeans and a fitted black long-sleeved t-shirt. We sat in her kitchen with high ceilings and bright red walls, the countertops full of cooking implements and produce, drinking tea over the light brown table. At the time of the interview, Alexandra's youngest daughter, Katja, was just over a month old. She spent most of the interview nestled in her mother's arms, oblivious to the fact that we were discussing her own conception in great detail as she slept.

Alexandra told me how she and her partner had searched for a donor by taking out an ad in two local, gay newspapers soliciting sperm donors. She described the many men who had responded, noting that few of them fit the criteria she and her partner privileged, namely, a man who would be willing to be in regular contact with their children but who would respect that she and her partner and the children would be the core family. When they finally did meet someone suitable, they discussed at length the role he would play in their potential children's lives before they tried to inseminate using his sperm. Then, Alexandra tracked her ovulation by checking her basal body temperature over a few months, and the donor came over on the right day with his sperm tucked under his arm. Alexandra's partner used a needleless syringe to deposit the sperm into her vagina. On the very first try, Alexandra became pregnant with their first daughter. With Katja it took just two tries before they were successful.

I met Joy, a white, 31-year-old lesbian, in her vintage apartment in Chicago. She wore a comfortable, maroon short-sleeved shirt and jeans, and had chin-length brown hair. During the interview, we sat on a plush, vintage couch, in a living room with wood floors and a throw rug, and myriad pictures, both artistic and family photographs, hanging from the walls. Mavis, Joy's

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[1] I use pseudonyms throughout the dissertation and sometimes change identifying details to protect the confidentiality of my respondents.

daughter, was not quite three months at the time of the interview, and she was asleep in a basinet when we arrived. After almost an hour, she began to cry, but she was easily comforted when her mother picked her up.

Joy and her partner found their sperm donor through careful perusal of sperm bank offerings. They prioritized finding a donor who, based on his height and "coloring," would not look out of place in either her or her partner's families. With the donors who fit those criteria, they narrowed the options by reading their profiles and looking for someone whose answers to the stock questions provided by the sperm bank resonated with them. They ended up with an identity-release donor, meaning a donor who agrees to have his name and contact information released to offspring upon request when they reach 18 years of age, although they had not ruled out anonymous donors during their initial searches. At the time of the interview, however, Joy was glad that they ultimately went with a donor who had agreed to have his name released when her daughter was old enough.

Because they knew that their inseminations would only count for insurance purposes if they were done by a physician, Joy did not try to inseminate at home. Instead, she went to her doctor's office for three rounds of intrauterine inseminations (IUI), after which she transferred to a fertility specialist. The specialist undertook three more IUIs, this time with the addition of ovulation stimulation hormones, and ran "all the tests" to check for hormone levels and potential blockages. Although the tests did not indicate any fertility issues, after the three IUIs at the fertility center, Joy underwent in vitro fertilization (IVF), paid for by her insurance, which resulted in Mavis.

These two cases highlight some of the most salient differences I found between lesbian childbearing experiences in Germany and the US: location of conception, level of medicalization of conception, and kind of donor chosen. In the following chapters, I explore how these differences are influenced by the different regulations in each country.

## ASSISTED REPRODUCTION AND LESBIAN CHILDBEARING

Assisted reproductive technologies (ART) generally refer to "any fertility procedures in which both eggs and sperm are manipulated outside the body in a laboratory" (Arons 2005:7). However, in this project, I use the more general term "assisted reproduction" to encompass procedures in which sperm or eggs alone are manipulated, such as assisted insemination (AI, also referred to as "artificial insemination" and "alternative insemination") and fertility hormone treatments that stimulate egg production.[2] I include these procedures because they are undoubtedly fertility treatments, and many of the same issues of access and regulation arise for individuals wishing to pursue these treatments medically.

Assisted reproductive technologies (ART) have profoundly changed the ways in which individuals are able to have children. Historically, infertility has been viewed as a moral failing to which almost exclusively women were prone (Mamo 2007). For centuries, women who had trouble conceiving had little more than spiritual recourse. As medical interventions developed – along with the related fields of biology and genetics – and physicians professionalized in the nineteenth and early twentieth centuries (Starr 1982), infertility came to be viewed as a biological pathology. Gradually, techniques were developed to address fertility issues, although for decades, these approaches continued to focus almost completely on female infertility (Mamo

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[2] Assisted reproductive technologies, then, include procedures in which (a) sperm is transferred into a woman's uterus (IUI), (b) sperm and egg are combined in a laboratory and then transferred to a woman's uterus (IVF), and (c) variations on those procedures. As Arons summarizes, "Variations on IVF include injecting sperm directly into an egg, combining sperm and egg in the lab but transferring them to the woman's body before fertilization, or transferring an embryo to the fallopian tubes instead of the uterus", with different procedures being indicated for different fertility problems (2007:7). ART also encompass a fourth category of procedure: (d) the testing that can be carried out on embryos created in the laboratory before they are implanted, referred to as Preimplantation Genetic Screening and Preimplantation Genetic Diagnosis. These tests inspect laboratory-created embryos for chromosomal abnormalities and genetic characteristics (ranging from life-threatening illnesses to embryo sex).

2007). Despite medical advances, “sterility” remained intimately tied to moral and character failings in the popular understanding, and “barrenness” continued to be viewed as resulting from the moral failing of individual women (May 1995), and only recently has attention begun to shift to the role of male factor infertility.

The first human sperm donation on record took place in 1909 (Mamo 2007), and throughout the twentieth century, reproductive technologies developed at a rapid pace, a trend that continues today (Spar 2006). Advances in sperm storage, selection, and cleaning gave rise to a large sperm bank industry in the late twentieth century (Spar 2006; Almeling 2011), and the techniques available to treat infertility have expanded in scope. Indeed, since the birth of the first “test tube” baby in 1978 through in vitro fertilization, reproductive medicine has grown immensely, both in terms of the number of patients and providers, as well as the techniques and approaches available.

By enabling conception without heterosexual intercourse, ART have opened new frontiers of childbearing for gay, lesbian, and single people. As early as 1975, lesbians were using AI techniques to become pregnant (Agigian 2004), and only ten years later, scholars began to speak of a “baby boom” in the gay and lesbian community (Steckel 1987, Patterson 1992). Firm estimates for the number of families involved in this baby boom are hard to obtain because of the difficulty of counting gay and lesbian families (Patterson 1992, Agigian 2004, Mamo 2007). Nonetheless, evidence suggests that same-sex couples are reproducing with increasing frequency, with “planned lesbian families” becoming more and more common (Bos, van Balen, and van den Boom 2003). While it is not currently possible to accurately report the number of lesbian couples using reproductive technologies, there are estimates of the number of gay and lesbian households currently raising children. Moore notes that, “more than one in four of the nearly 600,000 same-sex couples identified in the US Census have a child under the age of eighteen living in the home with them" (2010:229). These figures include a wide range of gay and lesbian family types, not only lesbians who intentionally have one partner gestate a biologically-related child. It is similarly difficult to estimate the incidence of "single mothers by choice", or those women who purposely become pregnant despite not having a partner. However, just as lesbian-headed families are on the rise, single-mothers by choice have been garnering attention as their numbers grow. Currently, one-third of all American children are born to an unwed mother, with 25% of those births to teenage mothers (Hertz 2006). The numbers of single women over 30 years old who gave birth have grown considerably since the 1970s, and various websites and books are devoted to this family choice.

Because AI is a procedure that can be done without the aid of a physician, there is no way to know the exact number of times AI is undertaken each year. The latest available statistics indicate that over 80,000 children in the US were born as the result of IVF or from donor sperm in 2004 alone (Mundy 2007), though this includes only inseminations performed by physicians. There is limited evidence that at least 1,000 lesbians request insemination services from a physician annually, yet this number is likely a vast underestimate (Agigian 2004). The numbers of gay and lesbian families in Germany is similarly uncertain, with estimates ranging from a few thousand to one million (Regenbogenfamilien 2008), and there are few statistics available on the number of women who intentionally pursue parenthood in the absence of a partner. Experts agree, though, that the number of families created this way is rising and that trend is likely to continue as tolerance for lesbian parenting increases and the techniques facilitating such childbearing continue to improve.

To date, little research connects medical and legal regulations of these technologies to their lived effects on both providers and patients. Furthermore, most existing literature focuses on single countries, in particular the US and the United Kingdom, thereby precluding the nuanced theoretical and empirical observations made available through comparative study. In the following pages, I address these research gaps by examining how the regulatory contexts in Germany and the US affect lesbian reproduction differentially.

These regulatory contexts include more than just the policies of the professional medical associations of each country. Thus, I examine how regulations regarding medical practice, insurance coverage, and legal definitions of family converge on lesbian reproduction. In addition, I examine how providers' conceptualizations of family and their orientation to their professional ethical guidelines influence their interaction with and service to lesbian patients. By comparing the cases of Germany and the US, I demonstrate how the regulatory context influences the reproductive practices and experiences of lesbians differentially, with lesbians in Germany ultimately pursuing pregnancy with less medical intervention because of the ways in which their reproduction is discouraged by the existing regulations. Lesbians in the US, however, experience reproduction in a more medicalized and commodified way, due in part to the regulatory openness of their national context. My argument follows the "law as culture" framework posited by Saguy and Stuart (2008), in that I do not argue that the regulatory context is an independent variable, causally influencing reproductive practices, nor do I argue that differential reproductive practices are driving the divergent regulatory frameworks in Germany and the US. Instead, I argue that the cultural practices of lesbian reproduction are shaped by the regulatory differences, at the same time as they reinforce these regulations. This is because lesbians in Germany and the US make their reproductive decisions in the framework of their national regulatory context, leading lesbians in Germany to a less medicalized experience and lesbians in the US to a more medicalized experience. At the same time, however, the relatively demedicalized reproductive experiences of German lesbians decreases the potential motivation for protest against the discriminatory practices, because lesbians view medical intervention as a last resort and thereby do not frame the current structure as a significant impediment. In the US, on the other hand, the framing of lesbians as important consumers of assisted reproductive treatments bolsters physician and sperm bank acceptance of these women into the "fertility industrial complex" (Agigian 2004), which serves to make medicalized reproduction a primary means of childbearing practices. In short, then, the regulatory context and a culture of medicalized lesbian reproduction serve to reinforce one another in the US, while in Germany, both cultural practices and the regulatory context discourage medicalization. In both cases, however, regulations and cultural practices are mutually reinforcing, leading to notable differences in the experiences of lesbians looking to reproduce and the physicians who offer fertility treatments.

## LITERATURE

This study contributes to literature on the medicalization and commodification of reproduction, as well as to the scholarly understanding of planned lesbian childbearing and kinship practices. By drawing upon these bodies of literature, I expose how questions regarding the impact of reproductive regulation – both legal and professional – on the reproductive decisions of lesbians have been left unexplored in the prior literature. In this project, then, I contribute to these bodies of literature by demonstrating the consequences of regulation – both intended and unintended – on lesbian reproduction, in particular with regard to the medicalization and commodification of childbearing.

### *From Medicalization to Biomedicalization*

Since the 1970s, scholars have been examining the process of medicalization, whereby medicine has expanded its purview and control over a number of arenas, ranging from birth to impotence (Zola 1972). Conrad provides a concise definition of the term: “Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (1992:209). He argues that, while the term medicalization literally means “to make medical,” in practice the term is used more critically, often implying an overstepping of the boundaries of medicine (1992:210). In the realm of reproduction, birth has been extensively analyzed as an example of medicalization, as birth has moved from the home to the hospital, birth attendants have gone from mostly midwives to mostly obstetricians/gynecologists, and medical interventions such as electronic fetal heart monitoring and cesarean section have become increasingly common (see, for instance, Block 2007; Simonds, Rothman, and Norman 2007; Wagner 2006).

Relatedly, Starr described the professionalization of doctors, through which medicine became a respected, powerful profession (1984). Physicians gained cultural authority by capitalizing on their strategic position in the healthcare industry, by lobbying for legal and governmental protection and autonomy, and by emphasizing their specialized skill set and their perceived trustworthiness as a profession. Moreover, physicians have exercised their cultural authority and their professional status to achieve various ends in the battles over reproductive control that have taken place over the years, particularly with respect to abortion, contraception, sterilization, and birthing methods (see, for example, Luker 1984; Flavin 2009; Smith-Rosenberg 1985; Burns 2005; Solinger 2005; Schoen 2005; and Rooks 1997 ).

To encapsulate the myriad transformations taking place in the profession of medicine since these early formulations, researchers have more recently identified another crucial phenomenon in medicine, that of biomedicalization (Clarke et al 2003). Biomedicalization comprises several complex and interrelated processes, the most relevant of which, for my project, are: (a) the increasing reliance on technology for medical diagnosis, treatment, and routine organizational tasks; (b) the continuing commodification of treatment; and (c) the exacerbation of inequality in health care. ART are a prime example of the biomedicalization of medical care, as technology has expanded its reach in every arena of fertility treatment. The range of techniques has expanded immensely since the first successful pregnancy from IVF was achieved in 1978. The related techniques present an alphabet-soup of acronyms, such as AI, IUI, IVF, and ICSI (see Glossary in Appendix C for definitions). New developments almost inevitably involve more intensive medical intervention in reproduction. In addition to the expanded scope of technologies and techniques available for treating fertility related issues, managed care organizations have grown increasingly dominant in the structure of US health care, as insurance companies are increasingly involved in defining what treatments are covered for which diagnoses.

### *Commodification of Fertility Treatment*

For fertility-related issues, although medicalization has grown immensely, insurance coverage is far from guaranteed, and treatment costs are significant. Consequently, new reproductive technologies have raised significant class implications in reproduction. Doctors may have incentives to cater to wealthy patients who can pay out-of-pocket for multiple rounds of escalating (in both level of intervention and cost) treatments. As researchers have noted, the increasing biomedicalization of society relates in part to the increasing commodification of health care (Clarke 2003). With ART, the existence of market mechanisms in treatment is particularly problematic, as there is a persistent lack of adequate insurance coverage for these procedures, as well as ongoing debates about whether infertility is a “condition” or a “disease”, only the latter of which would qualify it for treatment as a medical issue.

In general, health care has only passing resemblance to an ideal market, as demand for treatments is often inelastic and patients have little prior knowledge of the costs of treatment, nor do they have the ability to effectively compare the care offered at different facilities and by different doctors. Spar notes that:

> In [a certain] respect, the fertility trade functions very much like the medical trade in general. That is, the people who purchase fertility services don’t see themselves as participating in a commercial relationship. They switch providers only reluctantly; they don’t argue about price; and they generally don’t blame the doctors when treatment fails (2006:49).

Questions of acceptable treatment and professional discretion thus become profound, as the boundary between patients receiving medical treatment and consumers purchasing an incredibly valuable item blur. Success rates for treatments, such as IVF, hover in the 30% range. Yet many individuals and couples spend thousands of dollars pursuing pregnancy through fertility treatments. Such individuals are determined – possibly even desperate – to have a baby, and a low chance of success is nevertheless a chance.

Furthermore, many of the technologies now provided by doctors of reproductive medicine contribute to the possibility that people will strive to create “designer babies.” As infertile couples engage in practices, such as offering thousands of dollars for the ova of blonde, Ivy League graduates or paying lower-class women to carry implanted embryos to term for them, many have questioned the extent to which today’s physicians are engaging in a modern form of eugenics (see, for example, Duster 2003). Physicians face pressure from various sources when it comes to the broad swath of available treatments, ranging from pro-life advocates, who decry the destruction of embryos that may accompany the fertility and screening technologies, to couples desperate to provide the "best possible start" for their potential child, compelled by the increasing focus on genes as the basis for health, disease, and developmental success (Evans 2010; Clarke et al 2003). Thus, fertility medicine provides a context ripe for the analysis of biomedicalization, as issues of technology, stratification, and commodification are at the forefront for these treatments. Several researchers have exposed the increasingly medicalized nature of reproductive technologies (Becker 2000; Franklin 1997; Hertz 2006; May 1995; Almeling 2011). However, the impact of regulatory context on the likelihood of biomedicalization remains unexplored.

### *Lesbian Family Building*

Family sociologists have referred to the profound changes in family life that have occurred over the past 50 years as a "family revolution" (Goldscheider and Waite 1993; McLanahan and Casper 1995; Cherlin 2009). This revolution encompasses a host of changes that have taken place: (a) from the rise of premarital sex and childbearing out of wedlock to the increase of women working in the paid labor force, (b) from the rise in cohabitation and divorce to the delayed age at first marriage, and (c) the increasing percentage of households consisting of one solitary individual. Included among this revolution are the rise in visible gay and lesbian families and the increase in single motherhood; both trends have been flashpoints of controversy in the political debates of recent decades.

Many studies of gay and lesbian families examine how these families compare to their heterosexual counterparts. One focus of these studies has been the outcomes for children in gay and lesbian headed households, with widespread agreement that children in these families have similar life outcomes to their counterparts raised by heterosexual parents (Stacey and Biblarz 2001; Stacey 1998; Manning, Fettro, and Lamidi 2014). Weston's groundbreaking work demonstrated how gay and lesbian people often create family ties without genetic bonds, both with and without children (1991). Further work on gay and lesbian families has questioned whether these families threaten the heterosexual marital order or whether they instead conform to heteronormative societal expectations, thereby strengthening the legitimacy of the "normal" family (e.g., Lewin 1993, Mamo 2007). These studies have begun the crucial work of theorizing how gay and lesbian families render problematic the heretofore taken-for-granted assumptions of what constitutes a family (e.g., Powell 2010).

Much of the work that has been done in anthropology and sociology on ART thus far has also theorized how these technologies challenge traditional notions of family and kinship. The "new" kinship studies in anthropology have demonstrated how not only kinship, but also the presumed biological facts of reproduction, are socially constructed in culturally and historically contingent ways. Franklin emphasized how assisted reproduction laid bare the culturally and historically grounded assumptions present in prior research on kinship, demonstrating that, with the increasing scientific knowledge and techniques available today, the "facts" of reproduction become less clear (1997). Others have shown that kinship can be used in contradictory ways across contexts, particularly when ART are involved (Edwards et al 1999; Cahn 2013). Early sociological examinations of reproductive technologies recognized that these new family possibilities provide a "direct challenge to the traditional family paradigm" that is widely used in family sociology (Edwards 1991:350). More specifically, Edwards noted that "the new technologies present the need in the short run to redefine 'parenthood' and 'family' relations" (1991:356) – a process that is only beginning in sociology.

Researchers have also examined the "lesbian baby boom" to survey how new family forms may simultaneously destabilize, reinscribe, and make visible traditional assumptions about what family means (Agigian 2004; Luce 2010; Mamo 2007). These authors examine the ways that technology-assisted reproduction among lesbians "brings into sharp relief some of our most taken-for-granted assumptions about families" (Agigian 2004:1). Mirroring the anthropological texts discussed above, these researchers investigate the novel ways that lesbian parents navigate the complex terrain of kinship ties when constructing their families. For instance, Mamo argues that "kinship itself is a kind of doing," meaning kinship ties are enacted and constructed through family building practices and choices (Mamo 2007:223). Similarly, Hertz (2006) explores how single mothers by choice choose donors to match certain genetic characteristics and develop their own understanding of kinship and relatedness. All of these studies explore the extent to which these new forms of reproduction challenge the traditional family model. Hertz goes so far as to assert that the core of the family is now comprised of the mother and her children, arguing that this is true not only for the single mothers by choice whom she studies, but also for lesbians. In short, each of these texts makes clear how relevant issues of family creation using ART are for the concept of family itself, by demonstrating the wide-ranging implications of these technologies for understanding relatedness and identity, and by reemphasizing the need for sociologists to redefine the meaning of family itself.

### *Redefining Family in the Face of Lesbian Parenting*

While the legal and professional regulations about lesbian parenthood are major ways that family is defined, these regulations do not comprise the only way that family is understood. Indeed, as Richman states, "The diversity of the American family, just like homosexuality itself, is something that has preceded legal efforts to protect, dismantle, or even define it" (2009:19).

Furthermore, in Richman's study of American family law dealing with gay and lesbian families, she finds that "in 40 percent of the cases… family and parenthood were explicitly treated by judges as institutions or constructs to be defined – in other words, their definitions were not taken for granted or assumed to be settled as a matter of law or linguistics" (2009:22). Although Richman's study does not allow for an assessment of whether the same shifts have happened in family law cases that do not involve gay and lesbian parents, she does assert that these cases represent a clear transition from an era in which the concept of family did not require explicit definition. Thus, even in legal analyses of court cases, there is clear recognition that the law is but one of many institutions that help shape how people understand the boundaries of family and relatedness. While I do not wish to make a causal argument regarding the interrelated and mutually reinforcing roles that the law and public opinion play in defining family, I do want to briefly review the ways in which the public understands what constitutes "family" in both Germany and the US, in particular for families headed by same-sex and single parents.

In national opinion surveys on family and gender roles collected in 2012, 62% of Germans indicate that same-sex couples can be equivalently good at parenting as heterosexual couples, compared to only 47% of Americans (Bolzendahl, Cheng, and Powell 2015). Germans, then, appear to have more positive views of same-sex parents than their American counterparts. At the same time, 58% of Germans say single-parents are as good as two parents, compared to 49% of Americans. Thus, more Germans support alternative family structures overall, but there is slightly more support in Germany for same-sex couples raising children, whereas Americans are slightly more likely to support single parent homes than same-sex parents.

In their 2010 study, Powell et al. examined how Americans define family. The study was motivated in large part by a desire to understand how same-sex couples are viewed, but the study design also examined whether respondents considered a number of different types of households – including but not limited to same-sex pairs – to be under the umbrella of "family." In brief, they found that there are three major groupings that roughly translate to how expansive a definition of family the respondent holds. Specifically, the largest group (45.3%) are "exclusionists" who "privileged the traditional heterosexual family (especially those with children)", whereas they classified 29.4% of respondents as "moderates", who considered family to encompass those arrangements where either children or "a legal bond (marriage)" were present. Finally, Powell et al. find that 25.4% of their respondents were "inclusionists", who viewed all of the living arrangements examined in the survey (from a husband and wife with children to two same-sex, unmarried partners without children) as family. These same researchers are currently conducting a similar study in Germany, and initial findings indicate that Germans have more varied definitions of family than Americans. On the one hand, there are some Germans who have more coherently conservative definitions of family than the exclusionists in the US. On the other hand, Germans overall tend to emphasize the presence of children as the key feature of a family, with far less emphasis placed on whether a couple decides to marry (Bolzendahl, personal communication, 10/20/15).

### *Lesbian Access to Assisted Reproduction*

While ART are generally created with the needs of heterosexual couples in mind, these techniques nevertheless can be used to facilitate childbearing of lesbians, gay men, and single people. Researchers have repeatedly confirmed the growing role of reproductive technologies in the creation of each of these family types (Agigian 2004; Luce 2010; Mamo 2007). The advent of ARTs has allowed doctors to employ both their own worldviews and economic calculations when deciding which patients to treat and how. On the one hand, as mentioned above, doctors may choose to treat anyone who can pay for treatment (e.g., the doctor who implanted multiple embryos in the "Octomom"[3]), while on the other, they may rely on their own stereotypes of whom is fit to parent. Because doctors performing reproductive procedures are not subject to much regulation about whom they treat, throughout the 1980s and 1990s and even to some extent today, physicians are easily able to screen patients they deem to be unacceptable patients:

> In the main, however, the restrictions placed by physicians on the exercise of artificial insemination are determined by their own personal sense of professional responsibility. Despite the difficulty of assessing the mothering ability of a nulliparous [childless] woman, nearly every comprehensive medical treatise on artificial insemination over the years has cautioned their physician readers to take this responsibility seriously (Wikler and Wikler 1991).

The determination of who might be a good mother and, by extension, what household would constitute an appropriate family for the potential offspring has led physicians to refuse to treat a range of "not good mothers", including: "single women, lesbians, welfare recipients, and other women" (Roberts 1997:248). For instance, fertility doctors may purposely guide non-white patients away from using reproductive technologies, and they may also rely on prejudices in screening infertility patients for causes differentially based on race (Roberts 1997). Similar tactics may be employed by physicians who disapprove of lesbian childbearing.

For lesbian couples and all single women attempting to become pregnant using reproductive technologies, physicians' control over these technologies is similarly troublesome. For many of these women, the greatest obstacle to treatment is the institutional definition of infertility adopted by doctors, clinics, and insurance companies. Because the current definition of infertility requires heterosexual intercourse, it seems that lesbians and single women not engaging in frequent sexual intercourse cannot qualify as infertile. This definitional criterion is

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[3] Nadya Suleman is often referred to as the Octomom because she was the first woman to give birth to octuplets who survived. This case is described in more detail in Chapter 2.

particularly problematic for women with fewer financial resources, as they are unlikely to be able to afford the full cost of the expensive medical interventions. For those with financial means, however, access to reproductive technologies seems to be relatively easy to come by in the US, which implies that the current, consumer-based structure of infertility treatments privileges patients with money (Mamo 2007). In other words, doctors motivated by profit may well accept patients who do not fit the traditional heterosexual family model. As Agigian (2004:xi) notes:

> …the infertility industry has consolidated, and lesbians have been recognized as a lucrative market [because they] must pay out of pocket, and therefore at higher rates than insurance companies would reimburse… In the struggle between capitalist imperatives and heterosexist prohibitions, the balance seems to be tipping toward the almighty dollar, with lesbian dollars increasingly welcomed.

Thus, class and insurance status may be usurping family structure and race as the least discussed yet nevertheless crucial variables for doctors considering fertility treatments. Yet ideas of appropriate family types may still play a role in doctors' decisions about providing ART treatment to certain women. While coupled lesbians certainly can face barriers to treatment, single women of any sexual orientation may also face discrimination when attempting to become pregnant without a partner. Indeed, a segment of society now believes that "two parents (even same-sex parents) are inherently better than one" (Hertz 2006:19). Furthermore, the information available to those choosing sperm donors has increased dramatically in recent years, with women seeking sperm now able to examine detailed profiles and even photographs of potential donors – though each piece of information comes with a fee attached.

## DESIGN OF THIS STUDY

To assess how regulation of reproduction affects lesbian childbearing practices and experiences, I compare two research sites with notably different regulations: the US and

Germany. Because these two nations are similar in their level of industrialization, economic power, and relative acceptance of alternative family structures, they provide a similar backdrop upon which to examine my research questions in depth. Yet because legal regulation of the family and medicine is notably different in these two nations, a comparison of the on-the-ground experiences of people in both places allows for a nuanced and in-depth examination of the subtle differences of how regulation influences opportunities, desires, and choices. I primarily collected data from two cities, Berlin and Chicago (Illinois), with smaller numbers of interviews conducted in Milwaukee (Wisconsin) and Munich to provide an assessment of the extent to which local differences affect experiences.

This study involves comparative analyses of sources from Germany and the US, which include reviews of legal regulations and professional guidelines, in-depth interviews with a range of respondents, and content analysis of major news sources, along with systematic analysis of websites of assisted reproductive clinics. To establish the current regulatory context, I researched the national and state governmental policies, as well as those of the medical associations in Germany and the US.

To explore how the regulatory context affects lesbians attempting to have children and medical professionals who provide fertility care, I conducted 77 in-depth interviews (see Appendix A for details). In particular, I interviewed 28 health care professionals who work in fertility medicine and 40 lesbians who were attempting to become pregnant or had recently given birth, with a roughly equal number of interviews conducted in Germany and the US. For both my health care provider and my parenting respondent groups, I continued to conduct interviews until I reached data saturation (Small 2009), meaning that additional interviews did not yield new information, nor did additional participants challenge the patterns I had observed in previous interviews (see Appendix B for more information on the researching design).

Throughout the dissertation, I refer to differences between Germany and the US that surfaced in the analysis of my qualitative data. However, I do not mean to imply that the differences between my respondents' experiences in these two countries are statistically significant, because my research design is inappropriate for assessment of such concerns. I used convenience and snowball sampling to reach out to groups of people who are not equally distributed throughout the population and who cannot appropriately be studied using random sampling techniques. Furthermore, I intend for this project to produce qualitative conclusions about interpretive differences in meaning and experiences rather than tests of difference in underlying population distributions. The reader should keep this in mind when reviewing the data presented in later chapters.

## OVERVIEW OF THE DISSERTATION

Chapter 2 sets the stage for the following empirical chapters by giving an overview of the major regulatory factors for the analysis: the regulations regarding assisted reproduction, including medical guidelines, national legislation, and insurance coverage in both Germany and the US. In addition, I describe briefly what national survey data reveal about Germans' and Americans' beliefs about families, in particular those headed by lesbians and single women, as well as how non-traditional reproducers' use of reproductive technologies is framed in popular news media.

In Chapter 3, I explore how medical doctors integrate their country-based regulatory context with their personal beliefs when making treatment decisions. I find that, although my physician respondents' range of beliefs about families is similar in Germany and the US, treatment practices vary notably between these two countries. In particular, traditional physicians in Germany refuse to treat lesbians and single women, while their American counterparts undertake such treatments. I argue that the professional guidelines in Germany allow traditional physicians a convenient rationalization for discrimination, allowing them to refuse treatment to non-traditional reproducers without feeling as though they are taking a moral stance. On the other hand, traditional physicians in the US, lacking a regulatory cover for discrimination, offer treatment to lesbians and single women even when they do not support the creation of such families.

In Chapter 4, I explore how lesbian couples in Germany and the US navigate conception options. I find that most women pursue conception according to what I term their "conception worldview." My research demonstrates that there are two distinct conception worldviews. Broadly, the *natural conception worldview* posits that conception is a natural process preferentially undertaken at home, for which doctors are unnecessary, and in which bodily expertise is privileged over other forms of expertise. By contrast, the *medical conception worldview* holds that conception is a process improved through the use of technology, for which physicians are well-trained, and in which their professional expertise is given the final authority. I find that, in both countries, the natural conception worldview is more widely held by my respondents, which is reflected in the fact that the vast majority of my respondents initially attempt to conceive at home. However, the German women I interviewed were more likely to remain attached to the natural conception worldview even when faced with difficulty conceiving, in part because they anticipated the possibility of discrimination in a medical setting, compared to their US counterparts. My US respondents, by contrast, more readily embraced medical settings for conception, in part because they wished to access insurance benefits that only recognized inseminations performed by a physician as legitimate. Thus, the regulatory context influenced my German and US respondents in opposite ways, with the latter being encouraged to embrace a more medicalized approach to conception, whereas the former are discouraged from doing so. This in turn deepens the divergences between cultural reproductive practices in Germany and the US, which thereby reinforces the differences between regulatory contexts.

In Chapter 5, I explore how donor selection processes are influenced by the regulatory context and by my respondents' personal preferences regarding donor characteristics. I find that my German respondents are far more likely to persist in seeking a private donor than their US counterparts, who often turn quite readily to sperm banks. Furthermore, the selection processes undertaken by respondents seeking known donors privilege trust, intuition, and a sympathetic feeling toward the donor, whereas respondents sorting through sperm bank offerings focus on matching the ethnic background and appearance of their partner. I argue that these different approaches to donor selection reflect the divergent regulatory contexts and serve to reinforce them. In Germany, my respondents avoid interactions with the medical establishment in part due to fears of discrimination and a desire to keep costs down, which reinforces these women's understandings of conception as non-medicalized. By contrast, in the US, my respondents react to a perceived litigious culture, and they often cited custody disputes as reasons to privilege a nuclear family model. This serves to reify the two-parent family as the dominant model, while also cementing lesbians' incorporation as sperm bank clientele.

In the final chapter, I review the findings and briefly describe recent developments (such as the Supreme Court ruling for gay marriage in the US and adjustments to the regulations in Germany) and how these changes may affect the practices of lesbian family building in the near future, both for lesbians and for the physicians who may treat them.

# CHAPTER 2: REGULATING ASSISTED REPRODUCTION IN GERMANY AND THE UNITED STATES

## INTRODUCTION

Germany is widely considered a progressive nation regarding gay and lesbian rights, with notable legal accomplishments achieved since 2000, such as civil union partnerships and prohibitions on employment discrimination on the basis of sexual orientation. Although the Supreme Court's landmark ruling on gay marriage in 2015 shifted the legal landscape while I was conducting this research, at the outset of the project, the US appeared considerably less inclusive, and in some respects it remains so. A paradox arises, then, when one considers that the situation is reversed in the realm of reproductive technologies: the American Medical Association (AMA) states that it is "not unethical" (and therefore not legally sanctioned) for doctors to treat lesbians and single women with AI, whereas the current guidelines of the Bundesärztekammer (German Medical Association, BÄK hereafter) declare that such treatments should be offered only to married couples or unmarried women who live in a stable (*festgefügt*) partnership with an unmarried man who will acknowledge the child as his own. However, these professional guidelines provide just one level of regulation in a complex web of statutes, policies, and discourses that affect non-tradiational reproduction.

In this chapter, I provide an overview of the major regulations that influence my comparative findings, including legislation, professional guidelines, insurance coverage, and family law cases. Before describing the regulations, I examine briefly the themes and cases that dominate popular media coverage of families created through assisted reproduction in recent years. Together, these various influences provide the context for lesbian reproductive planning and physicians' treatment decisions that I explore in the following chapters.

# DISCOURSES IN MEDIA COVERAGE OF ASSISTED REPRODUCTION BY LESBIANS

As described in the previous chapter, public opinion in Germany emphasizes the importance of children for defining family, while in the US, marriage plays a larger role in shaping public opinion regarding who counts as a family (Powell et al. 2010). In addition, while there is wider support in Germany for both lesbian- and single-headed families structures, Americans are slightly more likely to support the latter, while the Germans are more likely to support the former. In addition to public opinion, understanding the public discourses around assisted reproduction and non-traditional families is necessary for the contextualization of the experiences of my respondents. By examining how insemination of lesbians is covered by major news media, I am able to explore the cultural frameworks for thinking about lesbian childbearing through pregnancy and how these differ in Germany and the US. Thus, I reviewed the articles published in at least three major news sources in both countries. In the US, I reviewed *Newsweek*, *Time,* the *New York Times*, and *USA Today,* and in Germany, I examined *Der Spiegel*, *Die Zeit,* and the *Frankfurter Allgemeine Zeitung*. I aimed to include newspapers and magazines with wide circulation and a range of editorial political leanings in both countries. Further details are available in the methods appendix (Appendix B).

There are remarkable similarities in the coverage in both countries. For example, the following themes surface repeatedly: family change, child custody, and the role of the donor. Furthermore, the coverage exhibits notable parallels in the style and content of reporting. For instance, *Newsweek* includes a long article on a private donor who contracts with women online to donate sperm directly, and *Der Spiegel* publishes a similar article about a man in Germany who has fathered 84 children through similar methods. Throughout both articles – and indeed throughout the entirety of the coverage I reviewed – the theme of the donor's role comes up repeatedly, although subtle differences in focus exist. In the *Newsweek* article on the private donor, whom the author terms a "donorsexual," the risk to recipients of using a known donor is brought up repeatedly. The following quote encapsulates these concerns: "Of course, the market for free sperm raises its own set of questions. What if a donor sues for custody? What if he lies about an STD? Is he a potential threat to public health? What if his real motive is sex – and would that even matter? Just who are these guys anyway?" (Dokoupil 2011). Risk here is framed as something borne by the woman receiving the sperm – as in the potential for STD transmission, custody battles, and sexual exploitation – and to society at large, through the potential effect on public health.

By contrast, the risk to the donor receives the most coverage in the article in *Der Spiegel*, particularly the risk of him being expected to act as a father figure and/or a potential source of child support. Thus, the following quote, presented as an exchange with the donor himself, appears near the end of the article: "Is he never afraid? 'Of what?' [the donor] asks. That one day they [all his offspring] will stand in front of his door? 'Then I would have wanted it [that way],' he says. And if they all want money from him, then he won't have any anyway. He won't have it for 84 children. Or more" (Hardinghaus 2012). The focus here is on the risk to the donor of being expected to support his offspring financially and emotionally, rather than on the risks to the parents raising the children themselves. This subtle difference in the focus of coverage is also reflected in the policies regulating sperm donation and the cases that play out in court in the two countries. In Germany, a focus on the well-being of the child (and its presumed need for a father figure) has led to the outlawing of anonymous sperm donation, a concern which is underlined by an opinion piece in *Die Zeit,* titled "One who doesn't want to be a father shouldn't donate sperm"

(Stockrahm 2013a). In the US, by contrast, the risk to the potential parents, particularly of a lawsuit from the donor for custody, motivates more media coverage.

In another striking parallel, coverage in both countries centers on the changing character of families, a broad phenomenon to which reproductive technologies have contributed. The theme of what constitutes family is present in the majority of the articles surveyed, with a focus on both the legal aspects of how family is defined by the state and on the affective issues of how individuals experience their familial ties. Here again, though, despite sharing this thematic similarity, the articles differ in emphases. While many of the American articles explicitly explore what the donor's role is in the family, with a focus on the potential for custody battles between parents in non-traditional families, the German articles accentuate the "normality" of lesbian parents. For instance, in an article titled "Does 'Sperm Donor' Mean 'Dad'?" in the *New York Times*, a prominent celebrity custody case involving sperm donation is described thusly: "[The case] raises the question of who should be considered a legal parent and challenges state laws that try to bring order to the Wild West of nonanonymous sperm donations" (Barnes 2014). Later in the article, the case is framed as uncovering "a complicated debate that exposes America's increasingly fuzzy definition of what constitutes a family" (Barnes 2014). The focus here, as in many of the American articles about family change, is on the fraying of shared definitions of family that is hastened by reproductive technologies and assisted reproduction.

While the definition of family is present in the German articles as well, there is a persistent focus on the fact that children born to lesbian couples are always wanted children. For example, an article in *Die Zeit* titled "Gay-lesbian parents: Father, Father, Mother, Mother, Child, Child," which profiles "rainbow families" in Berlin, begins with the line, "Children are never accidental for gay or lesbian couples" (Stockrahm 2013b). The author of the article continues to trumpet this as a boon for the children, emphasizing that children in such families may fare better than those in heterosexual ones “because for gay and lesbian couples, children never happen easily” (Stockrahm 2013b). The “fitness” of lesbian parents is raised in articles published in both countries, and in both countries coverage reflects the fact that research has shown children raised in these families to be as healthy as their counterparts raised by heterosexual parents. But while the American coverage emphasizes the expanding definitions of family in a way that is quite neutral with regard to the impact for society, the German articles are more outspoken in emphasizing the positive outcomes such families can have. These different emphases reflect in part the more muted public support for lesbian-headed families in the US, and perhaps the recognition that the regulatory situation in Germany complicates childbearing by gay and lesbian couples far more than in the US (i.e., the German media may hasten to highlight that the children of lesbians are “wanted” because the barriers to lesbian childbearing are higher). I turn to the regulatory differences now.

## REGULATIONS

I examine the regulations of reproductive technologies at several different levels, including legislation at the national and state level, guidelines adopted by professional organizations, and policies regarding insurance coverage for assisted reproductive treatments. This mirrors the approach taken by Präg and Mills (2015) in their comparative review of the usage and regulation of ART in European nations. Furthermore, I consider an additional arena of regulation that is particularly relevant to the lesbians and single women on whom this study is centered, namely, case law. Family case law addresses the complex determinations of custody and parental rights and obligations in situations where a lesbian couple or a single woman was involved in the initial decision to pursue parenthood. Before addressing each of these aspects of regulation, I describe briefly the cultural and political contexts that shape the different approaches to regulation that each of these nations has adopted.

While the US is one of the most lax countries when it comes to regulating ART, Germany is near the most restrictive end of the spectrum. These opposing regulatory schemas follow from different cultural frameworks and philosophies surrounding the practice of medicine and the place of the law in regulating human life. In the US, the capitalist orientation toward medical care and the Supreme Court's interpretations of the right to privacy explain much of the reluctance to explicitly regulate reproductive technologies. As Robertson (2004) summarizes:

> The reception of ARTs in the US cannot be adequately understood without an appreciation of the country's long tradition of individual liberty, free market and free enterprise orientation, and grants of wide autonomy to physicians and other professionals. At the same time, religious liberty is also highly valued in the US, and strong religious views or religiosity often influence public policy debates. The US response to these competing concerns has often been to sharply separate the public and private spheres. For example, individuals in the US are free to practice abortion, contraception, assisted reproduction, and embryo research but have no right to receive state funds to do so (193).

Indeed, the contentious debates about abortion in US political life may discourage politicians from getting involved in discussions of reproductive technologies, as the potential for alienating certain groups of voters on both sides of the political spectrum is high. As Evans finds in his study of religiously affiliated laypeople in the US, many religious groups are likely to oppose at least some kinds of ART. For instance, he notes that Catholics and evangelicals tend to oppose IVF if embryonic death occurs as part of the procedure (2010:51). However, he finds that potential for productive debate over reproductive genetic technologies exists, because opponents and supporters of various techniques have shared discourses in common and less entrenched opinions than in the abortion debates. Nonetheless, his findings do not provide a clear path through which politicians and other mediating institutions might be incentivized to take up the cause, and so widespread public debate to institute comprehensive ART regulation seems unlikely.

On the other hand, the German constitution (West Germany's Basic Law, written shortly after the end of the Second World War) explicitly recognizes the "inviolability of human dignity" and grants that "every person shall have the right" to the free development of his [sic] personality" as well as "the right to life and physical integrity." In many respects, the German government still contends with the memory of the Holocaust and the history of Nazi medical experimentation. This history contributes to the strictness of the laws governing reproductive technologies and the discomfort felt by many regarding ART and the eugenic specters they conjure. Germans are particularly sensitive to "the use of genetic science to classify and extend rights to people" (Robertson 2004:195), which contributes to the lack of political will for widespread availability of the many procedures frequently practiced in the US. In the following, I explore the historical development (or lack thereof) of the existing governmental regulations of reproductive technologies in these two countries.

### *Governmental Regulation in the United States*

The US has enacted few regulations governing ART as compared to other Western, industrialized nations. In the US, the practice of medicine is regulated at the state level, and thus every state has a medical board. However, many states do not have regulations specific to reproductive technologies, and those states that do have laws that often lack consistency and are rarely well developed. Among those states that have enacted legislation, there is much diversity. Some state legislatures prohibit and even criminalize certain reproductive options, such as New York's ban on surrogacy, while other states actively encourage the development of reproductive technologies, such as California's attempt to foster embryonic stem cell research. For the purposes of this dissertation, the key point is that neither the federal government nor the various state legislative bodies have enacted a comprehensive regulatory framework regarding reproductive technologies. Germany, on the other hand, has national legislation that severely curtails the use of ART by outlawing certain procedures entirely, which is described below.

There is no major, binding federal regulation governing ART in the US, and the only significant federal debate on the topic occurred in the early 1990s. Interest in reproductive technologies ran high throughout the 1980s and 1990s, due in part to widespread coverage of technological developments, such as the first live birth from IVF in England in 1978, followed by the first in the US in 1981, then the first live birth from a donated egg in 1984, the first successful gestational surrogacy in 1985, and the first live birth from intracytoplasmic sperm injection (ICSI) in 1993. Popular interest in these technologies and concern over their unchecked advancement led the federal government to make its first (and only) major foray into legislation focused on reproductive technologies in 1992.[1] That year, the federal government passed the Fertility Clinic Success Rate and Certification Act, sometimes known by the eponymous moniker the Wyden Act, after its sponsor Representative Ron Wyden, a Democrat from Oregon. This act required the publication of clinic-specific data on success rates for ART procedures and the development of certification standards for clinics handling sperm and eggs. The Centers for Disease Control and Prevention (CDC) was the agency made responsible for publishing the data on clinic success rates, which it began doing in 1995.

The provisions of the Wyden Act are voluntary, meaning that a clinic that refuses to give its success rate data to the CDC faces no consequence other than being listed by the CDC as "non-reporting." Despite the lack of penalty for non-reporting, clinic compliance rates have

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[1] I do not discuss the government's prohibition on federal funding for cloning research or the debates on stem cell research as their focus is not on the use of reproductive technologies for fertility treatment.

steadily increased since the passage of the act, with over 98% of clinics reporting their results in the 2013 report (CDC 2013). However, the data collected by the CDC only cover procedures for which eggs or embryos are used, so procedures using only sperm (such as intravaginal or intrauterine inseminations) and hormonal treatments that stimulate ovulation are not included in the report. In addition, reporting "success rates" may encourage physicians to implant more embryos than they otherwise might, as clinics may wish to inflate their pregnancy rates at the expense of increasing multiple births, despite the fact that multiple births come with increased long- and short-term complications and costs.

During President George W. Bush's tenure in office, the President's Council on Bioethics produced a report that assessed the regulation of ART. The council noted that "assisted reproductive technologies (ARTs) are regulated as the practice of medicine—with licensure, certification, professional oversight, and malpractice litigation as the chief means of regulation," and that "[t]here is minimal direct governmental regulation of the practice of assisted reproduction" (President's Council 2004:174), further noting that the regulations that existed were largely voluntary (175). The Council recommended various options for improving the regulatory framework, including the creation of a new federal agency to oversee ART (similar to the Human Fertilisation Embryology Authority [HFEA[2]] in the United Kingdom), the augmentation of existing agencies, and federal legislation. However, these policy options were not pursued with any vigor, and there has been no change to federal ART regulation since that time. President Obama's Presidential Commission for the Study of Bioethical Issues has not produced any reports on ART, and the political will to legislate the provision of ART in the US

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[2] The Human Fertilisation and Embryology Association is the independent regulatory agency "dedicated to licensing and monitoring UK fertility clinics… and providing impartial and authoritative information to the public" (HFEA n.d.).

appears to be lacking. Various observers have connected the relatively little public debate on ART in the US to the ongoing abortion controversies. For instance, Hunter argues that abortion is the emblematic issue of the "culture wars" that divide segments of American public opinion into irreconcilable fronts in a moral fight (Hunter 1991; Hunter 1994). The "culture war" thesis has been debated and interrogated, and Evans examines the extent to which the issues surrounding ART reflect these same divides. While Evans argues that there are notable distinctions in how people engage with reproductive bioethics in the cases of ART and abortion (2010), this finding has not (yet) been borne out by vigorous public debates over the regulation of ART, and controversies over abortion continue unabated.

### *Governmental Regulation in Germany* [3]

The situation in Germany is decidedly different. In 1990, the German Parliament responded to developments in reproductive technologies – specifically, the ability to create embryos in the laboratory for research purposes – by passing the Embryo Protection Act (*Embryonenschutzgesetz*). This act enshrines certain rights of embryos, recognizing them as an early form of human life that is subject to governmental protection. Thus, the Embryo Protection Act forbids several activities that are commonplace in reproductive medicine in the US. Specifically, one cannot transfer more than three embryos in any one treatment cycle, nor can one intentionally fertilize more than three eggs in one cycle. In addition, egg donation and gestational surrogacy are prohibited. Each of the aforementioned activities can be prosecuted,

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[3] Germany is one of the member states of the European Union, which also has a bearing on its regulation of ART. However, the EU has taken few steps to pass member-wide regulation of these technologies, other than the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (also known as the Oviedo Convention). This convention culminated in the creation of certain guidelines relating to ART, such as the use of embryos for research purposes. However, Germany and the United Kingdom were two notable participants in the convention that did not ratify it. Germany is not a signatory to the convention, because the convention was viewed as too permissive regarding the rights of the embryo and therefore not in line with Germany's own Embryo Protection Act, whereas the United Kingdom deemed the convention's rulings too restrictive (Adorno 2005).

with either a fine or a three year prison sentence. However, the Embryo Protection Act does not regulate sperm donation.

The passage of the Embryo Protection Act resulted from a broad political consensus, made possible in part by the memory of the Nazis' crimes. As Richardt writes:

> Throughout the embryological research debate… it was important that no condition was placed on human life. The traumatic experience of a positive population policy leading to mass sterilization programs in Nazi Germany whereby 300,000 men and women were sterilized because of their physical and mental conditions contributed to a strong notion that life is an end in itself… In sum, the specific framing of the debate in terms of continuity of life supported the demand for a comprehensive protection of the embryo and a prohibition of research in the German case. Through references to historical legacies of a positive population policy, embryological research could be framed in terms of opening Pandora's box rather than making progress (Richardt 2003:110).

In particular, the Green Party and the Social Democratic Party supported the Embryo Protection Act because of their fear that reproductive technologies could be used for eugenic purposes, while the Christian Democratic Union (the party of current Chancellor Angela Merkel) supported the act based on the position that embryonic life is deserving of protection. Thus, German law takes a much stricter stance than American law regarding reproductive technologies that involve embryos because many techniques are outlawed. However, because the Embryo Protection Act does not cover sperm donation and AI directly, the professional guidelines of the German Medical Association (BÄK) become all the more important in understanding the regulatory framework as it applies to the topics of this dissertation.

In both countries, professional guidelines fill a void left by a lack of governmental regulation regarding treatments using only sperm, such as inseminations performed by a physician. However, the guidelines that physicians' professional associations have created differ substantially in the US and Germany, with the US being rather permissive of non-traditional family forms and Germany restricting the access of lesbians and single women to treatment. In the following section, I review the guidelines of the relevant associations in the US and in Germany.

### *Professional Regulation in the United States*

In the US, there are several professional associations for physicians involved in assisted reproduction. The AMA is the oldest professional body for physicians, founded in 1847, and this organization was the first in the world to publish a national code of medical ethics. In the preamble to the code of medical ethics, the document clearly states that the following "principles... are not laws, but standards of conduct which define the essentials of honorable behavior for the physician" (AMA 2001:Preamble). The AMA's guidelines regarding AI, outlined in their statement on "Artificial Insemination by Anonymous Donor," include the following: "In the case of single women or women who are in a homosexual couple, it is not unethical to provide artificial insemination as a reproductive option" (AMA 2004b:2.05). The inclusion of this sentence allows fertility doctors to treat single women and lesbians without fear of professional sanctioning. Furthermore, the AMA guidelines continue: "Anonymous donors cannot assume the rights or responsibilities of parenthood for children born through therapeutic donor insemination, nor should they be required to assume them" (AMA 2004b:2.05). This stance is echoed in many states' laws regarding donor insemination, in which sperm donors effectively strip themselves of their parental rights and responsibilities (Almeling 2011).

Because these clarifications are included in the AMA statement on anonymous donors, there is some possible uncertainty surrounding situations in which lesbians or single women might wish to use a known donor. However, the AMA has a separate opinion on known donors, in which it discusses the importance of full medical history for the donor, informed consent for the prospective parent(s), and counseling regarding parental rights and obligations. Although lesbian couples are not mentioned explicitly in this opinion, it begins with the line, "[a]ny individual or couple contemplating artificial insemination by husband, partner, or other known donor." (AMA 2004a:2.04). This statement clearly includes single women (through the use of "individual") and certainly does not exclude lesbian couples (through the use of "other known donor").

In addition to the AMA, there are more specialized organizations for physicians who deal with fertility issues, and the American Society for Reproductive Medicine (ASRM), formed in 1944, provides an umbrella organization for these various medical groups. In 1987, the Society for Assisted Reproductive Technology (SART) formed as an organization of professionals dedicated to the practice of ART in the US, with a particular focus on physicians performing IVF. SART's first major undertaking was data collection and reporting of fertility clinic success rates, which it began doing voluntarily in the late 1980s. In the early 1990s, SART helped establish standards for the accreditation of ART clinics, though SART itself is not an accrediting agency. Although today the CDC is the federal agency responsible for reporting of clinic success rates, SART and other professional organizations still play an important role in creating guidelines for physicians regarding treatment standards.

Similar to the AMA, ASRM publishes medical ethical opinions to guide physician practices. In 2013, ASRM published a committee opinion on the treatment of lesbian and gay couples, unmarried heterosexual couples, and single people. This opinion states: "programs should treat all requests for assisted reproduction equally without regard to marital/partner status or sexual orientation" and that "data do not support restricting access" due to these factors (ASRM 2013:1524). Even with regard to professional autonomy, the committee opinion was that physicians may run afoul of bans on discrimination for sexual orientation and marital status if they refuse to treat these patients. The document specifies that "the ethical duty to treat persons with equal respect requires that fertility programs treat single persons and gay and lesbian couples equally to heterosexual married couples in determining which services to provide" (ASRM 2013:1526). Thus, the medical professional organizations in the US explicitly state that fertility-related treatments should not be withheld from individuals or couples on the basis of marital status or sexual orientation.

Being a member of SART or ASRM does not necessarily mean that a clinic follows its guidelines, as these opinions are suggested standards, not legal directives. Although SART previously claimed to be a "governmental watchdog for ART" (SART 2011), that statement has been removed from the organization's website in recent years, perhaps as a result of the fallout from the case of the "Octomom." Nadya Suleman had up to 12 embryos implanted in her uterus by a physician who was a member of SART, and she subsequently gave birth to the first set of surviving octuplets. Extensive media coverage resulted in widespread negative public reaction to the case, in large part because it was revealed that Suleman was unmarried, had six children through IVF prior to the octuplets, and was relying on state support in the form of welfare and disability payments. In the ensuing scandal, the doctor had his membership in SART revoked and his medical license was revoked by the California Board of Medicine for "gross negligence" (Stanglin 2010). Indeed, the publicity surrounding the octuplets led to renewed calls for governmental oversight and regulation of fertility clinics, but no major legislation resulted. The takeaway for this project is that, even when professional medical organizations have relatively well developed professional practice guidelines, they should not be taken as legally binding. This means that the investigation of physicians' actual practices undertaken in this research (see Chapter 3) is particularly illuminating because it reveals the gap between professional opinion and medical practice.

### *Professional Regulation in Germany*

The German equivalent to the American Medical Association is the *Bundesärztekammer (*BÄK). As the joint association for the 17 State Chambers of Physicians (*Landesärztekammern*), it publishes guidelines and recommendations for the conduct of German physicians, but these are not automatically binding. In order to become legally binding, the guidelines have to be adopted by the state chambers. Each physician is required to be a member of the chamber of the state (*Landesärztekammer)* in which he practices medicine. The guidelines and codes of this chamber become legally binding for him or her.

In 2011, the BÄK issued a Sample Professional Code of Conduct (*Muster-Berufsordnung*) for all physicians practicing medicine in Germany. It does not talk explicitly about ART, but states that when special medical procedures cause ethical problems, doctors have to obey the recommendations by their local chamber of physicians (Bundesärztekammer 2011). In a footnote, ART is cited as an example for such a contentious procedure, and physicians are referred to a "Sample-Guideline for the Implementation of Assisted Reproduction" that has been issued by the scientific advisory council of the BÄK in 2006 (Bundesärztekammer 2006).

This guideline states that in the interest of the child's well-being (*Kindeswohl*), ART should only be offered to married couples. On principle, only the husband's semen should be used. For the use of third-party semen, special requirements have to be met (Bundesärztekammer 2006). In the case of an unmarried woman, ART should only be offered if (in her doctor's opinion) this woman is in a stable relationship to an unmarried man who will acknowledge the child as his own. In a lengthy, "nonbinding" (*unverbindlich*) commentary attached to these guidelines, the authors justify these positions by pointing out that in the case of homologous insemination, there is no legal difference between a birth caused by unassisted or assisted fertilization (*Zeugung*). Therefore, homologous insemination among married (heterosexual) couples is seen as unproblematic because the mother's husband is simultaneously the child's genetic and legal father. In the case of unmarried heterosexual couples, however, the BÄK holds that, "it should be guaranteed that the child born through a method of assisted reproduction does not grow up without a social and legal father" (Bundesärztekammer 2006). Due to its unclear legal consequences, the authors demand even stricter requirements for heterologous insemination. Especially for unmarried couples, doctors are advised to approach it with special caution in order to guarantee the child a stable relationship to both parents. For the same reason, the guidelines state that "heterologous insemination is currently impossible (*ausgeschlossen*) for women who are either unpartnered or in a homosexual relationship" (Bundesärztekammer 2006). As these statements demonstrate, the focus in the BÄK guidelines is on the child's well-being which is predicated on the presumed need for either a father figure or a stable relationship to both a father and a mother.

As mentioned above, the state chambers are not required to adopt the BÄK guidelines. However, because the medical procedures associated with ART may raise ethical issues, most state chambers have issued their own guidelines for it. While most of them are congruent with the sample BÄK guideline, there are notable exceptions: for example, the city-state of Hamburg explicitly allows ART for a woman who lives with another woman in a civil union. The states of Bayern, Berlin, and Brandenburg did not issue a professional guideline for ART and consequently leave it to the doctors to decide what they think is ethical and what not. Only the states of Saarland, Sachsen, and Thüringen have adopted the non-binding commentary mentioned above. Thus, there is no consensus on the availability of ART for lesbians and single women in Germany.

The fact that the Berlin Chamber of Physicians (*Ärztekammer Berlin*) did not adopt the guidelines of the BÄK has resulted in some confusion among the physicians in Berlin regarding whether the guidelines are applicable to their practice or not. The present investigation does not include an argument with regard to the legal situation for physicians, but in chapter 3, I explore how my physician respondents understand the guidelines and their potential applicability to their own practices.

### *Health Insurance Coverage in the United States*

While the legal and professional regulations reviewed so far have a clear impact on how physicians practice, which certainly may affect the experiences of non-traditional patients, access to treatments via health insurance coverage plays another major role in the reproductive options of lesbians and single women. The differences between the insurance options in Germany and the US are noteworthy. In Germany, statutory insurance provides little to no financial support for non-traditional reproducers but much broader coverage for married heterosexual couples than is present in most of the US, whereas in the US, there is rarely insurance coverage offered for fertility treatments regardless of marital status or sexual orientation. However, where such coverage is available, it is often more inclusive than what is offered in Germany.

Although infertility can be due to individual biological factors, it also has a social component; reproduction in humans requires the reproductive cells of a male and a female body, in other words, a sperm and an egg. Historically, the definition of infertility has often presumed both heterosexuality and marriage. For instance, in 1990, ASRM defined infertility as follows: “a marriage is to be considered barren or infertile when pregnancy has not occurred after a year of coitus without contraception” (quoted in Spar 2006:14). This definition demonstrates the notion of infertility as a couple's disease yet it also enshrines infertility as a disease that can *only* affect a couple, and a married couple at that. A more recent definition of infertility offered by the World Health Organization (WHO) defines infertility as: "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" (Zegers-Hochschild et al. 2009:1522). Although this updated definition avoids explicitly labeling infertility as tied to a given family form, it nonetheless relies on the model of a heterosexual couple to define infertility medically. In this sense, the inability of lesbians and single women to conceive a child is technically not infertility, or as Mamo states, "[lesbian] infertility thus becomes a social condition without cause for treatment" (2007:131). In other words, because lesbians and single women are unable to reproduce due to a lack of sperm rather than an underlying medical condition, the diagnosis of infertility often does not apply, which can further complicate access to health insurance coverage.

In the US, insurance coverage is generally regulated at the state level, and the majority of the states do not have any legislation regarding health insurance and ART. Three states (California, Louisiana, and New York) explicitly exclude coverage of IVF in their laws that require coverage for other fertility treatments. As of 2015, there were a total of 15 states that have instituted either a mandate to cover or offer infertility benefits in health insurance plans in their respective states. Just because certain treatments are covered, however, does not mean they are covered in all circumstances. Thus, the question of what circumstances *are* covered is crucial, and this question often hinges on the definition of infertility. As mentioned above, infertility is often defined medically as the inability to conceive after 12 months of unprotected (heterosexual) intercourse. However, such a definition may be used to exclude lesbian women as well as heterosexual women who wish to conceive without a partner. In addition, restrictions based on age, marital status, or receiving public benefits further limit who is eligible for coverage. Eight of the 15 states with mandates to offer or cover the condition of infertility do limit coverage in some way, either based on age of the treatment-seeker or marital status.[4] Six of the states' mandates include benefit caps, which set a maximum for either the amount that can be spent seeking infertility treatment or the number of times a certain treatment can be covered by insurance.[5] When conducting a review of the policies, Arons found that the vast majority of these states "routinely refer to coverage for 'medically necessary expenses' or define infertility to be the inability to conceive after a specified period of unprotected sexual intercourse, thereby implicitly excluding from coverage single people and lesbian, gay, and transgender couples" (2007:8). Even with these restrictions, these 15 states provide far more coverage of infertility issues than the rest of the country. In the 35 states where insurance providers have not been legally required to offer or cover infertility, it is extremely unlikely that fertility coverage is included in insurance policies. Thus, the coverage for fertility treatments is haphazard and incomplete in almost every state, and there are few where insurance coverage could be expected to apply to non-traditional reproducers.

However, Illinois provides an exception to that rule. In Illinois, where I conducted much of my US research, the state has mandated coverage of certain reproductive services since 1991. Specifically, the Illinois Revised Statute chapter 215 section 5/356m requires that coverage be provided for "the diagnosis and treatment of infertility," with coverage limited "to four oocyte

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[4] Connecticut, New Jersey, New York, and Rhode Island limit coverage to people under a certain age, which ranges from 40 to 46, with Rhode Island further mandating that benefits extend only to individuals over the age of 25. The provisions in Arkansas, Hawaii, Maryland, and Texas include the caveat that "the patient's eggs must be fertilized with her spouse's sperm," which effectively limits coverage to married, heterosexual couples.

[5] The states with benefit caps include Arkansas, Connecticut, Hawaii, Illinois, Maryland, and Rhode Island. In states where the cap is a maximum lifetime benefit, the threshold ranges from $15,000 in Arkansas to $100,000 in Maryland, whereas in states with a maximum number of procedures covered, the number of cycles and the procedures specified vary considerably, but generally do not extend beyond six egg retrievals total.

retrievals, except if a live birth follows a completed cycle, then two more completed oocyte retrievals are covered" (Illinois Insurance Facts 2014). In other words, insurers in Illinois must cover four egg retrievals, which allow for fertilization outside of the body. If a woman successfully gives birth as a result of one of those first four retrievals, then she is entitled to two additional retrievals if she wishes to have a second child.

This coverage is not limited based on marital status or sexual orientation. In fact, since 2014, Illinois confers and recognizes marriages between same-sex partnerships. Because the law in Illinois does not require that the "patient" use her "spouse's sperm" for fertilization, lesbian couples are not excluded from receiving the benefits if they are legally married. In fact, the law explicitly covers situations in which an individual or couple is attempting to conceive through insemination, as the law extends coverage when "efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial inseminations, have failed and are not likely to lead to a successful pregnancy" (Illinois Insurance Facts 2014). Since AI is included in the insurance language, lesbians and single women's efforts to conceive are explicitly included, provided that they work with a physician. To have "more advanced" treatments covered, one must first have tried "reasonable, less costly medically appropriate infertility treatments for which coverage is available under the policy," which include testing, prescription drugs, and several rounds of AI (Illinois Insurance Facts 2014). (The medicalizing pressures of this policy are explored in more depth in Chapter 4.)

Furthermore, in Illinois, there are no limits regarding age, relationship status, or other categories, contrary to the coverage restrictions in place in many other states. Small businesses (under 25 employees), religious employers, and "employers who self-insure" are exempt from coverage. Nonetheless, among the women I interviewed in Illinois, almost all of them had insurance coverage for certain reproductive treatments. By contrast, none of the smaller number of respondents I interviewed in Wisconsin had insurance coverage for infertility.

Even in Illinois, which has one of the most inclusive insurance coverage mandates in the US, there is no provision for the cost of sperm acquisition, meaning that women who are purchasing sperm from a sperm bank – whether they are inseminating at home or with a physician – must pay for the sperm themselves, and inseminations in a doctor's office may be accompanied by additional fees. There are several large sperm banks in the US, and many of them cater to lesbian and single clients explicitly. It is common for women to order sperm from an out-of-state bank, as the sperm can be shipped easily (for an additional cost) to either the home or a physician's office. The costs of sperm purchased from a bank range from $300 to $840 per vial, depending on factors such as sperm washing (see Glossary in Appendix C for definition), donor availability, and identity release status (see, for instance, Midwest Sperm Bank 2015 and California Cryobank 2015). Thus, when women attempt to conceive over several months, the costs accumulate quickly, as each attempt brings a repeated expense. In addition to the cost of sperm itself, most sperm banks charge for access to in-depth materials on their donors. For instance, California Cryobank provides a la carte access to a range of information about donors, including childhood photos, handwriting analyses, and extended donor profiles, for $25 to $30 per item. Alternatively, interested parties can purchase a 90 day subscription to their full databases. Thus, even in a state where many fertility treatments are included, insurance coverage does not mean conception is necessarily free or even affordable, though the costs depend on the type of donor as well as the location of treatment.

### *Health Insurance Coverage in Germany*

Unlike the situation in the US, the vast majority of people in Germany have health insurance through the national statutory insurance program. As of 2010, only 10.5% of Germans were covered by private insurance. Certain infertility treatments are covered by the federal health insurance, but a significant change took place in 2004 that greatly reduced coverage. Between 1990 and 2003, Germans with statutory health insurance could receive up to four full treatment cycles with 100% of costs covered. In 2004, the relevant paragraph in the *Sozialgesetzbuch* (Social Security Statutes) was revised such that health insurance pays only 50% of three treatments.[6] In addition, the revisions added age restrictions, such that the federal health insurance limits coverage of these treatments to women between the ages of 25 and 39 years old and men between 25 and 49 years old. Furthermore, couples must undergo counseling before receiving treatment, and "treatments of non-married couples or of HIV-positive patients, and treatments involving third parties (sperm donation) are completely excluded from coverage" (Rauprich, Berns, and Vollman 2010: 1226).

Scholars have investigated the effect that these revisions have had on demand for these services. Perhaps unsurprisingly, there have been significant reductions (between 38% to 48%) in the number of treatment cycles, the number of patients treated, and the number of children born as a result of these treatments (Rauprich, Berns, and Vollman 2010). In a study of couples who visited a clinic yet did not undertake treatment, the findings indicated that cost was a major barrier. Fully 75% of those couples stated that reduced or eliminated co-payments would lead them to undertake treatment (Wilke et al., 2008, quoted in Rauprich, Berns, and Vollman 2010).

Individuals holding private insurance may have greater levels of coverage, because certain policies cover the full cost of procedures and may have looser restrictions on eligibility

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[6] Practically speaking, the couples seeking treatment must now pay approximately 1500 Euros per cycle for in vitro fertilization and 1800 Euros per cycle for intracytoplasmic sperm injection, with the average expenditure ranging from 3000 to 5000 Euros, given the average of two to three treatment cycles attempted.

for the treatments. Some private health insurance companies in Germany do not regulate reimbursement on the basis of the marital status of the person or couple seeking treatment. In addition, private insurers do not necessarily enforce strict age limits for reimbursement, although they may require additional proof that treatment is warranted past the 40-year-old age limit for women.

Because the German statutory plan does not cover third-party reproduction, any form of assisted reproduction for a woman not married to a man is excluded from coverage, as in the vast majority of health insurance plans in the US. Indeed, this coverage is akin to that offered in the four US states in which fertility treatments are included in insurance plans only when “the patient” uses the “spouse’s sperm.” The statutory insurance provided in Germany applies to far more people than have access to fertility coverage in the US, but nonetheless encourages a traditional model of the nuclear family, mirroring the professional guidelines of the BÄK.

When it comes to the cost of sperm acquisition, the situation in Germany is similar to the US, in that lesbians and single women must bear the costs of sperm acquisition themselves, and the costs of sperm are fairly comparable. For instance, the *Berliner Samenbank* (Berlin Sperm Bank) charges 200€ (approximately $225 USD) per sperm sample, along with a 135€ (approximately $150) preparation fee (Berlin Sperm Bank 2015). There is often more mediation between sperm purchasers and donors provided by sperm bank employees in Germany, however. Whereas in the US, the vast majority of sperm banks allow individuals or couples to select donors from their substantial array, in Germany the transaction is often mediated by the sperm bank staff, who interview the couple and who have access to in-depth information about donors. The bank often provides the couple with a short list of potential donors based on the factors emphasized as important by the recipients. The sperm bank staff may focus primarily on the perceived physical match between the parents-to-be and the donor, though factors such as education and occupation may be considered as well. Additionally, many sperm banks ship internationally, so it is possible to purchase sperm from abroad. Indeed, I found that my respondents in Germany sometimes considered and utilized this option, particularly if they desired a wider range of potential donors. In any case, there is no insurance coverage for sperm acquisition for my respondents in Germany, so these women must bear the costs of procuring sperm, similar to my respondents in the US.

### *Legal Regulation of Families in the United States and Germany*

While family law decisions encompass a wide range of lesbian, gay, bisexual, and transgender (LGBT) families, including adoption of non-biologically-related children, determinations of parenthood in surrogacy arrangements, second-parent adoptions rulings, and parental obligations of egg and sperm donors, I focus here only on the law as it applies to my lesbian respondents. Thus, I concentrate on the legal rights and obligations afforded to sperm donors and legal determinations regarding parental rights for lesbian women using sperm donors. For lesbian couples in which one partner becomes pregnant with a biologically-related child through sperm donation, the two major legal questions are (1) how can the parental rights of the non-biological partner be secured, and (2) does the sperm donor have any legal claim to a resultant child?

In terms of securing the parental rights of the non-biological partner, the most secure option in both Germany and the US is to obtain a second-parent adoption, which allows the non-biological parent to secure a legal parental status through adoption of the partner's biological child without terminating that parent's rights. In Germany, *Stiefkindadoption* (which translates as step-child adoption) has been legal for same-sex couples since 2005, if the child is biologically related to one partner, and since 2013, if the child is not biologically related to either partner but has been legally adopted by one of them already. In the US, second-parent adoptions were first granted in 1985 (in Oregon and Alaska), but the indeterminacy of family law in the US means that second parent adoptions were only available nationally after the Supreme Court's 2015 decision in favor of allowing same-sex couples to marry (Obergefell v. Hodges 2015). For unmarried couples in the US (regardless of the parents' genders), second parent adoptions are explicitly allowed in a number of states but legally prohibited in many others. Although the Supreme Court's 2015 decision legalizing same-sex marriage may eventually render second-parent adoptions for married LGBT couples unnecessary, the National Center for Lesbian Rights (NCLR) urges lesbian couples to continue to obtain second-parent adoptions for non-biological partners, even if the partners are married and the non-biological parent is listed as a parent on the birth certificate (NCLR 2015). A second parent adoption guarantees a legally recognized parental status for a non-biological parent, whereas parental recognition on the birth certificate or conferred through marriage may be challenged in court. Thus, although recent judicial rulings have begun to assert that second-parent adoptions are unnecessary because the married partner of a birth parent should be assumed to be the second parent (Dodge 2014), until this precedent has been established beyond doubt, a second parent adoption is the recommended route to secure parental rights for non-biological parents.

Regarding the legal rights of the sperm donor, there is more uncertainty in both countries, and the type of donor becomes relevant. At the most basic level, a major difference exists between German and US law with regard to sperm donors: in Germany anonymous sperm donation is prohibited, whereas in the US it is common practice. In Germany, anonymous sperm donation is rendered impossible by a long-standing legal consensus that every individual has a right to know his/her origin. As far back as 1989, the *Bundesverfassungsgericht* (BVG, German Supreme Court) has affirmed this right in great detail. As an expression of this consensus, German sperm banks have long been required to keep records of donor names for at least ten year after the birth of a child. In 2007, this period was extended to 30 years. In 2013, a regional court in the city of Hamm ruled that children of anonymous donors have the right to know the name of their father and obligated a fertility clinic to reveal the name of an anonymous donor to his biological daughter. This ruling was affirmed by the highest court in the German judiciary system, the *Bundesgerichtshof* (BGH, German Federal Court of Justice) in January 2015. The BGH's 2015 ruling also revoked a mandated age requirement, so that now children of all ages are allowed to know the name of their donor (Spenderkinder 2015). Thus, German courts have taken a clear stance in favor of resultant children's right to know the name of their donors over and above a donor's right to anonymity. That said, women who expressly wish to use anonymous donor sperm still have legal loopholes, such as having sperm imported from other countries where anonymity is still allowed or traveling to nearby countries for treatment where anonymous sperm donation still occurs.

In the US, anonymous sperm donation is the rule rather than the exception, though there is a nascent move toward the use of identity-release donors. All US sperm banks I am aware of have sperm available from both anonymous and identity-release donors, though generally the latter is in much more limited supply. Because anonymous donors are in such wide use, there are online communities dedicated to bringing together genetic half-siblings created through the use of donor sperm as well (see Eva 2012 and Cahn 2013). Unlike many other countries, the US does not have regulations regarding how many children a donor may have, although ASRM recommends no more than 25 live births per population area of 850,000. There is no central tracking mechanism or penalty for failure to follow this guideline, and there are intimations that popular donors may have far more genetic offspring, in some cases over 150 (Mroz 2011). An exaggerated version of this scenario also was used as the backdrop for a comedy starring Vince Vaughn, *Delivery Man*, in which the protagonist is a serial sperm donor who ends up unintentionally fathering 533 children (see Levy 2013 and Rechtshaffen 2013). Germany, by contrast, limits donors to 15 total offspring. (Showing the variety across countries, the United Kingdom allows a donor's sperm to be used for up to 10 families' offspring, with no limit on how many children each family may have.)

When it comes to whether a sperm donor may have any legal rights or obligations to resultant children born to lesbian couples, the legal situation in both Germany and the US is remarkably unclear. In general in the US, sperm donors who donate to a sperm bank are absolved of parental rights. When it comes to sperm donation outside of the context of a sperm bank, however, the situation is murky. Most states have adopted some version of the Uniform Parentage Act (UPA), first established in 1973, which holds that a sperm donor who provides semen to a licensed physician to impregnate a woman to whom the donor is not married is not a legal parent to any resultant children. An updated version of the UPA, passed in 2000, has been adopted by a limited number of states, which allows the sperm donor to avoid legal parental status without requiring that the sperm be provided to a licensed physician (Sroka 2013).

However, many other states have no explicit provisions for these cases, so lesbian couples may attempt to clarify the role of the sperm donor through a written agreement. These agreements do not necessarily protect the lesbian couple or the donor, however, because, "[i]n many states, there is no statutory guidance about the impact of contracts on the parental status of known sperm providers, and the cases have differed in their treatment of these contracts"

(Forman 2011). Although in some cases courts have deferred to such contracts to resolve disputes regarding whether the donor is a legal parent, in others, the contracts have had unintended consequences. In particular, contracts that attempt to provide for a limited role for a known donor to be in contact with a child while exempting him from financial obligations have been particularly vulnerable in the courts, because donors have been ruled to be liable for child support in multiple cases. The statutes and the case law vary extensively from state to state, so no clear or generalizable pattern emerges in the US, other than that known donor arrangements can be vulnerable to revision in the courts when challenged by either party.

In Germany, the situation is similar. While anonymous donation is illegal in Germany, sperm donors who provide semen to a sperm bank are generally free from parental obligations. However, whether this applies when the sperm is used by lesbian couples or single women has not yet been established by the courts in Germany. In addition, there is some concern among fertility physicians in Germany regarding treatment of single women in particular because of a court case in which two gynecologists were required to pay child support briefly for twins they helped a woman conceive (Deutsche Presse-Agentur 2012). The case involves a heterosexual, unmarried couple who had three children through alternative insemination. The man in this case alleges that the children were conceived after the yearlong storage agreement should have ended, and thus his sperm should have been destroyed already by the clinic. While the lower court of Dortmund mandated the two physicians pay child support, the higher regional court of Hamm later reversed the ruling, arguing that the documents held by the clinic were not forged (as the donor alleges they were); thus, the donor is a legally responsible parent of the resultant children (Figge 2013).

The lower court's ruling, in 2012, has had clear repercussions on doctors' practices, because many doctors who treat single women require that they have a second "guarantee person" who is willing to assume financial responsibility for the children should something happen to the mother. That said, the more recent ruling has absolved the physicians involved from payment, and the specifics of the case are such that it should be quite clear that it was not the singleness of the woman involved that caused an issue but rather the alleged lack of consent by the man who acted as de facto sperm donor (Figge 2013). Nonetheless, the parental status of a sperm donor to lesbian couples or single women has not been determined by the Federal Court of Justice, and there is considerable concern in the LGBT community in Germany that any written documentation of a known donor's involvement with a child could be used to recognize his parental status by the courts. Thus, certain lesbian advocacy groups in Germany recommend that lesbian couples using known donor sperm do not attempt to draw up a written agreement regarding the arrangement.

## CONCLUSION

Throughout this chapter, I provided background information to contextualize my respondents' experiences, which are examined in the remaining chapter. In Germany, national legislation curtails the availability of certain assisted reproductive treatments, such as surrogacy and egg donation, for everyone, and anonymous sperm donation also is not allowed. The guidelines of the national professional medical association prohibit treatment of lesbians and single women. Although some local medical associations have not adopted these guidelines, physicians nonetheless face uncertain legal rulings regarding parental rights in cases of contested sperm donations. The statutory health insurance plan also restricts coverage of assisted reproductive treatments to married, heterosexual couples. Finally, the public discourses on lesbian childbearing focus on issues of the “normality” of lesbian parenting practices and the fact that their children are always planned and wanted.

In the US, no national legislation regarding assisted reproduction exists, and the professional medical associations explicitly allow for the treatment of lesbians and single women. Anonymous sperm donation is the rule at most sperm banks, though identity-release donors are increasingly offered as well. Public coverage of lesbian childbearing in major news sources focuses on the role of the sperm donor and the potential for custody disputes between known donors and lesbian parents. Most states do not require that infertility treatments be covered by health insurance plans, but in the few states where such coverage is mandated, lesbian couples are able to access treatment since the Supreme Court’s 2015 ruling in favor of marriage equality (Obergefell v. Hodges 2015).

These regulations structure what my respondents view as normal and possible in both countries. Therefore, they have real impacts on how physicians define family and treat lesbian couples pursuing parenthood, as well as how lesbian couples attempt to conceive and whose sperm they use. Thus, throughout the remaining chapters, I return to the regulatory context and my respondents’ understandings of it to explore how this context influences decision making in both expected and unintended ways.

# CHAPTER 3: THE INTERPLAY OF REGULATIONS AND PERSONAL BELIEFS ON PHYSICIANS' PRACTICES

## INTRODUCTION

Physicians belong to a profession in which ethical decision-making plays a key role. Professional medical associations publish ethical guidelines to guide medical doctors' treatment decisions. Additionally, physician education includes a component focused on ethics, and many medical doctors[1] continue to take an oath modeled on Hippocrates' credo to "keep [the sick] from harm and injustice" (cited in King et al. 2005). However, while physicians are guided by medical ethics in their daily patient care decisions, their moral and religious views also inform their practices, and these beliefs are shaped by a range of influences, including their life experiences, values, and other individual characteristics.

As I showed in the previous chapter, there are non-binding professional guidelines that relate to fertility treatment for lesbians and single women in both Germany and the US, although the content of these guidelines differs notably: in Germany, the guidelines suggest against treatment, whereas in the US, treatment is allowed. The question explored in this chapter, then, is how medical doctors reconcile their country-based regulatory context with their personal beliefs when making treatment decisions. Given the ethos of individualism that pervades the US, one might expect American physicians to emphasize their own moral values in making decisions more than German doctors. Thus, I originally hypothesized that my respondents' beliefs and treatment decisions in the US would exhibit more consistency than in Germany. Specifically, I

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[1] Colloquial usage often assumes the term 'doctor' refers to a medical doctor (MD) or physician. Indeed, there have been actions taken in several US states to restrict the use of the term 'doctor' to MDs, rather than to allow other types of doctorally prepared professionals (e.g., PhDs) in various fields to use the title of 'doctor'. For variety, I use physician, medical doctor, and (occasionally) doctor interchangeably in my analysis and reporting.

expected American physicians would prioritize their values about families in making treatment decisions more so than their German counterparts, whereas German medical doctors might prioritize following regulations more heavily. However, my findings contradicted this idea: the German physicians I interviewed are more likely to make treatment decisions that align with their personal beliefs about families, whereas my American physician respondents closely adhere to the guidelines of professional medical organizations to treat lesbian and/or single patients regardless of the doctors' personal beliefs.

Briefly, I review the relevant and fundamentally different regulatory contexts in Germany and the US. Then, I describe the broadly similar range of personal beliefs I encountered in my interviews with fertility physicians in these two countries. I proceed to explore physicians' practices regarding treatment of lesbians and single-women in Germany and the US. I find that, despite doctors holding a similar range of personal beliefs regarding "non-traditional" families, my physician respondents in American all reported regular treatment of lesbians and single-women, whereas respondents in Germany were split into just under half who do treat these women, and slightly over half who do not. In most cases, my German physician respondents' personal beliefs regarding lesbian and single-headed households mapped onto whether they were willing to treat these women, whereas in the US, physicians treated these patients regardless of the doctors' own personal beliefs. I find that there is a divide between doctors, but it is not one based on the nation in which the physician practices. Rather, what appears to influence treatment decisions more decisively is the extent to which the physician holds traditional beliefs about families, parenting, and gender roles.

## REVIEW OF THE REGULATORY CONTEXT

There is no major federal regulation governing assisted reproductive technologies in the

US, and most of the relevant regulations exist only at the professional organizational level. Professional guidelines are voluntary, but sanctions can result from failure to follow them. Most relevant to this argument, both the AMA and the ASRM have professional statements that allow treatment of lesbians and unmarried women with fertility medicine.  The AMA holds that treatment of lesbians and single women is "not unethical."

By contrast, in Germany, national legislation exists in the form of the Embryo Protection Act, which enshrines certain rights of embryos and forbids several treatments, such as egg donation and gestational surrogacy. The BÄK suggests guidelines for the statewide medical councils to follow, and when adopted they are legally binding. These guidelines place great importance on the presence of a legal father and essentially forbid using assisted reproductive technologies to create families where a father will not be present, such as in single-mother and lesbian households. However, in Berlin, the local medical council has not adopted these guidelines, so doctors are not legally bound to follow them. Nonetheless, my interviews with doctors in Berlin revealed that they are aware of and influenced by the content of these guidelines.

Physicians in Germany may fear being held liable for child support payments when treating single women because of the Dortmund case described in Chapter 2, whereas there are no cases that I am aware of in which an American fertility physician is expected to pay child support. Between the BÄK's suggested guidelines for fertility physicians and the Dortmund case, fertility physicians in Germany operate in a legal gray area, in which treatment is by no means outlawed, but neither is it clearly supported by the legal and professional situation. The comparison of beliefs and practices in Germany and the US, then, provides fertile ground for examining how physicians engage with non-binding guidelines, in particular how these guidelines are cited or dismissed based on personal beliefs that support or oppose the guidelines.

## PHYSICIANS' BELIEFS REGARDING FAMILY STRUCTURE

While the regulatory situation is quite different in Germany and the US, the data from my interviews suggest that the personal beliefs of doctors are similar across contexts. Although there are some differences in the range of opinions expressed by physician respondents in Chicago, Milwaukee, Berlin, and Munich, overall I find that the fertility physicians I spoke with share many common beliefs regarding non-traditional families. In short, I find that my physician respondents' views on families generally can be categorized as either *traditional* or *inclusive*, with a smaller number falling somewhere in between (see Table 3.1). There are three major aspects upon which the traditional and inclusive views differed: family structure, gender roles, and sources of evidence. There were a smaller number of physicians in both Germany and the US whose views did not clearly fit into either of the categories outlined above. These physicians held a mix of traditional and inclusive beliefs about the family, and I term them *mixed view* physicians.

**Table 3.1. Physician Respondents' Expressed Beliefs about Families by Country**

| | Germany | US | Total |
|---|---|---|---|
| Traditional | 5 | 4 | 9 |
| Mixed | 4 | 2 | 6 |
| Inclusive | 7 | 6 | 13 |
| Total | 16 | 12 | 28 |

In both countries, slightly fewer than half of the physicians I interviewed expressed traditional views of the family, which are summarized in the following interaction with Dr. Hamscha, a female, Berlin-based physician of Middle Eastern descent:

> AV: Do you think that children need two parents?
>
> Dr. Hamscha: Yes, definitely.
>
> AV: And why?
>
> Dr. Hamscha: Yes, well I think that a father *always* belongs to [the family]. The child needs *both* a mother and a father equally.

This quote demonstrates the first theme that emerged in physicians' discussions of family, namely, a persistent focus on the nuclear family structure, with the assumption that families consist of two, differently gendered parents with children. As a corollary to this, single-parent families and same-gendered parent families were framed by these physicians as inferior, meaning they assumed worse childhood outcomes for children raised in such environments. Secondly, these physicians believe in the prominence and importance of distinctive gender roles within the family. Finally, physicians holding traditional views of families relied primarily on two sorts of evidence to support their views: their own families and evolutionary arguments.

By contrast, about half of my respondents in both countries expressed inclusive views regarding what constitutes an appropriate family. The contrast between the responses of the traditional and the inclusive physicians' stands out starkly when examining how Dr. Weiss, a white, female physician in her early 40s practicing in Munich, responded to a question regarding family structures and two parent households. Whereas Dr. Hamscha describes a mother and father as central to a family, Dr. Weiss describes first the existence of single-parent families openly and then concludes that, "two people are great, but they don't have to be man and woman."

The inclusive respondents' views reflected several common themes that contrast with the traditional physicians' views on the same dimensions of family structure, gender roles, and sources of evidence. First, these physicians highlighted that children can be raised well in many different household environments, including single-parent and same-gendered parent families, with a focus on good parenting rather than family structure as central to positive childhood outcomes. Second, these physicians highlighted that gender role models could be found outside the family unit and emphasized that there are multiple sources for such role models. Finally, the inclusive physician respondents were more likely to base their arguments on positive experiences with non-traditional patients, as well as on recent social science research.

### *Traditional Physicians*

The physicians whose beliefs about the family I characterize as traditional emphasized three overlapping themes. They are: the nuclear heterosexual family as the ideal environment for raising children, the importance of distinctive gender roles for men and women, and a reliance on evidence provided by their own family experiences and/or by ideas of naturalness and evolution.

Examining the first theme, these respondents often describe two, heterosexual parents as the ideal possible family form. For instance, Dr. Coolidge, a white, male physician in his early 70s practicing in the Chicago area, states, "Well, I think I have very, very orthodox ideas on that subject [family]. I think that family is essentially a mother and a father and one or more children. And basically [a] loving relationship between those individuals. We have unfortunately, not often this type of a situation – families do not [always] function according to the ideals, but that would be the ideal." While some physicians with traditional views of the family tempered their statements a bit more than Dr. Coolidge, the assumption that the nuclear family provided an ideal family form undergirded many of their comments.

Similarly, these respondents rarely cited alternative family structures explicitly without direct prompting, often answering in ways that assume that two heterosexual parents were the implied family structure, even when our discussion prior to that point had been lacking in specificity regarding gender. In other words, among these physicians, discussions of families prompted descriptions of nuclear, heterosexual families to the exclusion of other alternatives. When the interview became focused on issues of family, despite my purposely wording questions open-endedly, these physicians automatically responded by discussing mothers and fathers and the importance of distinctive gender roles. For example, take the following interaction with Dr. Riedl, a white male physician in his late 40s in Berlin:

> AV: Do you think that children need two parents?
>
> Dr. Riedl: Yes.
>
> AV: And why do you think so?
>
> Dr. Riedl: Because I think that it's good, when a child has a fatherly person and a motherly person.

Traditional physicians routinely answered non-specific questions about parents with references to heterosexual households comprised of a mother and father, particularly during discussions of single-parent versus two-parent households. When I would raise questions regarding family structure, the traditional physicians' responses often presumed the heterosexuality of parents, automatically framing discussions of family around a heteronormative ideal. This tendency was exhibited by traditional physicians I interviewed in both Germany and the US. Similar to Dr. Riedl's comments, the following interaction with Dr. Trimborn, a white physician in his late 40s practicing in Milwaukee, demonstrates how these physicians' responses assumed parental heterosexuality in both national contexts:

> AV: So do you think that children need to have two parents?

> Dr. Trimborn: They don't *need* to, but I think it's better if they do.
>
> AV: And could you say a bit about why?
>
> Dr. Trimborn: Well, I think that men and women are different. We are created different and we bring different things to the family.

Thus, the traditional physicians conflated two parent households with heterosexual parents, and they viewed the nuclear family of two differently-gendered parents as ideal for childhood outcomes.

Second, the physicians with traditional family views were likely to emphasize the importance of distinctive gender roles in society and the corresponding importance of having a mother and a father. As Dr. Weber, a white, male, Berlin-based physician in his early 40s states, "Human offspring need at least 15 to 20 years until they're grown up, and that's how long two people have to care for the child. In the best case, yes, I would say two differently gendered people, because there are sons and daughters and one must have examples of both." Beyond simply needing differently gendered role models, the physicians with traditional views often spoke of mothers and fathers in ways that framed gender differences as essential characteristics of differently gendered parents. For example, Dr. Hamscha cited the need for fathers and mothers in her response:

> Well I think a father should *always* be included. The child needs *both*, so a mother as well as a father, as I said, in order to see life from both sides, or to get enough [sentence left unfinished by respondent]. And for support. A mother alone is overwhelmed in many ways. Also financially fathers should contribute, and there are – one sees that in one's own life, yeah? So like when I don't want to decide, I say [to my kids], 'Go to your father, ask your father' because some decisions one leaves to others, because maybe the final word just needs to be said, and mothers probably won't do it. Because we [women] are more emotional, and what goes along with that, yeah? So I think that both need to be there, in order to give something good to the child.

This physician evinces traditional gender roles, going so far as to cite fundamental gender differences to explain why families should consist of two heterosexual parents. Women, on the one hand, are prone to under-discipline children while being overly emotional, whereas men act as a counterbalance to this by saying “the final word” and by providing financial support to the family.

To support these beliefs, the traditional physician respondents tended to rely on evidence provided either by their own families or by ideas of naturalness and evolution. Dr. Hamscha makes reference to her own family as a case study in the different aspects men and women provide for children. Similarly, Dr. Trimborn states: “I think that men and women are different, we are created different and we bring different things to the family. I think...I see it in my own family, what I bring to my daughters is a lot different than what my wife brings to my daughters. I think they benefit from both of those.” He relies on essentialist notions of gender to explain why his own children are better off having two differently-gendered parents.

By looking to their own family experiences, these physicians are providing anecdotal evidence to support their worldviews without recognizing the existence of alternative models. For example, Dr. Riedl evidences his belief in the importance of traditional gender roles, stating:

> Look, when I think about it now… I was just at the Baltic Sea for four days with my family, and if [my kids] had gone alone with their mother, then they would have… it would have still worked, but they wanted naturally, they wanted to go fishing with me and [they] want to do certain things with their dads that mothers don’t do with them or can’t do with them. And there are also differences, when their fear levels are concerned. It is simply so, that with the father one can usually do certain things, that are a bit more dangerous, and it’s good that way. And on the other hand it’s also good, that there’s a corrective from the side of the mother. So I think, nature established it this way consciously.

This quote exemplifies an adoption of essentialist gender roles and the focus on one's own experience as a major source of knowledge, as well as the allusion to the "naturalness" of heterosexuality in parenting.

The quote above demonstrates how "nature" provides evidence for the traditional physician respondents, who look to evolutionary arguments to support their views of heterosexual, nuclear families as ideal. For instance, Dr. Mueller, a white, Berlin-based, male physician in his late 50s, cites anthropological evidence to demonstrate why he views the nuclear family as preferable, stating, "In general if you look from an anthropological background, to the history of man worldwide, you can say, 'okay, in most of the cultures you have a female and a male and the children will grow up with a female and a male.' So from this psychological and anthropological background, it seems to make sense that there are two persons." While evidence drawn from understandings of evolution and the historical record do represent a reliance of outside sources of knowledge, these physicians made fewer references to these sorts of evidence than they did to their own family experiences.

Traditional physicians were also less likely to cite social science research than were their inclusive counterparts to support their beliefs. Additionally, they relied on their own family interactions rather than interactions with patients to explain their perception that the nuclear family is preferable to alternative family structures. One exception to this was Dr. Coolidge, who supported his traditional views on the family by stating, "Just look at the statistics. Crime records for families with single-parent families."[2] While other physicians in the traditional group looked

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[2] The effects of single parenthood on childhood outcomes have been widely studied and debated, and there is conflicting evidence in the literature regarding the long-term effects. For instance, one study found that "father absence increases adolescents' risky behavior" which could have implications for criminality (McLanahan, Tach, & Schneider, 2013:422) There is no consensus regarding whether single parenthood itself causes increases in criminal activity. What is interesting for my argument is that there were select doctors in both the traditional and tolerant groups who cited "statistics" to justify their beliefs regarding family structures.

to “nature” and anthropology when referring to outside sources of expertise, Dr. Coolidge was the only one to reference statistical research, whereas reference to social science studies was more widespread among the inclusive physicians, whose beliefs are described below.

*Inclusive Physicians*

I characterize my physician respondents as holding inclusive views about families when they expressed the following themes: (a) the multiplicity of family environments in which children can be raised well, (b) the overlap between gender roles for men and women and the many individuals who can serve as gender role models for children, and (c) evidentiary arguments based in social science research and their experiences with non-traditional patients.

First, the inclusive physicians described in positive terms the existence of non-traditional families, such as single-parent or lesbian-couple households. Notably, even the inclusive physicians sometimes asserted that two-parent families were preferable on average, but these respondents couched these opinions in caveats regarding parental quality rather than stating them as facts. For example, Dr. Hausmann, a white female physician in her early 30s in Berlin, asserts, “I think having two parents is the ideal, but it certainly works other ways and when there is one parent who takes care of the child well, that works too. Definitely.” Additionally, Dr. Frese, a white, male physician in his 40s who practices in Berlin states: “At the end of the day, a child can certainly be raised by only one parent or absolutely [by parents] in a lesbian relationship or a homosexual relationship. This is certainly, as always, certainly possible.” It is not that these physicians present lesbian-couple or single-headed households as better environments for raising children, but rather that they present these non-nuclear families as situations that are potentially as healthy for children as the heterosexual nuclear family.

Inclusive physicians in both countries often mentioned “bad parents” when explaining their views, in particular to explain their support of patients who wish to become single parents. A common theme among their responses was that quality, not quantity, of parents is what truly matters for children. Dr. Hausmann summed up this stance succinctly in her comment: “Better [to have] a good mother or a good father than two bad parents.” Indeed, Dr. Miles, a white, male Milwaukee-based physician in his 40s, echoed this sentiment almost verbatim: “One good parent is better than two bad ones.” Again, the inclusive physicians do not argue that having one parent is necessarily preferable to having two, but they emphasize that an overwhelming focus on family structure can blind one to deeper problems, such as abuse. Dr. Johnson, a medical doctor in his early 60s practicing in Chicago, noted, “I think it’s easier to raise children with two parents, but you look at [the] divorce rate of 50 percent in lots of the US and this is not universal reality, so I think that two [parents], that have the same agenda and support the kids are better than one. If [parent] one is abusive, they flunk. [If parent] two is abusive, I think it’s better to have one.” These physicians recognize that children benefit from having loving adults in their environment, and that the presence of adults who are not loving and supportive does not improve childhood outcomes.

Instead of privileging the nuclear family ideal of two heterosexual parents, these doctors focus on parental quality, often by making reference to low-quality (i.e., abusive) parenting. Again, it is not that these inclusive physicians argue that single-parent households are necessarily an improvement over the nuclear family. As Dr. Jameson, a white, Milwaukee-based physician in his late 30s, explains, “In the ideal world, the more people around a child, the better. As long as they are decent people obviously, because then that’s why not necessarily more than one parent is good, because if one parent is an abuser or an alcoholic or whatever, then they [the children] would be better off with one parent." Similarly, Dr. Jameson states, "The more support the better, right? I mean it's great if they have grandparents too. It's great if they have uncles and aunts I think. Unless there is something wrong with them [laughs]." An active array of loving, supportive adults is the ideal held up by physicians with inclusive family views, but they emphasize that only one high-quality parent is required to ensure positive childhood outcomes. The physicians I interviewed who hold inclusive views of families do not express universal support for non-traditional family structures, but they nonetheless readily describe an array of family environments as positive, healthy circumstances for children. Furthermore, these physicians are quick to describe how nuclear families may be unhealthy family environments through references to abuse, alcoholism, and other issues.[3] While referencing abusive nuclear families to provide support for non-traditional family structures is perhaps a backhanded compliment, I see inclusive physicians' mentions of abuse function as a form of their evidence that nuclear families are not equivalent with "good parents" just as non-traditional families do not equate to "bad parents."

The second theme that emerged from inclusive physicians' discussions of families involves gender role models. For traditional physicians, the focus of their discussion centered on the need for male and female gender role models due to the distinctive nature of men's and women's roles in society. To an extent, the inclusive physicians' comments about gender reflected this same belief in the fundamentally different and opposite nature of masculinity and femininity. However, the traditional physicians focused on the need for mothers and fathers within a family, whereas their inclusive counterparts noted the many people who could serve as

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[3] The apparent dichotomy of parenting expressed here is interesting in and of itself. My physician respondents seem to frame parents as either "abusive" or "loving and supportive", presenting parenting quality as a dichotomous rather than continuous variable. In-depth analysis of this finding is outside the scope of this paper, but this result and its implications should be explored in further research.

gender role models for children both within the extended family and in wider society. For instance, Dr. Weiss says:

> I simply think that it is nice, when there are two [people] who love the child and who care for it, yeah? Sometimes that's a mother and a grandmother or something, because life is… [trails off]. So I believe, one shouldn't have strongly held ideas about, 'this is how it has to be,' because life will often bring very different circumstances… I think that happiness [for children] is when [a child] has at least definitely one person who loves [him or her] from the heart and when [this child] has that feeling of being at home with that person. And two people are great, but they don't have to be man and woman. I mean, masculine and feminine role models are important, so with lesbian couples, I think it's important that there are men in the circle of friends. But I don't think that one absolutely needs a father, or that one must have a father.

This interviewee mentions that role models are important more as support people for the child and explicitly mentions that these parental figures can be other than mother/father when she mentions the possibility of the two primary caregivers being a mother and a grandmother. Furthermore, she explicitly asserts that, although she believes masculine and feminine models are important, these role models can be found outside of the nuclear family. Again, she harkens back to the overarching theme raised by inclusive physicians – that children need love and care, but the source of that love and care need not be two heterosexual parents.

Several of the inclusive physicians also emphasized that the gender of role models is less important than their presence. For example, Dr. Miles notes:

> I think ideally it seems like it's good to have male and female role models, but I think that it has much more to do with having a role model and less whether it's a male or a female. You know, there's plenty of people who are raised by single females who did just great and plenty of women who were raised by just a single male and did just great and there's plenty of people raised by both sexes who are terrible. So I mean, I don't – I think it's helpful [to have male and female role models] but I don't think it's necessary.

This quote exemplifies the belief expressed by several inclusive physicians that the importance of role models for children is not confined to their gender but rather stems from their stable presence in the child's life. Furthermore, in Dr. Miles' quote, the focus on positive childhood outcomes with single parents is once again present, as well as the discussion of traditional families as not necessarily providing a loving, healthy environment for children.

Finally, the inclusive physicians draw upon different sources of evidence than their traditional counterparts. Whereas the traditional physicians focused on their own families and evolutionary arguments, the inclusive physicians made reference to their experiences with lesbian or single patients to support their view, while others mentioned social science studies demonstrating the positive outcomes associated with non-traditional family structures. As Dr. Smith, a white, female physician in her early 40s practicing in Chicago, states:

> I see a lot of kids raised with one parent who get enough love, enough attention, good education, everything that they need from one person. I see a lot of kids who get everything they need from two parents, too. But then I also see a lot of patients, people, kids who *don't* get what they need from two parents. I think it's very individual; it depends who the parent is and what they're doing.

Here, Dr. Smith clarifies that positive childhood outcomes do not, in her view, flow from family structure but rather from good parenting practices. There are hints of the above theme as well, as she notes that family structure is a poor proxy for parental abilities, echoing the inclusive physicians' quotes above, in which they note that abusive situations exist in a variety of households, including two-parent, heterosexual ones.

In addition, Dr. Weiss explains her belief that many family structures can provide healthy environments for children by referencing studies of lesbian parents as well as anecdotal evidence regarding families:

> Well, I believe that it's great, when one has two parents. By which I don't mean that one needs man and woman. So one knows very well by now from studies that even lesbian couples… that [their] children can grow up really well. There aren't that many gay [male] couples that have children. … I think it's great, that I have a father and a mother, right? But I think that there are also many mothers, who are left by their husbands and who can give a really good family atmosphere [to their children]. So I believe, that these days one has to be a bit flexible. One may not say that only *this* is a family, and all the rest is bad. Life can present so many circumstances. I believe only that you must think really well if

> you are ready, even if your partner leaves you, if you're single, or something, if you have the strength and the will to, so to speak, cut back on things for your child. But I believe that it's good, when there are two [parents], but there are also many children with single mothers or fathers who are raised very well.

Dr. Weiss' statement encapsulates the openness to a variety of family forms that the inclusive physicians demonstrated. By referencing both "many mothers who are left by their husbands" but nonetheless "give a really good family atmosphere," as well as studies that find lesbian couples to be healthy environments, this respondent draws on both expert social science research and her own experiences with a variety of families.

While several inclusive physicians describe their beliefs about family structure by discussing patients they have treated, several others, like Dr. Weiss, rely explicitly on social science research to explain their inclusive feelings toward single-parent and gay- or lesbian-headed households. Dr. Williams, an African-American physician in Milwaukee in his early 50s, referred to crime statistics to explain why he believes children do not need two parents. As he says:

> Again, just [look at] the sheer statistics. Fifty percent of kids are living with one parent primarily. And no one has ever shown that children from single-parent homes commit more crimes, more robberies, have more-I mean, they might say they have issues and this or that and the other, but in terms of death, destruction, murder, homicide, rape...[4] So, these single parents-fathers, mothers, women, men-are somehow or another raising a number of children to be reasonable citizens. Is it easier to have two parents? Yes. But only if the two parents are contributing.

This quote also nods to another prevalent theme among inclusive physicians' discussions of families: the strain on parents of raising a child without a partner.

While inclusive physicians were quick to note that children can be "raised well" in all sorts of situations, they were not hesitant to express their belief that having two parents was an ideal situation. The major difference between the ways in which this idea (two parent families

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[4] Please see previous footnote for discussion of the ongoing debates about criminal behavior and family structures.

are ideal) was expressed by inclusive versus traditional physicians was that the former were far more likely to focus on the difficulty for parents of raising a child alone while the latter would often focus on poor childhood outcomes. For example, Dr. Schultz, a white, female Berlin-based physician in her early 40s, states:

> I don't believe [that children need two parents]. I mean, simply, I believe that it's also nice for the parents [when there are two] because obviously one can share the responsibilities, and it's surely nice for the children, when they don't have one overwhelmed parent. But I believe there are enough examples, where children have been raised wonderfully by one parent.

Again, there is a focus on childhood outcomes, but the issue raised by this physician is not whether a single parent does a good job raising children but rather whether that parent's stress levels are overly high.[5]

Overall, then, in my analysis of inclusive physicians' discussions of families, I find these physicians frequently expressing the same three major themes. In particular, these physicians often describe a range of family structures as healthy, loving environments for children, and they note that heterosexual, two-parent families can be abusive. In addition, these physicians view gender roles as less distinctive than their traditional counterparts, and they highlight the ability of children to have role models outside of the traditional father/mother structure. Finally, these physician respondents were more likely to draw upon experiences with non-traditional patients for evidence that lesbian- and single-headed households can be positive family environments, and they also based their beliefs on contemporary social science research that finds lesbian- and single-parent families to have equivalent childhood outcomes to heterosexual and two-parent families.

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[5] Occasionally, inclusive physicians draw upon their own family experiences when describing their beliefs, such as Dr. Johnson, who says, "I don't think either my wife [or] I could have done such a good job if we were alone, but we probably could have pulled it through somehow."

### *Mixed View Physicians*

While most of the physicians I spoke with in both Germany and the US evinced traditional or inclusive views of the family quite consistently, there were a smaller number in both countries (two in the US and four in Germany) whose views I classify as mixed view because they made comments at certain points supporting both traditional and inclusive family ideals.

For example, Dr. Schwabe, a white, female physician in her late 60s practicing in Berlin, describes how studies show that children raised by lesbian couples do well, while still stating her belief in having two heterosexual parents: "…statistics show, that lesbian relationships with children can go very, very well. Right? So maybe it doesn't need to be always Father and Mother, even though I think that it's still probably better, to have both roles in the family. But statistics say that lesbian relationships with children go well." This doctor's statements indicate that she is conflicted between her personal feeling that heterosexual parents provide a better environment for raising children and her knowledge that social science research has shown lesbian couples to be equally adept parents to heterosexuals. She then continues, adding that she approves of single women wanting to have children as well, when they have enough support from their family and friends, despite her belief that children should have a father and mother in their household. Thus, Dr. Schwabe's comments, like a few other physicians I interviewed in both countries, demonstrate incomplete adoption of either the traditional or inclusive view of the family as outlined above.

Overall, then, I find that the views regarding families of physicians I interviewed in Chicago, Milwaukee, Berlin, and Munich do not split into recognizable groupings based on the country in which the physician practices. Rather, a similar number of my interviewees in both countries expressed family ideals that were either inclusive, traditional, or mixed (see Table 3.1). The physicians I characterize as traditional described the nuclear family as ideal and often ignored the existence of alternative family structures. Furthermore, they expressed strong belief in binary gender roles and the importance of having both a mother and father within a family to provide adequate models. They also relied on their own families and evolution/nature to support their views. By contrast, those with inclusive views discussed the positive childhood outcomes associated with a range of family forms and the negative outcomes that can result in abusive yet traditional families. They highlighted the range of persons in a child's life who can act as role models and caregivers with little focus on gender and explicitly expressed that gendered role models need not be mothers and fathers. In addition, they cited experiences with lesbian- and single-patients and social science research to support their beliefs. The range of beliefs my physician respondents expressed was similar in both Germany and the US, despite the regulatory context being notably different. By examining when my physician respondents practice in ways that reflect their personal beliefs and when they do not, I explore the role of personal beliefs and regulatory context in shaping physician practices.

## PHYSICIAN PRACTICES: CONSISTENT WITH BELIEFS OR REGULATIONS?

I have demonstrated that the range of beliefs held by doctors I interviewed about the family is quite similar in Germany and the US, while the regulatory situation is different. To examine how both beliefs and regulations influence practice, the question becomes what physicians do when faced with lesbians and single women as patients. In short, I find that all of the doctors I interviewed in Chicago and Milwaukee treat lesbians and single women as a matter of course, whereas slightly more than half of the doctors interviewed in Germany stated that they do not treat lesbian or single patients, while about half do (see Table 3.1). This begs the question:

how do personal beliefs and regulatory context influence physician practices? In other words, how consistent are personal practices with personal beliefs and regulatory context?

I find that doctors holding traditional beliefs about the family in Germany do deny treatment to “nontraditional reproducers,” but they often cite the legal situation to explain their refusal rather than their personal beliefs. On the other hand, those holding inclusive views on lesbian- and single-headed families argue that the guidelines are unenforceable and non-binding, and go on to treat these women despite the guidelines’ prohibitions. By contrast, the physicians I interviewed in Chicago and Milwaukee report treating women regardless of sexual orientation or relationship status.[6] While similar numbers of doctors in both research sites hold traditional views of family, only those operating in Germany decline to treat non-traditional patients.

*United States: Treatment as Routine*

All twelve of the fertility specialists I spoke with in Chicago and Milwaukee indicated that they see single patients as well as lesbian couples in their clinics and that they treat them, meaning provide them with a range of fertility services up to and including IVF and ICSI. When discussing the demographic breakdown of their clinics, these physicians estimated that between one and ten percent of their patients are single women, and that another one to ten percent of their patients are lesbian couples. These physicians, whether they held traditional or inclusive views of the family, presented treatment of lesbians and single women as a matter of course, simply replying affirmatively when asked if they treat lesbian women or single women. The following exchange, with Dr. Miles is typical:

AV: And do you also see single patients?

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[6] These results are corroborated by the interviews of lesbians and single women I conducted, as my US respondents did not report being refused treatment or turned away by fertility physicians, whereas my German respondents described having to research which practices would be open to treating them before seeking treatment.

> Dr. Miles: Mm-hmm [affirmative].
>
> AV: Could you estimate what percentage of the patients are single?
>
> Dr. Miles: Single, maybe 5% or so. And then there are people who are just in common-law relationships I guess.
>
> AV: And do you also see gay or lesbian patients?
>
> Dr. Miles: Mm-hmm [affirmative].
>
> AV: Can you estimate what percentage they would comprise of the patients?
>
> Dr. Miles: Hmm… Probably fairly small, but you know, um, I'm trying to think, if we did that math, maybe 3, 4 percent I guess. If I work my numbers… (laughing). More lesbians than gay men I would say. Very few gay men, I would say. It's more complicated then, because you need an egg donor and a surrogate, whereas with most lesbian couples all they need is donor sperm and insemination cycle. So, very different kind of price on those cycles.

Dr. Miles' comments reflect the apparent openness to treating lesbians and single women expressed by all of my American physician respondents, regardless of whether they hold more traditional views on family. Indeed, although Dr. Miles holds inclusive views on family, his response to these questions was similar to those of the traditional physicians I interviewed as well. While lesbians and single women do not comprise a majority of their clients, they are nonetheless treated routinely, even by physicians whose personal views do not support such family structures.

In addition, traditional physicians did not raise family structure as an important area for more regulation at any point during the interview, nor did they describe relying on their views about family when evaluating patients. When describing what criteria might cause him to refuse to treat a patient, Dr. Coolidge, who expressed traditional views of the family, referred only to their patients' reproductive capabilities and not to sexual orientation, marital status, or even age:

> It's never a type of a thing where I—the way I approach this is that I do have a way of getting information regarding patients' reproductive function and chances of pregnancy.

> And that involves a number of different approaches and currently we have very sophisticated approaches, say, using a third party pregnancy. And there is always something that can be offered. Patients may not want to accept, for instance, gamete donors. They may want to—they may prefer to have an adoption. … So I think I get that concept of what you're asking about. Do we tell a patient, "We're absolutely not going to see you," for instance? No. That's not practiced in this country. In Europe, you might come across a situation where certain rules and regulations and things need to be done because of that. Here, there is more of an approach looking at alternative options and trying to select something that may be available.

Rather than describing potential criteria of exclusion, Dr. Coolidge instead outlines the lengths to which he and his colleagues go to provide treatment options for their patients. They can employ a battery of "sophisticated approaches" that include "third party pregnancy" (surrogacy) and "gamete donors." The role of the physician, then, is to provide "alternative options" for patients who wish to reproduce, and the patients ultimately decide whether they want to pursue treatment. Thus, it seems that the physicians in the US whom I interviewed do not view their personal beliefs about the family as relevant to their decision-making regarding treatment, whereas in Germany, personal beliefs play a notable role.

### *Germany: Treatment as a Matter of Belief and Regulations*

About half of the fifteen physicians I interviewed in Germany do not treat lesbians and/or single women. Almost all of the physicians with whom I spoke in Berlin and Munich practice in ways that are consistent with their stated beliefs about the family. The only doctor I interviewed in Germany whose practices were inconsistent with her beliefs was Dr. Hausmann who expressed inclusive views about the family yet did not treat single women and explained this refusal simply by stating: "[Insemination for single women] is just not allowed in Germany." However, she also indicated that she thinks the regulations should be changed to allow for such treatment, whereas few traditional physicians in Germany expressed any interest in changing the regulations that prohibit treatment for single and/or lesbian women. While some of the traditional physicians who refuse treatment to non-traditional reproducers explain this decision as solely the result of the legal situation, others view their decision as an interaction between regulations and personal beliefs.

Several of the traditional respondents mention legal barriers when explaining their refusal to treat non-traditional reproducers. For instance, Dr. Riedl cites a legal precedent when explaining why his clinic does not treat single women:

Riedl: We don't do that [treat single women].

AV: For what reasons?

Riedl: For legal reasons. So the doctor is allowed to – [trails off].

AV: Is it dangerous for doctors?

Riedl: Yes, then the doctor is the father, or the doctor is responsible for the money, yeah.

Dr. Riedl is here referencing the Dortmund case mentioned previously. However, that case does not relate to single women generally but rather to a very specific set of circumstances, and moreover the original decision in which the physician was held financially responsible was later overturned by a higher court. That said, this case seems to cast a long shadow over traditional physicians' practices, as they see it as a sign of legal uncertainty and perceived riskiness of treating women who are not in heterosexual unions.

Similarly, Dr. Mueller was explicit in stating that the legal situation kept him from treating single women:

> Mueller: If the legal situation would be better in Germany, then it [would be] up to the patient to decide because then you can follow the patient's autonomy. From the ethical background the patient's autonomy is the, from my point of view, the most important thing. Unless it is not possible to follow the patient's autonomy. And you cannot follow the patient's autonomy if you have either legal restrictions or as I stated before restrictions regarding the welfare of the child from a psychiatric standpoint. But patient's autonomy mainly is the most important thing. And so if I have some idea that there might

> be some major, some minor problems, let me say, [with] lesbian couples [parenting], that is not that important NOT to follow the patient's autonomy.
>
> AV: So in the case of a lesbian couple, you think it's, as long as they seem psychologically sound, it would be their decision--
>
> Mueller: Yeah.
>
> AV: And the same with a single patient?
>
> Mueller: [With a] single patient as well, yeah.

With my data, it is not possible to distinguish stated justifications for not treating from underlying motives, in cases where those do not match. Yet the idea that single women or lesbians cannot be treated in Germany was directly countered by several of the physicians I spoke with who do treat single women and/or lesbians in Germany.

While some of the traditional physicians I interviewed who refuse treatment to lesbians and/or single women locate this refusal in the regulatory situation, others describe the ways in which this policy is in line with their personal views. For instance, Dr. Damböck, a male Berlin-based doctor in his 50s, states:

> Damböck: Well, I only treat couples. I wouldn't… I wouldn't treat single women.
>
> Alicia: … even if it were legally supported?
>
> Damböck: [pause] I don't know. So when the women sit in front of me, I can understand their situation really well… but I don't know if that is really the best thing for a child. [The child] should at least have the chance to have a father. So I'm glad that the decision isn't up to me.

From this interaction, it is clear that Dr. Damböck recognizes that his own views overlap with the stated policy of the BÄK, and he indicates his uncertainty regarding how he would deal with a change in official policy allowing for less restrictive treatment guidelines. This doctor, then, exemplifies those traditional physicians in Germany who use the official statement of the physicians' professional association to justify their refusal, although their own views likely play a role as well.

Similarly, the following interaction with Dr. Riedl demonstrates that some traditional physicians recognize that their own beliefs hold an influential position in their decision-making process.

> Dr. Riedl: The worst thing, in my opinion, is one person [parenting] alone. That works too, everything can work, we have enough examples of single parents, but ideally a child needs a father and a mother.
>
> Alicia: Do you think that your opinion about that influences your work?
>
> Dr. Riedl: Yeah, certainly. For example, it is the case that I therefore do not treat single women *at all*. I only *advise* single women but I undertake no treatments with them. For that reason (words in italics spoken with particular emphasis).

Unlike Dr. Damböck's uncertainty regarding the ultimate determination of his practice decisions, Dr. Riedl seems to indicate that his own beliefs guide his practice more than professional guidelines. While most of the traditional physicians I spoke with in Germany did not express displeasure with the current guidelines, there was one physician whose comments indicated that she held traditional views of the family yet struggled with the official policy. Specifically, Dr. Hoefer, a white, female physician in her early 30s practicing in Berlin, when asked if there are patients she regrets not treating, responded: "Mhmm, I'm sorry sometimes, when I'm not able to treat single women, but we only follow the legislators in that regard and we unfortunately can't get around that." Again, though, it is hard to disentangle the effects of personal beliefs on practice, since, as I outline below, this adherence to the regulatory context was by no means universal among my German interviewees. In short, a slight majority of my German respondents do not undertake fertility treatments with single women and/or lesbians, yet there are some among them who view the legal uncertainty of these treatments as the primary barrier, whereas others view the legal situation as providing a perhaps convenient shield from having to treat these women.

While a slight majority of the fertility specialists I spoke with in Germany do not provide fertility treatment to single patients and/or lesbians, almost half of my respondents do, despite the professional guidelines and regulations that preclude such practice. These doctors ignore or directly flout the regulations that discourage or prohibit treatment. Upon examination, it is clear that the physicians in Germany who choose to do so also express inclusive views of the family. As Dr. Weiss asserts: "Many people think [it's not possible to treat single women]. But that's not judicially enforceable – so, it's not a law. It's something that the Bundesärztekammer wrote, but it is actually discrimination under our laws. So it's not forbidden [to treat single women]. It's not a law – it's not valid according to the law." It seems, then, as though physicians selectively draw upon laws and guidelines to support their own views. While traditional physicians rely on the BÄK's guidelines to justify not treating lesbians and single women, inclusive physicians instead look to broader anti-discrimination laws to support their decision to treat these women.

Inclusive physicians also relied on their personal experiences with patients to support their practices. For example, Dr. Hoefer says:

> I treat lesbians, and I see, when they return with their kids and show them to us, when they come to have a second child, then we see the first child again. We have the impression that the child is happy and open, and that they simply have two dependable parents. And these lesbian relationships are in some ways very reflective about their wish to have a child. They must take on more burdens in order to have a child, and for most of these couples, their desire for a child has become very intensive and they take really good care of their children.

In this way, physicians who treat non-traditional reproducers have anecdotal evidence to reinforce their beliefs that families with a wide range of structures produce positive childhood outcomes. Because traditional physicians in Germany do not treat these women, they then do not have these same experiences to draw upon when making treatment decisions. This means that traditional physicians are not faced with counterevidence that might spur them to question their beliefs that nuclear families are the ideal structure for raising children. Whereas inclusive physicians in Germany do treat single women and lesbian couples and thereby deepen their beliefs that these families provide loving, stable family environments, traditional physicians do not encounter this evidence by virtue of their decision not to treat these women. This may further divide traditional and inclusive physicians in Germany, as the latter group becomes increasingly convinced of the appropriateness of treating non-traditional reproducers, while the former group remains persuaded that their decision not to treat is correct.

## CONCLUSION

The BÄK guidelines provide a clear example of the system of stratified reproduction, in which "some categories of people are empowered to nurture and reproduce, while others are disempowered" (Ginsburg & Rapp, 1995, p. 3). By privileging the medical treatment of certain family types and prohibiting that of others, these guidelines lead to discrimination against women who are lesbians and/or single and wish to reproduce. What is perhaps most interesting in the comparison of physicians' views in both countries is that, by and large, their opinions on non-traditional family structures are quite similar. There are medical doctors in both countries who express traditional views of the family, describing heterosexual, two-parent families as providing a superior environment for children, especially as they provide distinct gender role models within the family. These physicians rely on evolutionary arguments and evidence from their own family lives to explain their views. There are also doctors in both countries who express inclusive views of the family by (a) describing lesbian-headed families as loving, nurturing environments for children, (b) portraying gender roles as overlapping and multiple, and

(c) relying on non-traditional patients and social science research to support their beliefs. Although physicians in Germany have legal and professional restrictions that encourage them to turn away lesbian and single patients, their American counterparts have no such justification. Thus, the differential treatment of lesbians and single women in these two countries appears to result from the discriminatory legal and professional guidelines in Germany rather than from fundamentally different views on family.

The German physicians I interviewed generally reported that their behavior was consistent with their beliefs about the family, whether those were traditional or inclusive. Similarly, the inclusive doctors in the US also had consistent beliefs and practices. However, the doctors in the US who held more traditional views of family practiced in ways that were inconsistent with their stated personal beliefs. Thus, the regulatory system, when it suggests a cover for discrimination, is used by providers as such, allowing them to practice according to their own beliefs. When discrimination is not supported by regulations or guidelines, however, this discriminatory impulse is quashed by other pressures – whether toward increasing profits, equal treatment for all, focusing efforts on technical success (i.e., high rates of conception), or something else entirely. I find that despite the profession of medicine's focus on personal ethics and the US cultural emphasis on individualism, it is actually the doctors in the US who are more likely to follow guidelines regardless of personal beliefs. By contrast, physicians in Germany whose personal and professional ethics are in conflict are more likely to practice according to their belief systems, rather than follow regulatory recommendations.

Although physicians I interviewed in both Germany and the US demonstrate a similar range of opinions regarding families, with a comparable split evident between doctors with traditional and inclusive views of the family, this difference of opinion is only translated into differing treatment practices in Germany. Among my respondents in Chicago and Milwaukee, even physicians who strongly believe that two heterosexual parents provide a better home environment for children nevertheless treat lesbians and single women. It seems, then, that the guidelines in Germany encourage discriminatory practices, allowing physicians with traditional beliefs to exclude lesbians and single women from treatment, whereas physicians in the US, lacking regulatory reasons to exclude lesbians and single women, tend to provide treatment for alternative family structures even when these go against their personal values.

# CHAPTER 4: CONCEPTION WORLDVIEWS AND TRAJECTORIES

## INTRODUCTION

In this chapter, I explore how lesbians' experiences of conceiving are influenced by the regulatory context in which they live and by their beliefs about conception. Previously, I focused on the professional guidelines and the regulatory environments that influence physicians' treatment decisions. Here, I explore how lesbian couples in which one of the women is attempting to become pregnant[1] navigate conception options. Drawing on the work of Luker (1984), I find that most of my respondents pursue conception according to what I term their "conception worldview,"[2] with understandings of the regulatory context also playing a role. My research demonstrates that there are two distinct conception worldviews, the first is "conception as natural" and the second is "conception as medical." Broadly, the *natural conception worldview* posits that conception is a natural process preferentially undertaken at home, for which doctors are unnecessary, and in which bodily expertise is privileged over other forms of expertise. By contrast, the *medical conception worldview* holds that conception is a process improved through the use of technology, for which physicians are well-trained, and in which their professional expertise is given the final authority.

While conception worldviews are a key component of the narratives examined in this chapter, I use the term *conception trajectory* to describe the entire process of attempting to

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[1] Although I initially intended to include both coupled lesbians and single women of any sexual orientation in my analysis, I found that their experiences differed substantially enough that a merging of these categories threatened to collapse findings in ways that did not reflect the unique experiences of each group. In terms of the findings of this chapter, for instance, given the more advanced average age of my single women respondents (compared to my coupled lesbian respondents), the single women respondents' worldviews tended to be more medically focused and more eager for quick results, while my lesbian respondents' worldviews tended to be more focused on having a natural conception experience.

[2] I title these "conception worldviews" for concision, but each group includes the narratives of women who are still attempting to conceive in that particular way but who have as yet been unsuccessful.

conceive. This trajectory includes my respondents' preparation for conception, their initial attempt to become pregnant, and any subsequent efforts to conceive. I argue that the initial attempt best reflects my respondents' conception worldviews, because it is at this point that my respondents are structuring their efforts primarily based upon personal preferences. However, for respondents who are not successful on the first try, each subsequent attempt becomes a site for potential negotiation and revision. Examining how and when respondents change aspects of their practices provides insight into both how committed they are to their conception worldview and how the regulatory context influences their decision-making.

I find that in both countries the natural conception worldview is more widely held by my respondents, and this is reflected in the fact that the vast majority of my respondents initially attempt to conceive at home. However, the German women I interviewed were more likely to remain attached to the natural conception worldview even when faced with difficulty conceiving compared to their US counterparts, partially because they anticipated the possibility of discrimination in a medical setting. My US respondents, by contrast, more readily embraced medical settings for conception, in part because they wished to access insurance benefits that only recognized inseminations performed by physicians as legitimate. Thus, the regulatory context influenced my German and US respondents in opposite ways, with the latter being encouraged to embrace a more medicalized approach to conception, whereas the former are discouraged from doing so. In this chapter, I briefly describe common techniques used by lesbians to achieve pregnancy, and then I outline my respondents' conception worldviews. Then, I examine my respondents' conception trajectories to demonstrate how worldviews and regulatory context mutually influence conception attempts in the disparate regulatory environments of Germany and the US.

## BACKGROUND

By referring to my respondents' beliefs about conceptions as being part of their worldviews, I am drawing upon Luker's work on abortion (1984). She argues that in the abortion debate in the US, pro-life and pro-choice activists hold deeply divergent views related to questions of morality, sexuality, and family. Luker describes "those areas covered by a 'worldview'" as "those parts of life we take for granted, never imagine questioning, and cannot envision decent, moral people not sharing" (1984:158). Similarly, my respondents' orientations to conception were taken for granted, unquestioned aspects of their beliefs about how the world should work. While my respondents' orientations to conception were not articulated as directly opposing one another (as is the case in the abortion debate), there are some notable similarities in how these women's preferences relating to conception are situated in both larger discourses of morality and in their own understandings of what is "natural" and "right."

Conception is discussed as a moral issue less frequently than abortion. However, considerations of "naturalness" are inextricable from ideas of morality, especially because conception that occurs "naturally" (meaning without intervention or assistance) is sometimes seen as reflecting the will of a higher power or God. In his study of religious people's views on the morality of ART, Evans describes how his respondents' views often reflect a discourse of "Promethean fatalism, which claims that God has a plan for every person and to interrupt that plan is to usurp God's prerogatives" (2010:9). Furthermore, many of his respondents' views reflect a broad discourse that frames "nature as given; [implying that] it cannot be ethically controversial" (2010:78). In other words, he finds that many people view medical interventions to correct infertility as morally ambiguous because of the ways such treatments can be framed as interrupting "God's plan." Similarly, opposition to gay marriage can be viewed as a corollary to certain ideas of "naturalness." Part of the opposition to same-sex marriage is predicated on opposition to same-sex couples raising children. Indeed, a major argument used by opponents of same-sex marriage holds that precisely because same-sex couples cannot produce children who are biologically related to both parties, their unions should not be sanctioned by the state or by religious institutions. As Jowett states, "opponents of same-sex marriage often described the 'purpose' of marriage as being related to procreation and the formation of the nuclear family" (2014:43). Thus, even without explicitly framing their decisions to pursue pregnancy in ethical or moral terms, my respondents' attempts to conceive are steeped in morality discourses of the wider society, and decisions regarding how to conceive are inextricably related to questions of nature.

## HOW CONCEPTION WORKS

To understand the social practices my respondents undertake in pursuit of conception, it is first necessary to comprehend the biological process. When not actively trying to conceive, many people are aware of the biology of conception only to the extent that they recall that conception occurs when egg and sperm meet. However, the preconditions for successful conception are complicated. A woman's store of eggs is held in the ovaries, and during a typical menstrual cycle an egg is released from the ovary into the fallopian tube, which is called ovulation. For the egg to be fertilized, live sperm have to be present in the fallopian tube when a woman ovulates. When sperm are placed either in the vagina through sexual intercourse or insemination, they must travel through the cervix into the uterus and then through the fallopian tube to the egg. This journey can take several hours, and sperm have a limited life span. Fresh sperm can live for up to a week inside the body, whereas sperm that have been frozen can survive for only six to 24 hours (Pepper 2005). The goal of insemination with either fresh or frozen sperm is to have the sperm present and alive in the fallopian tube when ovulation occurs, so that fertilization (often referred to as “conception”) can happen.

When actively trying to get pregnant, then, a woman must understand her menstrual cycle to time inseminations so that the chances of a fortuitous encounter between a sperm and an egg are maximized. Ovulation is accompanied by some bodily signs that woman can monitor over several menstrual cycles to help predict the timing of inseminations. One signal of ovulation is the consistency of vaginal mucus. When a woman is approaching ovulation, her vaginal secretions tend to become more noticeable and to take on a stretchy, slippery character, often compared to egg whites, called *spinnbarkeit* by medical professionals in both the US and Germany.[3] Vaginal mucus with this consistency helps to draw sperm up into the uterus, whereas the mucus produced at other times of the month tends to repel or slow sperm until they die.

Another key predictor of ovulation is resting body temperature. To achieve accurate measurements, a woman tracks her temperature immediately upon waking, before getting out of bed, because the variations in temperature that relate to the menstrual cycle are very small. Typically, a woman’s temperature is low prior to ovulation, but her temperature will rise by about 0.4 degrees Fahrenheit right after ovulation due to a surge of progesterone that accompanies ovulation. Because this method of tracking only alerts a woman that ovulation has occurred, it is not useful for determining the timing of an insemination in a given month. However, tracking over several months allows a woman to determine how regular her menstrual cycle is and to estimate when ovulation will occur based on data from previous months.

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[3] Interestingly, the (English) medical terminology here uses the German term, which translates as “ability to be spun”, with spin here invoking the “spinning” done by a spider creating a web. The term *spinnbarkeit* is also referred to as “fibrosity.”

There are also ovulation predictor kits available at pharmacies and online. These kits test the urine for luteinizing hormone (LH), which is the hormone that causes ovulation. The surge of LH indicates that ovulation will occur roughly in the next 12 to 24 hours. Finally, some women feel ovulation occur in their bodies, through a feeling of slight to intense pain from one side of the lower abdomen, lasting anywhere from a moment to a few hours, known as *mittelschmerz*.[4]

Understanding ovulation is a necessary first step to pursuing pregnancy as a lesbian, since a woman needs to coordinate inseminations with her bodily fertility. Even when inseminating in time with ovulation, conception is not guaranteed. Conflicting information on fertility success rates at different ages abounds. On the one hand, the ASRM reports that, while "[a] healthy 30-year old woman has about a 20% chance of getting pregnant each month…[a] healthy 40-year old woman has about a 5% chance of getting pregnant each month" (ASRM n.d.). On the other hand, journalists have recently argued that these statistics are not supported by factual evidence, except for historical studies of fertility based on data from the seventeenth and eighteenth centuries (Twenge 2013). Rather than fertility decreasing precipitously during a woman's 30s, there is some evidence that, at least for women without underlying infertility issues, the chances of pregnancy decline only modestly with age, at least before the age of 40 (see Dunson, Baird, and Columbo 2004 and Rothman et al 2013). The disagreement just underscores the fact that no individual woman knows whether she will become pregnant during a given insemination cycle. The process of attempting to conceive is fraught with uncertainty, and women who are unsuccessful at conceiving may change many details of their approach over time, such as the timing of insemination, the tactics used to measure and predict ovulation, the bodily positioning during and after insemination, and the geographic locations where insemination is attempted.

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[4] Again, the term comes from German and translates literally as "middle pain."

The uncertainty of conception, along with a respondent's conception worldview and the regulatory context in which she lives, provide a backdrop for her decisions about how to conceive. Regulations in Germany are such that non-traditional reproducers may encounter providers unwilling to treat them, though they are likely to be able to find willing providers with a little searching. However, my German respondents are undertaking their conception attempts in a regulatory environment that does not provide any insurance coverage for their attempts (neither the cost of sperm nor the cost of fertility treatments). By contrast, in the US, no professional guidelines exist to discourage treatment, and my respondents in Illinois live in a state where treatment for fertility is likely covered by insurance, although the price of sperm is not. These different regulatory systems provide important contexts for my respondents' conception trajectories, but these trajectories are also influenced by their personal beliefs about conception, or what I have termed their "conception worldviews."

## CONCEPTION WORLDVIEWS

In the previous chapter, I argued that the range of beliefs held by my physician respondents toward "non-traditional" families were remarkably similar across national contexts, with many physicians in both countries holding "traditional", "inclusive", or "mixed" views. Similarly, I find that my respondents' beliefs regarding conception can be distilled into two conception worldviews – natural versus medical – with the split between these worldviews found in both Germany and the US, despite there being significant differences in the regulatory context. The first of these worldviews, what I term the natural conception worldview, is characterized by beliefs that conception is a natural, physical, bodily process that need not involve a doctor. Furthermore, the women holding this view tend to prefer the location of conception to be the home. These women characterize home conception as more comfortable, and many of these women hold somewhat negative, or at least skeptical, views of medicine and physicians. In addition, these women describe bodily experiences and processes in ways that demonstrate that they view the body as a source of knowledge or expertise. Thirteen of eighteen US respondents held the natural conception worldview, compared to 19 of 22 German respondents (see Table 4.1).

**Table 4.1. Conception Worldviews of Lesbian Respondents**

| Worldview | US | Germany |
|---|---|---|
| Natural | 13 | 19 |
| Medical | 5 | 3 |
| Total | 18 | 22 |

By contrast, the medical conception worldview is characterized by trust of medicine and doctors, with a corresponding emphasis on success rates with doctor-led conception as a more reliable method than insemination performed by the woman herself or her partner or friend. The women holding this worldview describe conception in a clinic in neutral to positive terms, which is contrasted with conception at home, which they frame as difficult or stressful. For these women, expertise emanates from doctors' training and experience, as opposed to being generated from a woman's knowledge of her body or her menstrual cycle. Five of 18 US respondents held medical conception worldviews compared to three of 21 respondents in Germany. In the following sections, I explore these worldviews in more depth, grounding them in my interview data.

### *Natural Conception Worldview*

One of the main components of the "natural conception" worldview is the trust placed in bodily expertise, in other words, the belief that a woman's body is a valid and useful source of information, along with an implicit privileging of this personal source of knowledge over medical learning. My respondents' adoption of the natural conception worldview is demonstrated in part by how women discuss one of the first steps in the conception process: ovulation tracking. While describing their efforts to pinpoint ovulation, the "natural conception" respondents described their bodily knowledge in much more positive and confident terms than their "medical conception" counterparts. For instance, Christin, a German lesbian in her 40s living in Munich, explains:

> For a year I used the temperature method [of tracking fertility]. So I knew my cycle really well, I had a really regular cycle. In that respect I could ignore it, where – while I was taking birth control, then I was younger and because of that my cycle was more regular. At that point I was thirty-nine, thirty-eight?, thirty-nine? And then, as I started to measure [my cycle], then it started to go all crazy. So that I suddenly didn't have a regular cycle. I had to totally pay attention and observe, so that I would know, roughly, when I was ovulating. We didn't use a machine, or buy anything to determine when it was. In the end it was just my observations.

Evident in Christin's account is that, even in cases where the embodied knowledge was uncertain or difficult to interpret, women with natural conception views relied on this information. Rather than turning to medical interventions, such as ultrasound, to determine ovulation, women with the natural conception worldview attempt to understand their bodily expertise with limited mediation. Some of my respondents with natural conception worldviews did purchase ovulation predictor kits to use at home, such as Emily, a white lesbian in her late 20s living in Chicago. She describes how she began by tracking her temperature for several months and eventually decided to use "pee sticks" to supplement the knowledge gained from temperature charting. According to Emily, "the pee sticks gave us more information to work from," when timing inseminations. While the rejection of technical assistance for determining ovulation was not expressed universally by the natural conception belief holders, the general themes of reliance on a woman's bodily signals and her understanding of and relationship to her body were prevalent throughout this group. What is notable, particularly in contrast with the women who hold medical conception views, is the confidence these women feel about their bodies and their abilities to conceive.

Another crucial component of the natural conception worldview is the notion that doctors and reproductive technologies are unnecessary to the process of conception, at least in most cases. This sentiment is summed up by Charlotte, a German lesbian in her late 30s living in Munich, who, when asked if she visited a doctor during her conception attempts, replied simply, “One doesn’t need a doctor.” Other respondents in both Germany and the US used words such as “normal,” “private,” “relaxed,” “low-tech,” and “personal” when describing the process of conception, which indicate different aspects of the natural conception worldview. My respondents often contrasted natural conception with medical conception, which they described as “cold,” “technology-heavy,” and “sterile.” For instance, Resi, a German lesbian in her mid-30s living in Munich, notes how she and her partner felt:

> We wanted to try to do it [get pregnant] as relaxing as possible, and… yeah. We just wanted to have the time for ourselves, privately, not go to a [doctor’s] practice. Because it’s a bit weird, like, ‘okay, we are procreating’. … So I wanted to do it as, as normal as possible. Also for myself, for my own feelings. I didn’t want to create a child in such a sterile [environment], in a doctor’s office. So that was somehow, it just didn’t feel right.

Here, the atmosphere for conception plays a major role in the discussion of how and where to conceive, with the home framed as “relaxing” and “private” while the doctor’s office is viewed as “sterile” and “less personal.” Many of the respondents who conceived at home reported similar feelings regarding the awkward, strange, or unpleasant interactions they anticipated in a health care facility, describing the home environment as their clear preference for their conception attempts.

While lesbians and single women may not suffer from feelings of failure in the same way that heterosexual women sometimes do when they struggle with infertility, they nonetheless often share the idea that conception is a process that *should* happen naturally, meaning without medical intervention, in a private, relaxed atmosphere, and without technological assistance. As Becker (2000) notes, her heterosexual respondents who underwent treatment for infertility grieved for “the loss of what they consider to be natural,” expressing “regret that conception could not have occurred without any intervention” (2000:6). Although my lesbian respondents expect to plan and execute their conception attempts (at a minimum, they expect to have to inseminate using acquired sperm), they still have ideas about what level of intervention feels “natural” or appropriately non-invasive.

In addition to preferring a low-technology approach to conception, women who hold natural conception worldviews sometimes expressed a dislike or distrust toward doctors and hospitals. These feelings seem to be related to medicine as an institution more than to specific negative experiences with the medical establishment, as very few of my respondents reported having had uncomfortable or discriminatory interactions with physicians in the past. For instance, Christin states:

> Basically I don’t like a hospital atmosphere. I like... I’ve gone to the same [female] gynecologist for years, [but] for example, I don’t like [male] gynecologists. And back then [when I was starting to try to get pregnant] I already knew that there are doctors in Munich who will do that, even though it’s not allowed legally to inseminate lesbians. But I didn’t want to go to the doctor.

My respondents with natural conception worldviews held neutral to negative views of doctors, hospitals, and clinics, and these views reinforced their idea that doctors are unnecessary for conception to occur.

### *Medical Conception Worldview*

My respondents who held medical conception worldviews consistently contrasted medical expertise with that of lay people and found it to be better, more reliable, and more convincing. Whereas women holding the natural conception view highlighted their own abilities to monitor their cycles and the breadth of knowledge they gathered through internet and word-of-mouth sources, these women instead frame doctors' knowledge as privileged. As Cassandra, a white lesbian in her early 30s living in Chicago, explains:

> We thought about [trying to conceive at home]. Because, with my schedule, I worked 80 hours a week and I felt like the timing wasn't going to work [with making it to appointments at a doctor's office]. Yeah, we looked into getting the sperm shipped here and the whole thing. But I think that would have put a lot of pressure on my partner, because it would be her job to try to get it in the right place. And she's not a doctor. I think that would have been hard. And in the end, we just decided like, that would be bad. And also, we would spend a lot of money and not get pregnant in the end.

Here, because her partner is "not a doctor," the respondent assumes the process of inseminating her could be "hard" and "bad." Thus, even though having a busy work schedule would have made it simpler to avoid scheduling appointments in a doctor's office when she was ovulating, the respondent and her partner felt the scheduling hassle was less important than the potential frustration of trying to conceive at home and not succeeding. In addition, the women expressing the medical worldview often describe relying on physician expertise as reducing their or their partners' stress levels, as achieving pregnancy then becomes the responsibility of the medical professional.

Related to the idea of medical expertise is the assertion that conception is a complex process that lay people are less able to understand and less likely to succeed in achieving than trained professionals. Doctors' expertise is contrasted with one's own lack of training, with the outcome that physicians' attempts to inseminate a woman are seen as more likely to be successful and less plagued with doubt for the women attempting to conceive. The following quote, in which Cassandra describes how she and her partner eschewed a local organization's alternative insemination program in favor of one based in a fertility clinic, exemplifies this line of thinking:

> I just didn't feel like they were very like medicalized. Which, so it was like one step up from home insemination. And they were really far from us, too. They basically had like eight people doing inseminations. They were people who had been trained, but they're not medical people. And it's...have you ever tried to find a cervix? Let alone thread something through it? And so if some like random person off the street learns to do that...I just think it's weird. Obviously I'm biased because I have a very comfortable medical setting, but it really just wasn't for us.

Cassandra's comments demonstrate the way in which my respondents who held a medical conception worldview put their faith in a "medical setting" that is staffed by "medical people" as opposed to a "random person off the street" who has only been "trained" in how to locate a cervix. This is typical of the clear preference for medical expertise expressed by my respondents who hold the medical conception worldview. Similarly, Ulrike, a German lesbian in her late 30s living in Berlin, describes how she and her partner decided to inseminate at a clinic from the outset:

> Because for us I think [inseminating at a clinic] seemed safer and somehow more enjoyable than [doing it] with our own hands. So, because then the time-window is also very small, it became very small, and yeah, we felt well advised at the medical practice, and so then we found it more reasonable somehow to just let ourselves use the professional help at that place [than to attempt to conceive at home].

Like Ulrike, my respondents who held the medical conception worldview framed medical assistance as preferable to attempting to conceive without professional help.

Another key feature of the medical conception worldview is the negative affective reaction many of these respondents have toward home conception. Just as the women I interviewed who hold a natural conception worldview describe their preferred location for conception as the home rather than in a clinic, the women holding a medical conception worldview engage in the opposite form of framing. The home, for these respondents, is described as a "stressful" environment for conception attempts, largely because of the uncertainty surrounding conception. By contrast, these women describe clinics in neutral to positive terms.

For instance, Amelia, a black lesbian in her mid-30s living in Chicago, describes the reasons she and her partner avoided home insemination:

> AV: And did you think about at all trying - inseminating at home or anything like that?
>
> Amelia: God no.
>
> AV: Okay, why not?
>
> Amelia: Oh, I felt like 'uh-uh' [negation]. I was like, 'this is too much money to be playing around [with]' and thinking, 'oh, are we doing it right?' I want to go to some professionals right off the bat. I'm like, 'no, this is not…' People want to try? No way. We're not rich like those people in California. I'm like, 'it's going to be delivered there [to a clinic], they're going to thaw it out, they know what they're doing. I didn't even want to play with that [inseminating at home], because it's like thousands of dollars. You want to do it [at home] just because? Uh-uh [negation]. Not me. Never thought about it once.

Home insemination, in this account, is contrasted with lay people (herself and her partner) who would be "playing around" and wondering "are we doing it right?" during any home insemination attempts. The idea that doctors have training about how best to conduct an insemination pervades the conception worldview of these respondents. These women attempt to alleviate their own worry and uncertainty about conception by placing the responsibility for success into the hands of someone else, namely physicians, who are framed as trained professionals.

In short, my respondents in both Germany and the US exhibited similar worldviews regarding conception, which split into two distinct groups: the natural conception and the medical conception worldviews. In both countries, the natural conception worldview was held by most respondents, with a smaller minority espousing the medical conception worldview. The rest of this chapter is devoted to disentangling how the regulatory context and personal beliefs regarding conception influence the conception trajectories of my respondents as they attempt to achieve pregnancy.

## CONCEPTION TRAJECTORIES

When examining my respondents' conception trajectories, a few salient findings emerge. Conception worldview clearly impacts the location of conception, as those holding natural conception worldviews initially attempt to conceive at home, whereas their medical conception counterparts begin in a clinic. However, because conception may not occur during the initial attempt, my respondents adjust their approaches over multiple attempts. These adjustments result in more of my respondents conceiving in medical settings than those who expressed medical conception worldviews. The movement toward medicalized reproductive experiences reflects many factors, including the psychological fallout from failed attempts at home conception, but the regulatory context also plays a role. In short, conception worldviews influence how my respondents begin their conception attempts, as well as how they persist in pursuing pregnancy, but regulatory context also impacts how my interviewees respond to attempts that are unsuccessful.

**Table 4.2. Conception Locations of Lesbian Respondents**

| Original / Ultimate Location | US | Germany |
|---|---|---|
| Home / Home | 9 | 15 |
| Home / Clinic | 4 | 3 |
| Clinic / Clinic | 5 | 3 |
| Total | 18 | 21 |

As I mentioned previously in this chapter, there were broad similarities between my German and American respondents' conception worldviews, with the majority of women I interviewed in both countries espousing natural conception worldviews. However, the conception trajectories of respondents in these two countries reveal striking differences.

Specifically, the women holding natural conception worldviews in Germany were more likely to persist in their attempts to conceive at home when faced with repeated unsuccessful attempts, with only six of my 21 German respondents ultimately attempting to conceive in a clinic, whereas their American counterparts turned to medical assistance more quickly, with nine of these 18 women conceiving in a medical setting (see Table 4.2). This difference seems to stem in part from the different regulatory contexts in Germany and the US, as insurance regulations encourage my American respondents to move to a medical setting, while professional guidelines in Germany discourage my respondents from turning to physicians for assistance.

*Natural Conception Worldviews and Home Conception*

I found many commonalities among the conception narratives of my respondents who successfully conceived at home, which reflected their belief in the natural conception worldview. In particular, these women describe how they preferred trying to conceive at home and had positive experiences doing so, used their own embodied expertise to guide their attempts, and avoided doctors when possible. Alexandra, a white lesbian in her late 30s living in Berlin, relates how she conceived:

> Okay, so it was just obvious that we wanted to use the "jar" method[5], so [we wanted to inseminate] at home. And so then the first time he [the donor] simply brought the sperm over and… (laughs). Right, because then he basically he injected the sperm into the syringe. And then for the first time it worked right away. And the second time [for the attempt to have a second child], it was basically the same, [except that] then it worked on the second try. So somehow we were a good match (laughs). So it was totally without problems, the actual impregnation.

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[5] "Jar method" is the literal translation of the German term "Bechermethode", which in English is colloquially described as the "turkey baster method." In short, both "jar method" and "turkey baster method" describe the process of intravaginal insemination preceded by the sperm donor ejaculating in a cup (or jar, hence the German terminology). The sperm is then transferred to the woman's vagina using a needleless syringe, for which a turkey baster can be substituted in a pinch, hence the English terminology.

Alexandra's description of her experience reflects the first of these common themes, as she views conceiving at home as the "obvious" choice, given her natural conception worldview. She and her partner saw their home as the ideal location for their conception, and thus they had the donor come to them for the insemination attempts. In addition, for her the experience of conception was quite positive, as the road to impregnation is "easy" and "without problems." While not every one of my respondents who conceived at home got pregnant on the first or second try, most of them conceived in five or fewer attempts, rendering their assessments of the process as "easy" to be quite accurate.[6]

Beyond the preference for home conception, these women described their conception trajectories with a focus on how they were able to track their own ovulation in a way that allowed them to estimate the most likely time in their menstrual cycles for conception to occur. For instance, Hannah, a white lesbian in her late 20s living in Chicago, describes how she got pregnant during her second insemination attempt, at home, when her donor happened to be visiting while she was ovulating:

> I'd been doing like, you know, they make these little, like, ovulations stick things that you just pee on every morning, so we'd been using that. But sometimes it would say that I didn't ovulate or that I really was only ovulating one day or something, which it wasn't supposed to say. [I heard that can happen] because the spike in whatever hormone that thing is detecting can be really short – it can be like 12 hours long, so if you are testing once every 24 hours then you might miss it. The month I got pregnant we were still doing that and doing the temperature tracking and like every single sign said I was ovulating, you know, so it wasn't like we got different results from the temperature than from that. There was no question – by every measure we had, this was the right time to try.

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[6] As mentioned earlier in the chapter, there is some debate over how likely it is that conception will occur during any given cycle, even when inseminations are well-timed with ovulation. One widely cited statistic is provided by the ASRM, which asserts that a 30-year-old woman has a 20% chance of conception per cycle implies that repeated attempts should be expected (ASRM n.d.). Similarly, infertility is only diagnosed when attempts to conceive have been unsuccessful for a full year. While it is not my intention to characterize any particular number of attempts as typical or to draw a line between "easy" and "difficult" conception trajectories, up to five attempts seem to be framed by my respondents as emotionally unproblematic, though with each repeated unsuccessful attempt, anxiety about the process rises.

Hannah's experience demonstrates that pinpointing the time of ovulation can be quite tricky, yet the women I interviewed who conceived at home tend to frame it as knowable without medical assistance. Their confidence in their ability to interpret signs of ovulation on their own mirrors their natural conception worldviews, and their conception trajectories demonstrate that, for some women at least, careful monitoring and perseverance yield positive results. Thus, when Hannah recalls how her experience with a urine-based ovulation predictor kit was sometimes confusing, she nonetheless explains how she sought additional information about this tracking method to understand her cycle more fully. In addition, she notes that she relied on several home-based techniques to predict her ovulation and thus felt confident in the timing of insemination, as she notes, "by every measure we had, this was the right time to try." This reliance on bodily and self-led methods of ovulation tracking and insemination timing was common among my respondents who conceived at home, all of whom held natural conception worldviews.

Finally, these respondents frame their conception experiences by emphasizing their desire not to rely on physician assistance. For instance, Resi describes her conception trajectory in very positive terms, saying that it was "very easy" to conceive through home insemination without the help of a doctor:

> It was for us, thank God, very very easy. So we had the first try, we did it at home with the "jar" method [turkey baster method], with a syringe, um, without a doctor, without everything, very, very relaxed. We said, we'll try it one time – [for up to] a year, and if that doesn't work, then we can still go to a doctor, to a practice. But we wanted first [to try] really realxed for us at home. And the first attempt we did, worked immediately. It was immediately positive, but unfortunately we lost the child in the tenth week [of pregnancy]. And then, I thought at first, I need a break, for a couple months. But then that felt somehow odd, and then one month later, I said, "No, I want to keep going now. Either it works or it takes awhile." And it worked right away again. We had the first try at the end of October and I was pregnant by the end of November.

Resi's description of her conception trajectory demonstrates that many of the women holding a natural conception worldview were not opposed to seeking medical assistance with their attempts to become pregnant if they were unsuccessful over a long time period, but these women expressed a strong preference for conceiving at home without medical assistance if possible. Even after losing a pregnancy, Resi did not waver in her commitment to inseminating at home. These women tend to frame medically assisted conception as an option of last resort, rather than a starting point, in contrast to the women I interviewed who hold medical conception worldviews.

The nine American and 15 German women whose experiences are described in this section all hold natural conception worldviews, and all of them achieved successful pregnancy with home inseminations. However, they included little discussion of their country or state-based regulatory context, whether that was the discriminatory regulations precluding treatment in Germany, the role of insurance coverage for some respondents in Illinois, or the lack of insurance coverage for respondents in other locations. Thus, these respondents framed their decisions about conception as resulting from their personal beliefs rather than from the regulatory context. In the next section, I explore how the trajectories of women with medical conception worldviews differed from those described above, both in terms of the experiences themselves and the role of the regulatory context.

### *Medical Conception Worldviews and Clinic Conception*

In this section, I explain the common themes I found in the conception trajectories of women who began their conception attempts at a clinic. In particular, these women describe how they preferred trying to conceive with the help of a doctor and in a clinic, relied on medical technology and expertise to achieve pregnancy, and privileged these sources of expertise based on notions of likelihood of achieving a successful pregnancy. Furthermore, in many instances, these women's conception trajectories present medical intervention as inevitable. In other words, they frame their decision to conceive in a clinic not as a choice, but rather like a foregone conclusion. For instance, Heidi, a German lesbian in her late 20s living in Berlin, describes her initial conception attempt thusly, "So, we informed ourselves about the possibilities that there are. And… yeah, so we had heard good things about the [name omitted] Clinic and then we had a preliminary talk, just on the phone, and then we decided we'd go there." She successfully conceived on her first try using IUI at the clinic, and she and her partner plan to follow the same procedure when they try for a second child. In the perfunctory way in which she summarizes the decision to conceive in a clinic, Heidi's conception experience encapsulates the way in which these women frame beginning their conception trajectories in a clinic as a given.

Furthermore, my respondents with medical conception worldviews framed conception in a clinic in positive terms, sometimes describing their feelings about potential home-based conception as "stressful" and prompting worries such as "are we even doing this right?" These women's conception trajectories reflect these feelings, as these respondents emphasize the preference they had for conceiving in a physician's office, which stemmed from their belief that such attempts were more likely to succeed due to the physician's training and expertise. For instance, Cara, a white lesbian in her late 20s living in Chicago, who was planning to begin insemination soon when we spoke, described how she and her partner decided to inseminate in a medical setting:

> We - I'm the daughter of a physician and so I - while the idea of doing it at home sounded sort of nice and warm and all of that, I think we both have done so much research into sort of the statistics and how hard it is for straight couples to get pregnant sort of doing it the old fashioned way, and then you know, what the statistics are for doing, you know, IUI or anything like that, and so I think we both like - given the

> expense and the statistics, we would rather just maximize our opportunity for success. So we're going to have a doctor do it.

Cara's preference for attempting to conceive in a clinic clearly lies in her belief that "the old fashioned way" of conceiving for straight couples – the corollary of which would be home insemination for lesbians – is "hard", whereas she feels that "statistics" show that more technical procedures such as IUI "maximize [the] opportunity for success." Even though Cara had some positive associations regarding home conception, describing it as "nice and warm", she and her partner privileged their belief in medical technology and expertise more highly.

For my respondents who do begin insemination in a medical setting, the adjustments they made in the face of unsuccessful attempts followed only one path: escalating interventions meant to reduce the stress of conception while increasing the likelihood of success. For instance, Cassandra began by inseminating at a gynecologist's office but eventually conceived in a clinic that specializes in fertility medicine. Describing the switch, Cassandra says:

> I just didn't feel comfortable. Like [the staff at the gynecologist's office] would say ["let's schedule the insemination for 24 hours after your ovulation"] and I would say, "Actually I want to do 36," and they'd say, "Okay!" So I'm like, "Yeah, but you should be driving this ship, not me!" And it put a lot of stress on me, to feel like I had to be the one to make the right decisions. And if I wasn't getting pregnant, was it partially my fault?'

Cassandra subsequently switched to a fertility specialist under whose care her friend had recently gotten pregnant:

> I just decided to go to the doctor that [my recently pregnant friend] saw. And they treated me very much like an infertile person. I had blood draws at least once a week. I had this crazy test called the hysterosalpingogram, if you've ever heard of that. Yeah, it's really special. They put like essentially a catheter inside your uterus [and Fallopian tubes], shoot dye up it [and take x-rays]. It's really uncomfortable. But they did it up, and I got pregnant.

Cassandra's conception narrative demonstrates the privileging of medical expertise that is common among respondents with the medical conception worldview. When faced with a medical encounter that is “stressful” and unsuccessful, these women do not adjust their trajectory to try conceiving at home. Rather, they switch providers, often moving from a generalist physician to a fertility specialist.

Although these women put their faith in medical expertise, they nonetheless do research of their own, which is evident in Cassandra’s discussion with the gynecologist’s office about the timing of insemination. However, my medical conception worldview respondents want to trust that the recommendations of their healthcare providers are optimized to help them achieve pregnancy. Closely tied to this desire is the fear of personal failure and high stress levels that are evident in many other accounts of assisted reproduction (see, for example, Becker 2000 and Hammerli, Znoj, and Berger 2010). Because the process of getting pregnant is fraught with uncertainty and repeated attempts can become increasingly stressful, some women find it relieving to put the responsibility for success or failure into the hands of medical professionals. Thus, it seems that respondents with the medical conception worldview place their trust in medical expertise in part because it lowers the personal sense of failure that can result from unsuccessful conception attempts.

In addition, the narratives of these women demonstrate the ways in which the desire for a successful pregnancy and the perceived higher likelihood of success in a doctor’s office lead to a medicalized experience of conception. For instance, Ulrike describes why she conceived in a clinic after considering trying at home:

> I’m always getting older and there’s always less time and… yeah, the chances that it would work at home are simply relatively low and because of that… I mean, it costs something like a hundred euros for each try. And so then I’d quickly reach the price that I pay for one ICSI and the chances are higher [with ICSI]. That’s why now I’m doing that as my next step [after three IUIs in a clinic].

Susi lays out the two practical reasons that are cited with some frequency among the women I interviewed who hold medical conception worldviews: age and cost. On average, as mentioned above, fertility does decrease with age, although individual variation exists and there is debate within in the medical community regarding when this occurs. However, the popular conception is that fertility declines rapidly after the age of 35, and there is some decline on average, even if the magnitude is still unclear and the individual effects vary.[7] Furthermore, pregnant women over 35 years old are considered "high risk pregnancies" in the US because of the higher chance of complications, such as miscarriage, gestational diabetes, and low birth weight. However, "the change in risk [of carrying a pregnancy at older ages] is gradual over time; there's no 'light switch effect' at age 35" (Harms 2004:38). Because the discourses on the impact of age on declining fertility and increasing complication risks circulate widely, my respondents who are nearing or over 35 years old likely take this information into account, because they do not want to "waste time" with any attempts that may be unsuccessful.

There is no database tracking the success of home insemination attempts, so it is impossible to measure the effectiveness of well-timed inseminations in the home compared to a clinic. Furthermore, success rates for fertility procedures are notoriously difficult to calculate, as more invasive techniques, such as IVF and ICSI are often performed on women who are having trouble conceiving already. That said, my respondents' accounts demonstrate the role that the cost of treatment plays in decisions about how to conceive. As Susi and other respondents note, the costs of repeated conception attempts gradually add up over time, and women may perform a cost-benefit assessment when deciding whether to move to a more interventionist approach.

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[7] For instance, HFEA tracks fertility treatments in England closely and has calculated that IVF using fresh embryos and fresh eggs resulted in a live birth 32.2% of the time for women under 35 and 1.9% for women 45 and over (HFEA 2014).

Among my respondents who held medical conception worldviews, there was a move to employ more technology-heavy approaches when the initial conception attempts in a clinic were unsuccessful.

Shared between my German and American respondents with the medical conception worldview, then, was the sense that conception in a clinic is generally a more efficient path toward pregnancy than conception at home. These women highlighted the success rates of technical procedures, such as IUI, ICSI, and IVF, and they described clinic-based conception as less stressful. Furthermore, they framed the costs associated with conception attempts as justifying more interventionist approaches, because they viewed these techniques as having a higher chance of success. Indeed, these women's discussions of the escalating costs of treatment in their narratives was even more prevalent for the group of women whose conception trajectories I explore in the next section, who held natural conception worldviews and began inseminating at home but eventually turned to medical assistance.

### *Revisional Group: Natural Conception Worldviews and Conception from Home to Clinic*

Four of my German respondents and three in the US held natural conception worldviews yet ended up conceiving in a medical setting, usually after multiple unsuccessful attempts to conceive at home. These respondents espoused themes of the natural conception worldview. However, they also come to adopt the view that medically assisted conception is more likely to succeed than natural conception attempts, which fits their experiences. While the trajectories portrayed in this section follow a similar pattern, with initial attempts undertaken at home and an eventual shift to inseminations (and possibly more invasive techniques) performed by medical professionals, there are some notable differences across regulatory contexts. Specifically, my respondents in Germany generally describe more prolonged attempts to conceive at home before switching to a clinic than do their American counterparts, reflecting in part their understanding of medical professionals in Germany being likely to follow discriminatory professional policies. By contrast, my American respondents undertake fewer conception attempts at home before adjusting their strategies, in part because they wish to access insurance benefits that only apply to inseminations in a clinic.

In the following quote, Emma, a white lesbian in her early 40s living in Chicago, describes how she and her partner moved from inseminating at home to a clinic:

> So, using the guidance we got from the [a local women's health center] and reading up on it ourselves, we ordered the frozen sperm and did, I think, three rounds of insemination at home, which, in retrospect, probably had almost no chance of succeeding. But we really wanted to… we just really like the idea of doing it totally ourselves. After three months of that, and it's really expensive, we said, "Okay, we're ready to get some help."

Emma and her partner then went back to the local center for a few rounds of IUIs performed by staff who are trained to do inseminations but are not medical professionals. Because of difficulties conceiving there, which the respondent attributes to a physical anomaly, she and her partner then went to two different fertility clinics. She describes the final stretch in their conception trajectory: "After a couple of tries there [at the second fertility clinic], I went on to Clomid,[8] which I had been reluctant to do, but I went on to Clomid and after a couple tries, I conceived." In Emma's narrative, her affinity for natural conception is evidenced in her comments that she wished to avoid taking Clomid and her assertion that she and her partner wanted to "do it ourselves." However, three repeated failures to conceive at home led to a

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[8] Clomid is a common brand name for Clomiphene (also sold under the brand name Serophene), an oral prescription medication used to alter the preexisting balance of hormones in a woman's body in order to induce ovulation, and it is used often if a woman's menstrual cycle is irregular. Specifically, Clomiphene blocks a woman's estrogen receptors, which prompts the body to respond by producing more Gonadotropin-releasing hormone, which in turns leads the pituitary to release more luteinizing hormone and follicle stimulating hormone. Through this reaction, Clomiphene increases ovulation. Clomiphene has side effects, including bloating, abdominal pain, hot flashes, and mood swings. The use of Clomiphene is associated with a higher risk of multiples (e.g., twins, triplets) and the possibility of ovarian hyperstimulation syndrome.

reevaluation of their approach, in part because the attempts were “really expensive.” They gradually escalated the medicalization of their approach, first doing IUIs at a health center, then moving to a fertility clinic, and finally taking Clomid, despite the respondent’s initial antipathy toward hormonal intervention. This escalation marked the trajectories of each of my “revisional” respondents.

Also common among the narratives of my respondents who went from a home to a clinic-based conception is the respondent’s assertion that her attempts at home conception likely “had no chance of succeeding,” which reinforces her understanding that the medicalized approach facilitated her success. Furthermore, this respondent’s three attempts at home before moving to a more medical setting demonstrates that many of these women, particularly in America, spend only minimal time attempting to conceive before changing their approach in fundamental ways. There is a range of how many times these women attempted to conceive at home before switching to fertility clinics, as these women tried anywhere from one to fifteen times before approaching medical professionals. However, my American respondents shifted their conception location after fewer unsuccessful attempts than their German counterparts.

Cost seems to be a major driver of my “revisional” respondents’ decisions to switch from inseminating at home to in a clinic in both countries, in large part because of the costs of sperm acquisition, which must be borne by these women in both countries. For instance, Kendra, a white lesbian in her early 40s in Milwaukee, explains how she and her partner went from trying at home to a clinic:

> Well, we had hoped it would work. When you start out, you’re really like, “Oh my God, this is really awesome, it’s gonna happen really fast.” And it does happen for some people – I don’t know how – at home. They do one [insemination] and they get pregnant and you’re like, “oh, come on.” It seems a little but unlikely, but it does happen. So we tried at home because we thought that would be more romantic, whatever, not that it’s that romantic anyway, but [we thought] it would be nicer if that happened. And since we

> didn't have any insurance and it does get really expensive to ship the frozen sperm, that kind of thing, we pretty quickly went to the clinic. It really increases your chances by a lot to do it that way, insemination through your uterus.

The cost of sperm plays a major role in this couple's decision to abandon their attempts to conceive at home, but they also embraced the idea that home insemination, though perhaps more "romantic," is nonetheless unlikely to work, whereas trying to conceive in a medical setting using IUI "really increases your chances by a lot." Because insurance coverage will not pay for sperm in either Germany or the US, the cost of sperm plays a notable role in conception narratives for my respondents in both countries.

Yet there are cost considerations beyond the monthly expenditure for sperm, and insurance plays a role in my American respondents' conception trajectories. In fact, it seems that the inclusion of insurance coverage for fertility treatment for lesbians in Illinois may hasten the medicalization of these women's conception experiences, because these women reason that they will only be eligible for insurance coverage of more technical procedures after they have undergone several physician-assisted conception attempts. Kristen, a white lesbian in her mid-30s who was living in Chicago, describes her conception trajectory for her second child, after trying over ten times to conceive at home while living in a state without insurance coverage:

> We moved here [to Illinois]. We kind of got settled in and then we were like, you know, we've got those [sperm vials in storage] just sitting there. Now I have access to fertility treatments, [so we thought] maybe we should try that. So that's when we went and went to an IVF center and, you know, did the testing and the evaluation, talked to the doctor.

The doctor recommends IVF to this couple, and a successful pregnancy results from the first attempt. In Kristen's experience, the availability of insurance coverage for more medicalized treatments spurs a rapid escalation from home insemination to IVF. It seems likely that Kristen and her partner would have approached a clinic even earlier had they been living in a state with insurance coverage for fertility treatment during their initial attempts.

Similarly, Katherine and her partner, white lesbians in their mid-30s living in Chicago, approach a fertility clinic after several unsuccessful attempts to conceive at home:

> Yeah, we realized by the fall we needed [a] Plan B. So we went to my gynecologist and she referred me to a fertility specialist who she thought would be cool about us not having officially tried for a year which, you know, insurance covers if you've been trying for a year. And she did find someone who was cool. So they were willing to say, "Yes, they've been trying for a year."

Although this couple had tried to conceive at home for several cycles, technically they would not yet have qualified for an infertility diagnosis, because they had not been attempting to conceive for a full year, which is the medical standard. However, the fertility specialist they found was willing to consider their four unsuccessful attempts as sufficient evidence of fertility issues to submit the claim for coverage of their subsequent treatment.

By contrast, insurance coverage plays no role in the accounts of my German respondents, though they are as likely to emphasize the cost of repeated sperm acquisition as are their American counterparts. However, in their accounts, uncertainty or ambivalence around the possibility of finding medical professionals willing to treat them drives them to explore more circuitous routes to pregnancy. For instance, Elisabeth, a German lesbian in her early 40s living in Munich, describes how she began her conception attempts at home and eventually became pregnant but had to terminate because it was an ectopic pregnancy (meaning it occurred in the Fallopian tubes and therefore had to be terminated). After this, a doctor informed her that she should only attempt to become pregnant through IVF: "And it was clear to me that it's really difficult [to do] IVF and not [have] a married [male] partner. I didn't know if this was even possible in Germany." After splitting up with her female partner and realizing that her male friend who had been acting as donor was unwilling to participate in an IVF attempt, Elisabeth researched the possibilities and found that in Austria, there were doctors willing to treat lesbians and single women, including with IVF, but they did not offer known donor options, and she was unwilling to use an anonymous donor. Elisabeth then adds:

> I informed myself then, [and found] that in England there's a kind of totally official provision. There is a central policy, HFEA. It is totally official and it is all registered and it's not like "Oh, it's actually a little bit illegal…" and so on. Instead it's totally legal and totally okay.

Elisabeth notes that she went to England in part because of the explicit regulations of fertility treatment that clearly extend treatment to lesbians there, and she subsequently became pregnant through her first IVF. Elisabeth's account of conception demonstrates how living in an uncertain legal climate can push German women to seek alternative venues for treatment and how that can discourage women from receiving the care they need. Heidi also sought care in another country because she anticipated discrimination from German physicians. Similarly, because Elisabeth perceived IVF as unlikely to be offered to her by a German physician, she researched possibilities in other countries. Ultimately, her conception narrative ends in a successful pregnancy, yet it took considerable determination on her part to overcome the obstacles relating to her donor, her relationship, and her treatment options. Thus, the contrast between the regulatory contexts of my respondents becomes clear. Namely, in American states where insurance is available for fertility treatment, insurance coverage may lead women to embrace a medical approach more quickly when faced with unsuccessful attempts. By contrast, the ambiguous and uncertain regulatory situation for lesbians and single women in Germany may complicate and delay their approaching the medical establishment for help in treating fertility issues.

## CONCLUSION

This chapter demonstrates two relevant points regarding conception trajectories for my German and American respondents. First, there are significant similarities between the worldviews of my respondents in both countries. Specifically, I found two distinct conception worldviews guide the conception trajectories of my respondents. The natural conception worldview is characterized by the beliefs that conception is a natural process for which doctors are largely unnecessary, with a preference for conception at home and a privileging of personal experience over medical or technical expertise. By contrast, the medical conception worldview encapsulates the beliefs that conception is a difficult process that doctors are well trained to navigate, with a preference for conception in a clinic. The natural conception worldview was more prevalent among both my German and American respondents.

The second major conclusion from this chapter is that the regulatory context in which my respondents attempt to conceive influences how their ongoing conception attempts occur. In Germany, my respondents tend to prolong their attempts to conceive without assistance or, when medical intervention seems necessary, they sometimes opt for treatment in clinics outside their native land. These choices reflect their uncertainty whether they will be accepted for treatment as lesbians, given the discriminatory professional guidelines in Germany. On the other hand, for my American respondents based in Illinois, the availability of insurance coverage encouraged women to pursue medical treatment, given that physician-assisted attempts to conceive allow them to access more highly interventionist techniques, such as ICSI and IVF, should those be deemed necessary.

Another important point here is that many of the women who expressed affinity for the natural conception worldview nonetheless sought the assistance of the medical profession during their conception attempts after trying to conceive at home unsuccessfully. This demonstrates that ideologies about conception may be outweighed by the desire to conceive. This helps to explain the “revisional” approaches to conception that Mamo’s work (2007) portrays, in which women regularly reevaluate their approaches to conception to maximize their perceived chances of success. In a sense, these revisions serve to confirm the dominance of the medical model, as the trajectory of home to clinic is traveled regularly, but the trajectory of clinic to home is rarely, if ever, traversed. Because medicine is positioned as the solution to a failure to conceive naturally, the natural conception worldview is repeatedly challenged by assertions that medicine is “more successful” and that doctors’ knowledge is “more reliable” than women’s own experiences. Although most people are initially committed to the natural conception worldview, the pressure of the “biological clock,” the pervasive messages about success rates at clinics, and the mounting costs of sperm acquisition converge to encourage women to medicalize their conception trajectories.

# CHAPTER 5: SPERM DONOR SELECTION PROCESSES

## INTRODUCTION

In this chapter, I explore how lesbian couples in Germany and the US choose sperm donors for their conception attempts. The question I address is how my respondents' donor selection processes are influenced by the national regulatory context and their personal preferences. The search process rarely moves linearly or focuses exclusively on one donor at a time. Rather, my respondents often considered many options at once, including the simultaneous weighing of known donor options and sperm bank offerings. Because the narratives of donor selection told by my respondents are as varied as the respondents themselves, I concentrate on two moments in the donor selection process to help compare the experiences of my respondents both within and across national contexts: (1) the first donor approached, who represents a respondent's preferred donor type at the outset of the search, and (2) the donor with whom my respondents ultimately conceive. By looking at the beginning and end of the search process, I uncover the extent to which my respondents' preferences change as a result of the search itself, and I attempt to disentangle how regulatory contexts influence these trajectories.

I argue that the divergent regulatory contexts encourage my German respondents to create families with more room for new and unusual kinship and family configurations, while my US respondents are encouraged to privilege a narrow, rigid vision of family. I find that there appears to be an initial preference for known donors in both countries, evidenced by the donors my respondents considered early in the search. However, my US respondents more frequently end up using sperm purchased from a sperm bank, while my German respondents tend to use known donor sperm. I argue that this is because the regulatory context influences my respondents in divergent ways. Namely, respondents in the US ultimately decide against known donors because of concerns about custody and parental recognition. Furthermore, the prevalence of anonymous donors at American sperm banks normalizes a framing of the donor as tangential to reproduction. By contrast, my German respondents go to greater lengths to seek known donors, such as advertising on websites and in newspapers to find donors. I argue that this results from the regulatory and cultural weight given to knowing one's origin, which is also reflected in the unavailability of anonymous donors at sperm banks.

In the following pages, I give a brief summary of the relevant regulations in Germany and the US, which were described in detail in Chapter 2. I then review the donor selection processes of my respondents. In the first section, I focus on the initial preferences the respondents express and how these differ from the donors they ultimately use for their conception attempts, concentrating particularly on how donor selection processes differ between Germany and the US. Then, I analyze how my respondents ultimately select between different types of donors, demonstrating that my German respondents privilege their children's ability to know the donor while my American respondents prioritize the protection of their familial ties.

## BACKGROUND AND REGULATORY CONTEXT

When initially seeking a sperm donor, women in the US and in Germany face the following fundamental decision: whether to purchase sperm from a sperm bank or seek a known donor. Within these two basic options, however, there are numerous additional possibilities. Sperm banks offer a plethora of options, easily sorted by donors' height, weight, race, eye color, hair color, and so on (Spar 2006; Almeling 2011). Furthermore, many sperm banks in the US and abroad (though not in Germany) offer sperm from anonymous donors, meaning donors who wish to maintain their privacy and whose identity cannot be revealed to their offspring. In addition, there are identity-release donors, whose names can be released by the sperm bank if the child requests it (in the US, after his or her eighteenth birthday; in Germany, there are no age requirements since a court ruling). In this chapter, I use the following terms to differentiate between the types of sperm bank donors: *anonymous* vs. *identity-release*.

Just as there is extensive variation in sperm bank offerings, there are several different types of known donors. For all of these options, however, the major difference between sperm banks and known donors remains that the latter agree to give their sperm to a specific person or couple (rather than to an institution) with whom the role of sperm donor must be actively negotiated. The first type of known donor, which is accessible only to couples, is a male family member of the non-birthing mother. I refer to this type of donor as a *family-donor*. This option maximizes the genetic overlap between the donor and the non-birth mother, and it provides the couple with extensive background knowledge of the donor. Furthermore, this strategy can take advantage of (or complicate, depending on the framing) existing kinship relations among family members. For instance, the most commonly chosen option among my respondents is to use sperm from the non-birthing partner's brother, which renders him effectively a genetic father and uncle. This biological connection furthermore creates a genetic tie between the grandparents on the social mother's side, as well as on the birth mother's side.[1]

The second option is to procure sperm from a male friend, and I refer to these donors as *friend-donors*. This strategy again provides the couple with far more background information about the donor than can be achieved through a sperm bank because of the pre-existing social

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[1] This is similar to the strategy of creating a biological connection between both partners in a lesbian couple through using an embryo created with one partner's egg (and donor sperm) implanted into the other partner's womb (Pelka 2005).

ties between the parties. It also allows for open negotiation of the donor’s role in resultant children’s lives.

Finally, known donors can be individuals with no prior connection to the non-traditional reproducer(s). In this case, the donor is usually located through the use of personal advertisements posted online or in newspapers, which I refer to as *found-donors*. This option circumvents the sometimes unsuccessful process of soliciting sperm from friends or family members, because the men active in such forums or advertisements are already hoping to act as donors. However, it involves more effort to build a relationship with the donor, since one does not exist prior to the negotiation of the donor’s role. With all types of known donors, the role of the donor must be negotiated explicitly.

While each of these options is available to my respondents to some extent, regulations in Germany and the US affect accessibility. I discuss these regulatory contexts in detail in Chapter 2. However, as a reminder, there are three major relevant differences between the two countries regarding the limit of offspring per donor, anonymity of donors, and the legal regulation of the donor’s role. First, donors are limited to 15 total offspring in Germany, whereas in the US, professional guidelines suggest that donors should not be allowed to produce more than 25 offspring per population area of 850,000. Yet, no central tracking mechanism is in place, and cases of donors having over 150 offspring have surfaced (Mroz 2014). Second, in the US, donor anonymity is the rule rather than the exception, although there is a nascent move toward identity-release donors. Most sperm banks offer sperm from both anonymous and identity-release donors, though the offerings of the latter are generally more limited and frequently cost more. By contrast, in Germany, anonymous sperm donation is illegal, and children conceived using sperm donors through a clinic have the legal right to learn the identity of their donor at any time –

though reproductive tourism allows German individuals to get around the anonymous sperm donation ban, as nearby countries such as Denmark and Belgium have sperm available from anonymous donors. Finally, in Germany there remains a legal gray area regarding children born to single women and lesbian couples, because the courts have not yet settled the question of whether the genetic father retains some financial and legal tie to resultant offspring. When heterosexual couples use donor sperm, the sperm donor no longer retains any claim to resultant children. In the US, by contrast, donors who operate through sperm banks are absolved of all parental rights and responsibilities.

The laws and guidelines that affect sperm bank practices do not apply in cases where known donors are used, and indeed there are far larger legal gray areas regarding these practices. There is a patchwork of laws governing these relationships in the US, with some states recognizing written agreements between parties as legally binding while other states do not. In Germany, there is a similar legal uncertainty, but most experts agree that documents that attempt to terminate or delineate parental rights contractually between two or more parties are unenforceable. My respondents' ability to contractually delineate a known donor's role in the lives of any future children plays a major role in who they ultimately choose to use as a donor, the issue I turn to next.

## SHIFT IN PREFERRED TYPES OF DONOR DURING THE SELECTION PROCESS

Since my respondents make a series of decisions as they select a donor, I conceptualize donor selection as a process rather than a singular point in time. My respondents' narratives reflect the dynamic nature of this process, as many women describe considering potential donors far before any other steps on the road to childbearing, with sometimes drastic changes between initial preferences and the final donor selected. Although my respondents often do not end up attempting to conceive using the first donor they seriously consider or even the first donor they approach, I use these donors as a window into their early preferences. Table 5.1 represents a summary of the women's sperm donor selection trajectories between countries, from the first donor considered to the first donor approached, culminating in the final donor used.

**Table 5.1. Respondent Sperm Donor Selection Trajectories by Country**

| Type of Donor | Considered initially* | | First approached** | | Final donor used | |
|---|---|---|---|---|---|---|
| | *Germany* | *US* | *Germany* | *US* | *Germany* | *US* |
| Family member | 2 | 6 | 2 | 4 | 1 | 2 |
| Friend | 16 | 11 | 14 | 7 | 7 | 5 |
| Found through advertisement | 1 | 0 | 3 | 0 | 10 | 0 |
| Identity release sperm bank | 2 | 1 | 2 | 3 | 3 | 7 |
| Anonymous sperm bank | 1 | 0 | 1 | 4 | 1 | 4 |

*For the purposes of this table, I categorize respondents by the most intimate type of donor considered initially.
**The category "first approached" refers to the first donor the women either asked to donate sperm (in the case of a known donor) or ordered through a sperm bank.

One caveat to keep in mind when considering these data is that respondents are generally reporting on their experiences of seeking a donor after the fact, meaning that their descriptions of the process are likely to focus on the final donor selected, and they may discount, misremember, or misrepresent the early stages of the process. In other words, a comparison of the initial preferences to the final donor likely overstates the match between these two stages, due to common issues of memory recall and narrative structure (see, for example, Tourangeau, Rips, and Rasinski 2000:81-92). However, that makes the differences that I find between these stages all the more worthy of consideration.

The left-most columns in Table 5.1 (above) represent my respondents' donor preferences during the information-gathering stage, as my respondents explore the various routes for procuring sperm without a clear sense of set criteria regarding the donor they might use. During this initial phase, almost all of my respondents in both Germany and the US considered using a family- or friend-donor, with 36 of 40 respondents describing this as part of the early search, often in tandem with interested perusal of sperm bank websites. Of the four who did not describe considering a known donor, three were German and one was American. At this point in the process, couples tend to weigh several possible options against one another while conducting research on multiple options simultaneously. Initial thoughts of known donors frequently lead to "joking" considerations of several friends or family members, but as my respondents continue in their research, their preferences become clearer, and they often settle on a specific donor they would like to approach.

As the search process intensifies, my respondents give more serious thought to their preferences, eventually settling on a donor they would like to approach. This phase is represented in the middle columns of Table 5.1. Thus, the number of respondents who approach a family-, friend-, or found-donor drops to 30, compared to the 36 who initially consider doing so. Of the ten respondents who forgo asking a family-, friend-, or found-donor, seven are American and three are German. For the small number of respondents who have already decided against approaching a known donor after all, their "first donor approached" represents the first donor they selected from a sperm bank. However, 30 of my respondents in both countries approach a known donor during their initial search. For them, the "first donor approached" refers to the first man they asked to act as a sperm donor, although his selection as sperm donor is far from assured. He may decline the invitation, the couple may reassess their preferences, or subsequent discussions about the donor's role may derail negotiations between him and the couple. Regardless of the ultimate outcome, there are a number of respondents in both Germany and the US who initially approach a family- or friend-donor, although already the trend toward German respondents' use of known donors and US respondents' use of sperm bank donors is apparent.

Indeed, the type of donor that my respondents ultimately use for their conception attempts differs notably by country, as seen in the right-most columns of Table 5.1. In Germany, 18 of 22 respondents used a family-, friend-, or found-donor, whereas only seven of 18 of my American respondents did so. Furthermore, among my German respondents, a found-donor was the most common type of donor used, whereas it was the least common among American respondents. Ten of the German respondents used a found-donor, whereas none of my American respondents conceived with this type of donor (see Table 5.1.)

## SELECTING THE FINAL DONOR

Thus, I find that both my German and American respondents tend to approach friends or family members early in the process, and they are both likely to have discussions with these potential donors break down because of different expectations. However, whereas the next step for my US respondents is generally to pursue sperm bank offerings exclusively, my German respondents respond to these initial refusals by expanding their search for a known donor, often engaging the services of websites dedicated to private sperm donor matching. Furthermore, these respondents describe more intensive vetting of potential found-donors, while my American respondents explain how their initial consideration of known donors ends when the details of such an arrangement become complicated or uncertain. In the following sections, I explore the characteristics privileged by my respondents who used the five different kinds of donors outlined above (family, friend, found, identity-release, and anonymous). In particular, I highlight how the different regulatory contexts influence women with similar preferences for family- or friend-donors to pursue found-donors in Germany and sperm bank donors (identity-release and anonymous) in the US.

*Family-Donors*

A small number of my respondents in both countries (one in Germany and two in the US) successfully negotiated with family members (genetically related to the non-birth mother) to take on the role of donor. In cases where a family member was selected, the impetus for the consideration was mainly the indirect genetic tie that this would forge between the non-birth mother and the resultant child, as well as between her wider family (i.e., her parents, siblings, etc.). This tie brings with it, implicitly or explicitly, characteristics such as eye color, hair color, skin color and so on, as well as a similar ethnic background to the non-birthing partner and her family of origin.

In addition, using a family member – especially the non-birth mother's brother – ensures that the resultant child is the closest match possible to a genetic union between the two partners, which thereby solidifies a genetic bond between the parents of the non-birth mother and resultant children. For instance, Katherine describes why she and her partner asked her partner's brother to be a donor:

> We...well, we thought it would be so cool - I was sad that we couldn't, you know, I just love her so much - it was sad to me that we couldn't share, genetically, a child. And I really liked that idea of having a baby that was related to both of us and could share both of our characteristics. And so I guess we just - I don't remember exactly talking about it, but we thought he was the best candidate. We knew I was the one who was gonna get pregnant. [My partner] has two brothers and he was the one we just knew who could handle it, didn't want to be a parent to the children. [He] would just - he's just a rational guy, not very emotional. And he's a - he's got good genes. He's really smart and he's musical and you know, like, it made sense to ask him. And when he said yes, we're like, "well, okay!"

Katherine and her partner privileged the genetic tie when selecting her partner's brother as the donor, in part to make up for the inability of her and her partner to create a genetically-related baby of their own. On the one hand, she and her partner highlight the “good genes” of the donor, whose physical characteristics and talents are framed as heritable, while on the other hand, she describes the importance of her partner’s brother not wanting “to be a parent” to their children. In other words, the donor was selected in part because he fit into their ideal role for the donor, a theme I return to below, as it featured prominently in respondents’ considerations of friend- and found-donors as well.

However, while eight of my respondents contemplated the family-donor option initially, only three went through with it, because some of them did not feel comfortable negotiating the family-donor’s role. Respondents who decided against a family-donor concentrate on the unusual family kinship relations that would result from such a choice to explain their choice. For instance, Adrienne, a white lesbian in her early 30s living in Chicago, describes how she and her partner discussed the option with her partner’s brother and considered friends but ultimately decided they preferred a sperm bank donor:

> We talked to her brother about it. Like we thought about that and we actually got as far as to ask him and then like, sent him the list of tests he'd have to have. And we never heard anything back. We're like, “Oh, thank God.” It was one of those things where it like, you know, it sounded like a good idea until we started thinking about it more, and then we're like, “Oh actually, we don't have that kind of like...[trails off].” Her mom would have thought it was his kid, she would have gotten - she's already confused about what the family tree's gonna look like. You know, so I think it would have just not worked out well.

Thus, respondents who ultimately decided against a family-donor expressed unease with having their child be genetically related to the non-birth mother’s family member because of confusion that might arise as a result, in particular because this confusion could undermine their extended families’ recognition of their core family unit. In a sense, the family member option privileges genetic ties even as it acknowledges the exclusion of the non-birth mother from contributing genetically to the creation of the child. While for a small number of respondents in both Germany and the US, a family donor represented the best option, many others declined to pursue this option because of such concerns.

Of note is the higher number of US respondents who initially considered the family-donor option. Six of the eighteen respondents in the US, compared to two of 22 in Germany, began by contemplating using a family-donor, which perhaps indicates more cultural weight given to genetics in America than in Germany. However, the fact that ultimately only two American respondents used a family-donor indicates the prominent role of custody fears in these women's sperm donor selection processes, a theme that I address further in the following section on friend-donors.

### *Friend-Donors*

In both countries, friend-donors are the most common type of donor initially considered and first approached. In Germany, 16 of 22 respondents first considered a friend-donor, and in the US, the figure is 11 out of 18 (see Table 5.1). My respondents describe their reasons for considering a friend-donor in similar terms, emphasizing their initial hope that the person could be known to their children and would be someone they trusted. For instance, Deike, a white lesbian in her early 40s living in Berlin, describes how and why she and her partner began by looking for a friend-donor:

> We just asked all our friends we could imagine doing it [having a child] with, and it just - we also asked other people if they knew people. But we also wanted someone, you know, it's - we wanted someone we knew and trusted, so we didn't like just ask around anybody. But we did tell friends we were looking, and if they knew anyone who they really liked and trusted.

Similar to Deike, many respondents in both the US and Germany describe how they first considered a friend-donor because of their desire to have a donor who their children could meet and with whom they also felt safe procreating.

My respondents who ultimately choose a friend-donor (seven of 22 in Germany; 5 of 18 in the US) highlight their trust in the donor, based on their pre-existing ties, and the role that the donor can play in their children's lives. For instance, Molly, a lesbian in her early 40s living in Chicago, describes how she and her partner decided to use a friend-donor: "Then we were like, 'Okay, well, let's, you know, really look at this, and what is it that we do really want,' and that's where we - that's when we really started looking at it. And for us, it was more the relationship we would have with our donor than, you know, his eye color or how tall he is." Thus, my respondents who selected a known donor impressed upon me how important it was that they find a donor who agreed to take on the role they were looking for and that they trust the donor to adhere to that role.

In the next quote, the focus on the donor's role and the couple's trust in him is clearly linked to the potential risk involved in using a known donor. My respondents who used a friend-donor worried that the donor could appeal to the courts to gain some form of parental rights above and beyond what they had negotiated. Hannah recounts how important trust was to her and her partner's selection of a friend-donor:

> I mean [we looked for] somebody you really feel like you can trust because, I mean, we feel like we can trust [our donor] completely, but still life is long and we are a little worried about it. I mean, we've done everything we can do, but there is no legal way to absolutely make sure that if he went nuts in 15 years, and decided he wanted this kid to be, you know, his, and he wanted to have custody, like, there is nothing we can actually do about that that's gonna hold up for sure in court. So. We were looking for somebody we really thought we could trust.

Hannah's comments demonstrate that trust factors prominently into these respondents' selection processes. They feel they must rely on the donor to maintain his agreed upon role. Thus, trust undergirds the friend-donor selection process for my respondents when negotiations with friends are successful.

Furthermore, it was disagreements over the donor's role that often derailed my respondents' considerations of friend-donors. Many respondents in both countries considered friend-donors but ultimately chose another type of donor (nine in Germany and six in the US). One common issue my respondents in both Germany and the US faced was having a friend who declined to participate because he felt uncomfortable with the limited role he would have in the child's life. For instance, Lilli, a lesbian in her mid-30s living in Berlin, describes how she and her partner asked a friend to donate sperm but he ultimately declined:

> So first we asked someone in our circle of friends, if he could imagine donating sperm to us. He turned us down because he couldn't imagine for a child… well, where he contributed to a child's origin but then didn't take on any of the responsibilities. And for us it was important that we, that our, that we are the family and that the sperm donor doesn't belong to that family. We wanted to have a sperm donor that we know, because we wanted to give the children the chance to get to know the donor later. But after that didn't work [with the friend they initially asked], we couldn't think of anyone else we wanted to do it with.

Lilli describes how negotiations between friend-donors and lesbian couples can easily be disrupted over disagreement about the donor's role. Lilli and her partner want the donor to be known to their children but outside of "the family," whereas their potential donor balks at the idea of not contributing to raising the child. Not all respondents who decided against a friend-donor envisioned the donor as so completely outside of the family unit, yet Lilli's experience is emblematic of the general conflict between the couple who wants a limited role for the donor and the potential donor who is uncomfortable with the narrowness of his contribution.

With friend-donor considerations, then, my German and American respondents' experiences are similar, in that friend-donors are the most common type of donors first considered and approached, yet they are not the most common type of donor ultimately used in either country. Indeed, many respondents in both countries ultimately use a different kind of donor, in part because of the difficulties of negotiating the donor's role. In the US, these difficulties are often framed in terms of the potential for custody disputes, as in Hannah's comments, and this concern motivates many of my US respondents to use identity-release or anonymous-donors. In Germany, by contrast, the women focus on the donor's desire for a greater role in the child's life without mentioning custody explicitly, while still acknowledging the importance of the donor having a role. The desire for children to have contact with their donors (which is codified in German prohibitions on anonymous sperm donation) appears to be a primary motivation for my German respondents who seek found-donors. I examine how my respondents select found-donors in the following section.

### *Found-Donors*

None of my respondents in the US pursued a found-donor, while this donor type was the most common type ultimately selected by my German respondents. Although ten of my 22 German respondents used a found-donor, only one of these women considered a found-donor initially. I find that these respondents pursued the found-donor option after unsuccessfully searching for a friend-donor, as the found-donor preserved the couple's desire for a donor with whom their children could be in contact and allowed them to explicitly exclude donors whose vision of his role differed from their own. Thus, these respondents highlight the importance of finding a donor who shares their vision of his role and whom they trust to adhere to this role.

While these women disavow pre-existing criteria for appearance or education, they nonetheless tend to select donors who exhibit a high degree of homophily with themselves.

Seeking a found-donor involves a process akin to online dating, in that these women both peruse and post advertisements online and in newspapers and magazines, with the sole intent of meeting a sperm donor. The process of vetting these potential donors involves considerable time and energy. For instance, Alexandra describes her experience:

> Early on we had lots – so through email contact – really lots [of potential donors] who we didn't really consider seriously. We also had such diverse categories of "Sperminators," so people who want to put the most sperm in the world and to father the most children, or some who are somehow a little bit crazy and were seeking a family connection, so we didn't consider them either. And yeah, there were also a few in there who wanted to donate sperm but who already had their own family but didn't want to have any contact to the [resultant] child. And for us it was important to find someone who didn't take so much part but still had regular contact to the child. Right, so then we found our donor and he fit really well and we really have a model – yeah, a father she can see once a week. From birth on, or at least from three months on.

Indeed, many of these respondents describe a process of sorting through responses to eliminate those men whose visions of their role clashed with those of the couple. The specifics of the desired role for the donor varied substantially among the women. Some wanted known donors who would rarely if ever have more than email contact with the children, whereas others, like Alexandra, sought a donor who would take an active role in parenting, through activities such as picking kids up from preschool and often taking the kids for a weekend overnight. However, finding a donor whose preferred role mirrored the couple's vision was a requisite criterion for using a found-donor.

Beyond negotiating the donor's role, however, the German respondents who selected a found-donor describe the importance of innate compatibility between themselves and the donor. This sense of compatibility cannot be easily quantified or explained yet fundamentally shapes who my respondents selected. For example, Resi describes how she and her partner solicited sperm donors and selected from among the many candidates that they found:

> There are many men [advertising their sperm donation willingness online], really many within Munich, and so we just wrote to a few men and also posted our own advertisement [on the website] and it was through that that he wrote to us. So altogether it took a year, until we found [the donor they used]. So in between we met with approximately 13 or 14 men, so we did "man casting," and it was very, very stressful. … Totally crazy! Always the same questions and ugh… So yeah, it was very, very stressful and very nerve-wracking. So, honestly, it went substantively slowly. Like, I always said, "When we meet, there has to be a click." It must be like love at first sight a little bit. Where one really immediately has the feeling, "Totally!" And that never happened. Until him [their donor].

Resi's experience reflects the feeling of immediate connection that many of these respondents describe in their ultimate donor choice. These women's experiences call to mind the often unclear processes that influence mate selection. Other research, particularly in psychology, has explored the mysterious ways in which people are attracted to some and repulsed by others (see, for example, Feingold 1988 and Reid, Davis, and Green 2014) when looking for potential love interests and life partners. Interestingly, the process of found-donor selection seems to proceed along similar lines, with donors "clicking" in certain cases and being passed over when they do not.

In these respondents' narratives, other characteristics – such as appearance and intelligence – often were downplayed in their description of the selection process. This is not to say that implicit selection criteria are not shaping these processes; indeed, they almost certainly are, and my respondents recognize that part of what attracts them to a particular donor may well be his perceived intelligence, good looks, or charming personality. As Christin relates:

> Christin: Well, health was the first point and then, I don't know if we really thought about it. We had wished, I think, that he [the donor] was educated like we also are and, yeah, appearance – just that he was pleasant [looking] to us. So he didn't have to be a very attractive man, but just... decent. And we didn't seek out blond [hair], blue eyes, brown [hair], brown eyes, but rather it was just as it was.

Alicia: So you weren't trying, so to speak, to match your partner?

Christin: No, that was just a joke between us.

As Christin notes, while appearance and education mattered in the search, these characteristics were not specified according to preexisting categories, but rather guided their reactions to potential donors. Although my respondents searching for a known found-donor disavowed the importance of appearance, at least in terms of pre-defined categories of race, hair color, eye color, and so on, a preference for homophily may influence these "gut feelings" substantially. Indeed, even though these respondents frequently downplayed the extent to which they relied on predetermined categories when assessing potential donors, their final donor choices do reveal a notable amount of homophily, at least at the level of race, as none of my respondents selected a found-donor whose racial background differed from that of the respondent or her partner. An in-depth assessment of the role of homophily is outside the scope of this study, but – just as homophily shapes mate selection in fundamental ways – there is reason to believe that similarity between the donor and the respondents may well lead to greater feelings of trust, sympathy, and compatibility.

As noted above, none of my respondents in the US selected a found-donor, while this type of donor was the most common one used by my German respondents. This difference stems in part from the cultural emphasis placed on knowing one's origins in Germany, which is reflected in the regulatory context in the prohibition on anonymous sperm donation and the requirement that children born from sperm bank donors be allowed to learn the identity of the donor with no age requirement. My German respondents who selected a found-donor thus reflect the cultural importance of having a relationship with one's genetic father through their privileging of the child's connection to the donor over concerns about custody. These respondents are aware of the risk of using a found-donor; indeed, they use found-donors despite knowing that this choice leaves them vulnerable to custody disputes from the donor, at least until the second-parent adoption is approved by a judge. For instance, Deike says:

> We wanted - we really wanted someone we felt like - you're always going to have red tape, [so we wanted someone] who would definitely not change his mind because the [second parent] adoption process takes so long, between - between birth and the adoption, or between conception and adoption, you know. We wanted someone who within a two year period wouldn't change his mind about the adoption, and then, you know, who we liked and felt was responsible. We totally lucked out. In retrospect, we didn't ask any of the questions we should have.

Thus, the choice to use a found-donor demonstrates the ways in which the regulatory context both shapes cultural practices and is shaped by them. Even as the regulatory context allows for custody disputes in Germany, my respondents privilege the personal connection to the donor over and above potential risk.

In turn, their selection of found-donors further reinforces the cultural importance of knowing one's origins. Marina, a Berlin-based lesbian in her mid-30s, describes what she and her partner sought in a found-donor:

> Well, that he also consciously wants children, that he's also consciously decided to take part of the responsibility of the child, but also that he doesn't – so to speak – alone take over responsibility, or more than – we had said anything between zero, no, everything between 10 and 40 percent taking part [of raising the child] would be okay. But we also wanted that the center was by us. That was important, and that he, yeah, of course he shouldn't be really, *really* stupid or something, and what we were talking about before: that he'd be a father, so a father-figure for the child.

My German respondents seek found-donors because they want to provide their children with a "father-figure," thereby reflecting and reinforcing the regulatory and cultural context that privileges these ties. In so doing, these women challenge the tightly bounded nuclear family structure that allows for only two parents to be recognized. Even as these women create families in which the couple and their children are the "center," they contribute to a widening of the notion of kinship and a challenge to the heteronormative, nuclear family. No similar challenge arises through my US respondents' selection of identity-release donors, examined next.

### *Identity-Release Donors*

Few respondents in either country begin their donor search with a focus on identity-release donors, yet this is the most commonly used donor among my US respondents, with seven of 18 selecting them (and another four of the 18 selecting anonymous-donors). Whereas most of the German respondents who begin by considering friend-donors eventually use found-donors, the majority of my US respondents who move away from friend- and family-donors decide in favor of identity-release donors.

Although three of my 22 German respondents use identity-release donors, I focus in this section on my American respondents. This is for two reasons: (1) use of identity-release donors was far more common among my American respondents, and (2) the choice of the German women who selected identity-release donors is in some ways closer to their found-donor compatriots, analyzed above, than to their American identity-release counterparts. This is because, in Germany, the right to know one's origin is codified in law. Indeed, this right was extended even further in 2015, with a high court ruling that offspring may learn the identity of their donor at any age, so choosing this option does not preclude a relationship with the donor in childhood. By contrast, identity-release donors in the US can only be found after a child's eighteenth birthday. Perhaps because of this distinction, I find that the German women who used identity-release donors highlight the importance of contact to the donor, similar to those who used found-donors. For instance, Jana, a German lesbian in her late 30s living in Berlin, explains: "We chose a 'yes donor' because it's important to us that our children have the possibility to get to know their father – their whole other biological side." Thus, in the remainder of this section, I examine the decisions of my American respondents who use identity-release donors.

In describing their shift from seeking a friend-donor to an identity-release donor, my US respondents often explicitly focus on the legal implications of using a friend-donor. For instance, Kendra describes how she and her partner considered friends initially but eventually went with an identity-release donor because of a persistent worry that a known donor could threaten their family:

> So we may have asked somebody [early on], but I don't really remember - it wasn't really that serious. So then when we moved here, we became more serious. So I think we did have one guy here, to be - you know, he wouldn't be anonymous, somebody - an acquaintance. And he said no. The whole time, though, I wasn't really too thrilled with that idea, to be honest, because I'm worried about the legal ramifications of going with somebody [known] – it's not going to be formal as much as a sperm bank. So it's like a lot more official with a sperm bank, and that was always my point, but [my partner] wanted somebody who was known. I wanted - this guy [the donor they used] will be known [an identity-release donor], but yeah, when we were making the decision, we tried a couple people. They both said no essentially, and then we moved on to the sperm bank. … And the whole time [we were thinking about having a friend act as donor], I was saying, "what about the legal stuff, you know? And what about custody issues?" And then the whole health thing, they have to be completely screened. I don't know. For me, I was always saying, it's more- it's safer with the sperm bank. Ideally, you'd want all the qualities you can actually find out from the sperm bank, but you may not be able to find out when you just know somebody casually.

Kendra's worries about custody are raised frequently by my American respondents, with others highlighting the "horror stories" described in the media and their subsequent decision to use a sperm bank donor. Thus, many of these respondents view identity-release donors as a safe middle-ground between the perceived risk of involving a third party in their reproductive attempts directly and the complete anonymity of anonymous-donors.

Most – if not all – of my respondents using sperm banks were aware of anonymous donors as an option (even my German respondents recognized the possibility of ordering anonymous sperm from abroad), and many of my American respondents knew of other lesbians who had pursued this route. However, many of these respondents stated that it was inappropriate for them to determine whether their children could have contact with their genetic father. As Kendra explains, “I think it’s important for them to have that option, so that I’m not withholding anything from them.” Thus, the women who selected identity-release donors frequently cited their preferences for the donor’s level of future contact as the most important distinction in their search.

While the identity-release criterion is often the most important factor in these respondents’ final selection, the criteria that arise next in their narratives tend to be appearance-based, in particular as these characteristics relate to having their children appear similar to themselves and their families of origin. Appearance-based characteristics also function as a way to winnow the many choices available through sperm banks, while simultaneously allowing there to be a perceived connection between potential children and the non-birth mother. As Cara explains:

> I think we actually sorted by hair color and eye color, and in part because she - there aren’t that many people who have dark hair and blue eyes, so that was sort of a way to just narrow it down. And also, I mean I think, she [my partner] felt like that was something unique about her and that her entire family has the same, they all - like even her mom and dad, they both have dark hair and blue eyes. And so I think for her, that was something that was important. So that was the first way that we sorted, and then we would look at all the ones [who fit those criteria]. And to be honest, that ended up narrowing down quite a lot of people. So then within that category of, you know, they’ve got some version of brown hair and, you know, blue eyes, then we would sort of look at their ethnicity and their - you know, are they Irish, are they this, are they that. And then sort of height and weight. And then we would kind of look at the softer pieces, you know, like their family medical history and you know, their interests, and then their statements. We didn’t really prioritize education, I think because both of us realized that there are a lot of really smart people who either didn’t have access to education or found passion elsewhere and so for us, that wasn’t - you know, I don’t really care about their SAT scores.

Thus, matching the non-birth partner’s hair and eye color serves to narrow the field of options and to create a connection to the partner and her family of origin based on similar appearance.

The remaining selection criteria – "the softer pieces," generally assessed by reading through the longer profiles donor's write – help my respondents to make their final determinations between respondents who are similar in many other ways.

For biracial lesbian couples, race and ethnicity arose as the determinant factors in the donor selection process. For instance, Patricia is a white woman in her late 20s who is the birth mother for the children she and her Latina partner have, and this led them to seek out only donors from her partner's Caribbean country of origin available from sperm banks. As Patricia says:

> At the end of the day, we chose [the donor] because of his ethnicity. Because he was taller...it's harder to find a tall Caribbean donor. And he's not tall. He's five ten. But it was like...we thought we'd give him a fighting chance. You know, and...[the donor]'s a med student. There's all this other shit that we paid for, just by accident. Like, the bank charges you more because he's a med student. I don't give a fuck that he's a med student! Can I call them and be like, "We actually don't care. Can we not pay the extra hundred bucks?" We're actually not interested -we don't need him to be [a med student], you know...

In this exchange, the priority given to ethnicity is clear, as is the discounting that she and her partner engaged in regarding non-appearance-based potential factors, such as education. Whereas the sperm bank views the donor's education as a marketable characteristic worthy of an extra charge, this respondent and her partner privileged the donor's Caribbean background and found his level of education irrelevant to their selection process.

Similar to couples where the partners are the same race, a primary motivation in donor selection is to match the characteristics of the non-birth partner. For biracial couples, this is particularly important, because my respondents fear that the non-birth partner may not be read as their children's parent if the children do not share that partner's ethnic or racial background. For instance, Amelia, who is African-American, explains how she and her partner selected identity-release donors whose ethnic heritage matched her partner's European ancestry:

> So it was - you know, we looked at [other] stuff, but the determining factor was ethnicity. Because we wanted to try to find somebody that like our kids - we didn't care like if our kids were with [my partner], they [other people] can say, "oh, that's her mother," or if they're with me, like if I had gotten a donor who was just African-American, I mean, then we know who the birth mom is.

For biracial couples in particular, then, ethnicity matching becomes a means of forging a familial tie between the non-birth mother and their children. However, all of my respondents who selected identity-release donors reported filtering donors based on appearance-based criteria to some extent. These characteristics were central to: (a) creating a link between the non-birth mother and resultant children; (b) protecting children from intrusive questions about their familial origins; (c) forging a link between children and the wider extended family of grandparents, aunts, uncles, and cousins; and (d) providing some simple sorting mechanisms when faced with large catalogs of potential donors.

Once these respondents had narrowed the options based on appearance-based criteria, they finalized their choices by poring over the long-form donor profiles on their short-list of donor options, making subjective decisions similar to the ones made by the respondents who chose found-donors based on a feeling of compatibility. Describing how she and her partner made their final determinations based on information they took as proxies for personality, Adrienne describes that, "For us, [appearance] is definitely a consideration, but it's secondary to something like intellect, genes, stuff that we're trying pull out of this really vague information that we get." She notes that the information included in the donor profile is only a "vague" proxy from which these respondents are inferring broader personality characteristics. Indeed, some of these respondents viewed the personality distinction as particularly important, because the donors selected were identity-release. For instance, Emma explains:

> We also wanted a "yes" donor, someone who would release their identity. Because of that, we wanted somebody whose description of themselves sounded like a decent person.

> Some of them sounded kind of like jerks [laughs] and we didn't want our daughter, in 18 years, to go around looking for someone who could be - I mean, anyone could be a total jerk, but we tried to stay away from that.

Thus, my respondents who used identity-release donors attempted to select donors based on the limited information on personality included in the donor profile, but these concerns were secondary to appearance-matching and the identity-release feature.

Ultimately, my US-based respondents who privileged their children having a connection to their donor began by considering friend- and family-donors but often abandoned these options based on fears of custody battles and threats to their core family unit. Because the same risks are present when using found-donors, these respondents did not pursue this option, but rather they shifted their search to identity-release donors who represent a compromise between maintaining their children's link to the donor and minimizing the risk the donor represents.

### *Anonymous-Donors*

The respondents who ultimately used anonymous-donors prioritized the family bonds between their children, themselves, and their partners, and they viewed using anonymous sperm as a way to protect those bonds against any incursion from the donor. Only one respondent in either country considered an anonymous-donor initially, but anonymous-donors were the final choice for four US respondents and one German respondent. These respondents highlighted the importance of having a tightly bounded family unit, and they view the donor as irrelevant to their or their children's experiences.

The one respondent who was committed to using an anonymous-donor from the outset was a German woman named Heidi. She herself was adopted, and she had been unable to learn her father's identity. Through her own family experiences, Heidi had come to view the donor as irrelevant to the family unit she planned to build with her partner and child, even describing the involvement of a donor as potentially confusing for a child:

> One can show the child its father, but nevertheless one doesn't really have a family [that way]. So two main caregivers and a child. So now, I don't know, four caregivers – what – I don't know if that… maybe it's good for the child, maybe not. But we think, we should be the [only] family.

Heidi positions her choice in contrast to German women using friend-donors and found-donors who are helping to raise the children, implying that such a choice might not be good for the children. Furthermore, she emphasizes that she wishes for herself, her partner, and their child to constitute a self-contained family unit. Because of the restrictions on anonymous donations in Germany, Heidi had to travel abroad for her treatment to a nearby European country that allows for the use of anonymous-donors.

Although none of my US respondents indicated a similar commitment to using anonymous-donors at the outset, four of these women ultimately selected these donors, and their accounts are similar to Heidi's in certain ways. In particular, for these respondents, the donor should not play a role in their life or the lives of their children. For instance, Jessica, a white lesbian in her mid-30s living in Milwaukee, describes the donor she and her partner used:

> Yeah, he'll remain anonymous. I know there's like some donor registry that they - I don't know, it was on TV a while back, where donors could go on and try to match up, or people who have the same donor could go on and try to match up, but I have friends that did that and they've met other half siblings that way. To me, it just feels weird. I just don't want that and that's why we chose somebody that was anonymous because we want them to remain anonymous.

Like Heidi, Jessica views the forging of ties with genetically-related individuals outside of their core family unit as distasteful. Like Jessica, the other women who use anonymous-donors are aware of options like the Donor Sibling Registry, which allows sperm donor children to find their genetic half-siblings and possibly their donors, but they view the donor's role as tangential to their own families.

The few respondents who used anonymous-donors clearly define the donor as outside of the family. The higher number of respondents in the US who chose such donors reflects the divergent regulatory context, in that the simple availability of anonymous-donors in the US means that this option is easier to access for my American respondents. Heidi's story demonstrates that even my German respondents can select anonymous-donors, but only if they are willing to go abroad for treatment or actively circumvent the regulations in Germany. The priority given to knowing one's origin in the German regulations has the impact of reinforcing my German respondents' desire for a connection to the donor, except in outlier cases, such as Heidi's, where the respondent has unique reasons for downplaying the role of the donor. Alternatively, the regulatory context in the US, which allows anonymous donation, serves to promote a vision of the donor as tangential to reproduction. This framing discourages my American respondents from involving a third party directly, while the fear of custody battles reinforces their avoidance of friend- and found-donors.

## CONCLUSION

While the search processes begin similarly in Germany and the US, with most respondents seeking a family- or friend-donor, the ultimate donor type selected varies by country. In short, the most common type of donor used by my German respondents is a found-donor, whereas for my American respondents, it is an identity-release donor. I argue that this results in large part from the different regulatory contexts. My German respondents view having a donor who can be personally known to their children as crucial, in part because of the emphasis put on knowing one's genetic origin in Germany. One might assume that my German respondents favor known donors because they face discrimination in procuring sperm in such an ambivalent regulatory situation. However, I argue that this explains at best only a small part of the decision-making process. There are sperm banks even within Germany that highlight their service to lesbian couples, such as Cryobank München, which has an entire page devoted to their treatment (Cryobank München n.d.). Also, LGBT advocacy groups in Germany readily inform their constituents of lesbian-friendly clinics and sperm bank options. Rather, I argue that my German respondents embrace found-donors because they view the donor as a crucial, if peripheral, component of their children's lives, which serves to reinforce the cultural weight given to the father figure.

In the US, however, anonymously-donated sperm is commonplace at sperm banks, which normalizes a lack of connection between children and donors. Furthermore, my American respondents more often describe fearing custody battles with known donors and wanting to legitimize the couple as sole parents of their children. In other words, my respondents in the US only use known donors when they are trusted friends or family members, and they turn readily to sperm banks when these sources of sperm are unavailable. For my American respondents who wish to preserve their children's ability to know their donor, identity-release donors present an apparent compromise between the fears of custody that surround using known donors and the option of anonymous-donors.

The implications that these different regulatory structures have on the development of alternative family structures require further study. There is certainly the potential that my German respondents' use of friend- and especially found-donors will lead to a radical redefinition of kinship ties that allows for third parties to contribute to reproduction while preserving a relational link to resultant offspring. By avoiding situations where the donor's role is more open, my American respondents' donor selections preclude such challenges to the nuclear family model from the outset.

# CHAPTER 6: CONCLUSION

In this project, I explore how regulatory contexts affect the reproductive experiences and practices of lesbians attempting to have children, as well as the decisions of fertility physicians relating to these lesbian patients. I find that the regulatory context has multiple, overlapping, and sometimes contradictory impacts on these actors' decisions. In particular, the regulatory context encourages the medicalization of lesbian reproductive experiences in the US and discourages it in Germany, which has further implications for the ways in which individuals define and enact family.

Firstly, I find that a similar number of physician respondents in Germany and the US express traditional versus inclusive views of families. Correspondingly, my physician respondents in Germany who held traditional beliefs about the family often refused to treat lesbian or single patients. However, they rarely explained their decisions with reference to their beliefs but rather held that their professional guidelines restricted such treatments. Yet, German physicians with inclusive family beliefs generally indicated that they treat non-traditional patients. By contrast, personal beliefs of the physician respondents played no perceptible role in the treatment decisions of my American respondents.

These findings highlight the importance of analyzing the physician role as gatekeeper, because they demonstrate that personal beliefs influence medical practice. While physicians appear loath to admit to allowing prejudices to guide their treatment decisions, the German data indicate that personal beliefs do play a role in how physicians enforce (or ignore) discriminatory guidelines. While the data from the US indicate that outright refusal of treatment to lesbians is less likely to occur when guidelines do not provide a justification for it, current debates over religious objections to providing certain forms of (often reproductive) medical care demonstrate that these issues remain relevant in the US as well.

The US physician data also indicate that the market mechanisms in health care may have a positive effect on discouraging discrimination against lesbian patients, similar to Becker's classic argument regarding discrimination in employment decisions (1971). However, while lesbians may be welcomed as consumers of "Fertility, Inc.," their inclusion is predicated on their ability to pay, because fertility medicine is particularly commodified, given its uncertain status as "disease" versus "lifestyle choice." Furthermore, the findings that physicians are influenced by their own values in certain treatment decisions reminds us that it is crucial to study the micro-interactions of patients and physicians, because the personal beliefs of the latter may indeed lead them to steer certain patients away from reproductive treatments based on their own ideas of appropriate parents.

My second major finding is that my lesbian respondents articulate conception worldviews that can be categorized as either medical or natural. Most of my respondents express an initial commitment to a natural conception worldview, which is further reflected in their early attempts to conceive at home. Yet, my US respondents ultimately had more medicalized conception experiences than their German counterparts. For example, my respondents in Illinois had insurance benefits that encouraged them to access physician-assisted conceptions, whereas their German counterparts avoided physician involvement with more tenacity.

Thus, this project contributes to the literature on medicalization that emphasizes that this process is neither linear nor universal. By comparing experiences in two countries, I find that lesbians pursuing pregnancy in different regulatory contexts have notably different trajectories, even when they are similar in many other ways. At the same time, there are respondents in the

US who, despite being immersed in a regulatory context and culture that encourages medicalization of reproduction, resist this through a personal commitment to their natural conception worldviews. Similarly, there are German respondents who, even when they are aware of discriminatory guidelines, seek medical providers who are open to treating lesbians early in their conception trajectories. The important result, then, is that individuals are able to influence the spread of medicalization through their acceptance and resistance of its impact.

Furthermore, the findings support Starr's (1982) assertion that insurance companies play an outsized role in processes of medicalization. However, the important role of insurance companies is here viewed through the lens not of health care providers but patients. When infertility is diagnosed and treated as a medical issue that is covered by health insurance, patients are incentivized to utilize medical interventions in a way that is recognized as legitimate by the insurer, as illustrated by the respondents in Illinois. On the other hand, when fertility issues are an out-of-pocket expense, patients are unlikely to seek health care treatment – even when it is not extremely expensive, as in the German context – unless they face difficulties conceiving, at which point the lack of coverage becomes overtly discriminatory.

Finally, I find that my German respondents seek known donors with more persistence than their US counterparts, despite a shared initial preference for such donors. Again, the regulatory context is influential, because anonymity of donors is viewed as normal in the US while it is prohibited in Germany. The presence of anonymous donors in the US may serve to reorient the scale for my respondents, since identity-release donors seem like a compromise between anonymity and personal contact. By contrast, in Germany, my respondents appear to seek a compromise between sperm bank donors and family or friend donors. Thus, the known found-donor presents a middle ground between negotiating conception with a close friend and using a donor who one cannot meet before conceiving.

These findings add to our understanding of how families are changing in the context of assisted reproduction. While all of the women I interviewed had to incorporate a third party in their reproduction, fear of litigation – in other words, lack of ability to contractually define roles that can be reasonably expected to be upheld in a dispute – leads US respondents to avoid any situation that they view as endangering their parental rights. Similarly, the predominance of sperm banks – and anonymous sperm in particular – serves to reinforce the idea in the US that sperm donors are tangential to experiences of reproduction, rather than key figures in the lives of their future children.

By contrast, in Germany, the idea that sperm donors have something to lose (i.e., money in the form of child support) from having their donation recognized as parenthood may serve to protect against fears of custody battles. Furthermore, the highly developed welfare state in Germany may lead known donors to worry that they will be held financially responsible for their children, which in a sense protects the lesbian couples from fear that these men will try to gain legal rights to their offspring. The persistent focus on the "naturalness" of reproduction may further reinforce the desire for a known donor who can be incorporated into a child's life and who is present to the reproductive process in a way that the mediated interactions with a sperm bank can never approximate.

Thus, I find that the regulatory context is best analyzed with attention to its effects and a simultaneous understanding that regulations are not static nor removed from everyday life. As Saguy and Stuart (2008) posit, an analysis of the regulations that views them as either an independent or a dependent variable is inadequate, because the regulations themselves are remade and challenged by practices that circumvent and uphold them. In addition, the regulatory context has unintended consequences for the medicalization of reproduction and the cultural definitions of family.

## LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

One of the limitations of this project is the sample size. While over 75 interviews is a substantial number for in-depth qualitative analysis, no particular category has a high number of respondents because of the comparative nature of this project. However, I reached saturation in each category (Small 2009). Although in this dissertation, I attempt to compare the role of regulatory contexts in shaping lesbian reproductive decisions in Germany and the US, I limited the majority of my data collection efforts to the cities of Berlin and Chicago. Thus, the conclusions I draw may be biased by the choice of locations, because neither of these cities may be considered representative of their respective nations. While a small number of additional interviews were conducted in the cities of Milwaukee and Munich, and these by and large reinforced my main findings, my conclusions should nevertheless not be assumed to be generalizable to entire nations. For instance, there may be fertility physicians in the US who do refuse to treat lesbians because they are opposed to same-sex couples having children, or there may be lesbians in the US who find known donors through advertisement online (indeed, the content analysis revealed the existence of sites dedicated to connecting known donors to women seeking sperm). However, the goal of this research was not to draw generalizable conclusions about an underlying population. Rather, the goal was to understand how the meaning of conception and family is described and interpreted differently across contexts, and to uncover the ways that regulations both reflect and reinforce differences in cultural practices.

In addition, I used convenience sampling to reach the respondents, and the vast majority of the respondents were white and middle-class, which has been a limitation in much of the prior research on lesbian family building. Given that class has been shown to play an outsized role in access to fertility treatments, it is unfortunate that I was unable to solicit enough lesbians of varying economic means to examine whether class influenced their access to fertility treatments in meaningful ways. However, my sample consisted primarily of people with solidly middle-class occupations, rather than the upper-middle class patients of fertility medicine who are often studied. The lack of racial diversity may also influence my findings in other ways, such as the characteristics that were prioritized in searching for a sperm donor.

Furthermore, this study may not reflect the experiences of lesbians who try to become pregnant but run into fertility issues that are not successfully treated. Although I openly recruited people based on their attempts to get pregnant rather than the outcomes, no one who responded had stopped pursuing treatment without at least one pregnancy resulting in a live birth (but a small number of interviewees were still in the process of trying to become pregnant). Many of the lesbians I spoke with had little trouble achieving pregnancy with relatively low-tech means, but this may not reflect the experiences of lesbians as a group. Instead, it could indicate that people who are thwarted in their efforts to have children due to infertility need to be recruited more explicitly. It is possible that they may be less likely to want to discuss their experiences and/or may be unwilling to identify as lesbians who have attempted to become pregnant.

Each of these limitations suggests a direction for future research. As same-sex relationships become more institutionalized and better accounted for at the population level, it will become increasingly possible to recruit them using sampling techniques that involve randomization to better test and compare their experiences to other samples. Additional studies could be conducted to assess how intersectional identities complicate reproductive decision making, by expanding the focus beyond white, middle-class lesbians as the basis for claims regarding “lesbian experiences.” Race, class, and sexual orientation together influence the reproductive trajectories of women, and these factors also influence how the regulatory context affects their childbearing. Studies could be conducted that hold the regulatory context constant while examining a wider range of lesbian experiences within that geographic location to tease apart the role of intersectionality on reproduction.

Finally, although this study was initially designed to include the reproductive experiences of lesbians and single women, I ultimately decided to exclude my single respondents from this analysis because their experiences reflected different concerns and their reproduction is regulated in different ways. However, their experiences could be analyzed with similar attention in both German and American contexts.

## FUTURE DEVELOPMENTS

The regulatory context is treated in this research as stable when, in fact, it is undergoing renegotiation and change constantly. Individual actors make decisions regarding when to enforce particular regulations, and concerted efforts to alter regulations sometimes bear fruit. The year 2015 was a watershed for gay rights in the US, as the Supreme Court ruled that the Defense of Marriage Act (DOMA) was unconstitutional; gay marriage bans across the US were overturned (Obergefell v. Hodges 2015). The full impact of this change on the legal regulation of same-sex families remains to be seen, as institutions across the country attempt to grapple with newly-opened questions of who counts as a legal parent. Some judges have already indicated that same-sex married couples should both be listed on the birth certificates of children biologically related to one of the spouses (Dodge 2014), but struggles over same-sex parents are ongoing. Even as I was making the last edits to my dissertation, a story about a judge in Utah removing and then reinstating foster children in a household with lesbian mothers has been circulating in the news (Perez-Pena 2015).

With the recent overturning of DOMA, Germany no longer appears to be the clearly progressive nation of the two, as gay marriage remains illegal in Germany even as the rights accorded to couples in civil unions continue to grow. In 2013, the parental rights granted to same-sex couples were expanded when the *Bundesverfassungsgericht* ruled that a same-sex partner could adopt the adopted child of their partner, even as the courts reaffirmed that same-sex couples are still not allowed to adopt a child jointly (Ignatzi 2013). As the rights and privileges associated with civil unions in Germany edge closer to marriage, it seems to be just a matter of time before same-sex couples there are granted the right to marry. Yet in Germany, the role of marriage as the defining feature of family continues to decline. This decline may explain the lackluster collective organizing to extend this civil right to same-sex couples. Nonetheless, the legal importance of marriage has not declined, as is clear when one looks to the health insurance coverage for infertility and the professional guidelines of medical associations.

What will the future of lesbian reproduction in Germany and the US look like, given these developments? I predict that American lesbians –those with the material means to access increasingly commodified fertility treatments - will likely continue to have increasingly medicalized reproductive experiences as their role as consumers of fertility medicine and sperm bank offerings is recognized and exploited by capitalist imperatives. In other words, the market pressures that govern health care will continue to encourage fertility physicians to provide services to lesbian clients who can pay, as “family values” are expanded to include same-sex couples who fit into the white, middle-class family ideal. This ideal, in turn, serves to reinforce the two-parent model that disavows the role of a third party.

In Germany, however, rather than converging on a medicalized version of reproduction, lesbians may represent an alternate – but also widespread phenomenon: families outside of the context of heterosexual marriage. While Germans in general have moved away from marriage as the foundation of family, lesbians have necessarily been creating families outside of the context of marriage for years. As marriage loses its centrality, children become ever more important, and same-sex couples with children may gradually become widely accepted as families. At the same time, however, their reliance on connections to their donors may serve to expand the already common phenomenon of "patchwork families" (Gerlach 2010). This term includes a range of non-traditional family types. For example, lesbian couples whose children maintain ties to their sperm donors may become a commonly seen form of these families. The real question is when or even if a social movement can develop to demand full rights to social welfare systems that recognize, rather than discriminate against, these "rainbow families" (Gerlach 2013). Thus, in both countries, the pressure to expand the definition of family exists, but the likely resolutions may differ markedly.

# APPENDIX A: TABLES OF RESPONDENTS

Table A.1: Physician Respondents' Self-reported Characteristics (n=28)

| Name | Age | Gender | Race/Ethnicity | Location |
|---|---|---|---|---|
| Dr. Mueller | 55-59 | male | white | Berlin |
| Dr. Riedl | 45-49 | male | white | Berlin |
| Dr. Weber | 40-44 | male | white | Berlin |
| Dr. Schwabe | 65-69 | female | white | Berlin |
| Dr. Hausmann | 30-34 | female | white | Berlin |
| Dr. Seidler | 30-34 | female | white | Berlin |
| Dr. Damböck | 35-39 | female | white | Berlin |
| Dr. Frese | 35-39 | male | white | Berlin |
| Dr. Hamscha | 35-39 | female | Middle Eastern | Berlin |
| Dr. Schultz | 40-44 | female | white | Berlin |
| Dr. Faust | 35-39 | female | white | Berlin |
| Dr. Bosch | 30-34 | female | white | Berlin |
| Dr. Hoefer | 30-34 | female | white | Berlin |
| Dr. Kohl | 40-44 | female | white | Berlin |
| Dr. Weiss | 40-44 | female | white | Munich |
| Dr. Wassermann | 45-49 | male | white | Munich |
| Dr. Smith | 40-44 | female | white | Chicago |
| Dr. Jones | 45-49 | female | white | Chicago |
| Dr. Johnson | 60-64 | male | white | Chicago |
| Dr. Coolidge | 70-74 | male | white | Chicago |
| Dr. Schafer | 50-54 | male | Middle Eastern | Chicago |
| Dr. Suarez | 60-64 | female | white | Chicago |
| Dr. Wierzbicki | 30-34 | female | white | Chicago |
| Dr. Kilbridge | 55-60 | male | white | Chicago |
| Dr. Miles | 45-50 | male | white | Milwaukee |
| Dr. Jameson | 35-39 | male | white | Milwaukee |
| Dr. Trimborn | 45-49 | male | white | Milwaukee |
| Dr. Williams | 50-54 | male | African-American | Milwaukee |

Table A.2: Lesbian Respondents' Self-reported Characteristics (n=40)

| Name | Age at Interview | Race/Ethnicity | Occupation | Location |
|---|---|---|---|---|
| Karin | 30 | White | Advisor | Berlin |
| Senta | 38 | Middle Eastern | Editor | Berlin |
| Doerthe | 36 | White | Pre-school teacher | Berlin |
| Marina | 35 | White | Unknown | Berlin |
| Deike | 43 | White | Translator | Berlin |
| Barbara | 29 | White | Academic Lecturer | Berlin |
| Alexandra | 39 | White | Environmental Researcher | Berlin |
| Martina | 38 | White | Teacher | Munich |
| Christin | 45 | White | Program Manager | Munich |
| Charlotte | 38 | White | Publisher | Munich |
| Steffi | 29 | Hispanic | Educator | Munich |
| Marlene | 37 | White | Project Manager | Berlin |
| Renate | 38 | White | Project Manager | Berlin |
| Dagmar | 37 | White | Scientist | Munich |
| Anke | 28 | White | Management Consulting | Munich |
| Birgit | 39 | White | Physician | Berlin |
| Jana | 43 | White | Engineer | Berlin |
| Heidi | 29 | White | Acquisitions | Berlin |
| Ulrike | 37 | White | Social Worker | Berlin |
| Lilli | 35 | White | Special education teacher | Berlin |
| Resi | 34 | White | Child care worker | Munich |
| Elisabeth | 42 | White | Editor | Munich |
| Cara | 29 | White | Policy Researcher | Chicago |
| Hannah | 29 | White | PhD student | Chicago |
| Adrienne | 32 | White | Market Research | Chicago |
| Molly | 40 | Hispanic-American | Attorney | Chicago |
| Jessica | 36 | White | Teacher | Milwaukee |
| Amelia | 36 | African-American | Social Worker | Chicago |
| Cassandra | 31 | White | Physician | Chicago |
| Joy | 31 | White | Librarian | Chicago |
| Emma | 42 | White | Attorney | Chicago |
| Patricia | 29 | White | PhD student | Milwaukee |
| Katherine | 35 | White | Teacher | Chicago |
| Kendra | 40 | White | University Administration | Milwaukee |
| Kristen | 34 | White | Stay-at-home Parent | Chicago |
| Alice | 33 | White | Non-profit Administration | Milwaukee |
| Andrea | 32 | White | Social Worker | Milwaukee |
| Emily | 29 | White | Minister | Chicago |
| Kelly | 31 | Hispanic-American | Advertiser | Milwaukee |
| Mary | 39 | White | Child Care Worker | Chicago |

## APPENDIX B: METHODOLOGY

This study is a comparative analysis of sources from Germany and the United States. The data include reviews of legal regulations and professional medical guidelines, in-depth interviews with a range of actors, content analysis of major news sources, and systematic analysis of websites of assisted reproductive clinics.

To examine the current regulatory context, I conducted research on the policies of the national and state governments and the medical associations in Germany and the US. In particular, I examined debates in each country's major legislative bodies regarding assisted reproduction, gay marriage, and parenting by LGBT and single people that took place in the years during data collection. Furthermore, I familiarized myself with the current legal status and professional regulation of assisted reproduction and remained up-to-date as developments occurred, both through textual review of the statutes and frequent internet searches for ongoing developments.

My primary source of data consists of in-depth interviews. I interviewed 10 key actors who represent important stakeholders in debates about the regulation of assisted reproduction, including people who work for gay rights organizations, religious groups, and political parties. These interviews provided background information and clarified aspects of the regulatory context. In addition, I interviewed 28 physicians who work in fertility medicine and 40 lesbians who are attempting to become pregnant or have recently given birth, with a roughly equal number of interviews conducted in Germany and the US. I also interviewed single heterosexual women about their experiences, but their experiences are not analyzed in this dissertation. Although I initially intended to include both coupled lesbians and single women of any sexual orientation in my analysis, I found that their experiences differed substantially enough that a merging of these categories threatened to collapse findings in ways that did not reflect the unique experiences of each group. For instance, given the more advanced average age of my single women respondents (compared to my coupled lesbian respondents), the single women more frequently held medical conception worldviews, which is likely related to their higher average age. In addition, because of the different regulatory issues about single women's treatment by fertility physicians, I found that my single women respondents' experiences differed from their lesbian counterparts in ways that deserve to be analyzed separately. Thus, these results will be explored in a separate publication from a secondary analysis.

This project yielded qualitative results, and I analyzed the experiences of my German and American respondents to examine how they compared and contrasted with one another. My intent was not to be representative of the underlying groups to compare statistically significant differences between the populations of German and American lesbians who are having children. Thus, the differences I suggest exist between these two contexts should be viewed as qualitatively meaningful rather than statistically significant. In following best practices for qualitative research, however, I continued to conduct interviews until I reached saturation, meaning that additional interviews did not yield new information, nor did additional participants challenge the patterns I had observed in previous interviews (see Small 2009).

Respondents for the interviews with medical professionals were solicited using mail contacts, as well as through email and telephone queries. I researched reproductive clinics in a given city by doing extensive online searching and scouring of professional association websites, and I sent letters to all of the doctors of fertility medicine listed on each clinic's website. During the interviews, respondents were asked general questions about their jobs, as well as questions about the clinics where they practice. Additional interview topics include how patients are selected and who is treated, physicians' broad opinions on family and alternative family structures, and their view about their professional guidelines. Of the health care professionals, there was a nearly equal split between men and women. One of the physicians I interviewed is African-American, and two are of Middle Eastern descent, while the rest are white. The doctors were fairly evenly split with regard to age, with slightly higher numbers of physicians in their 30s and 40s, as compared to those in their 50s or 60s and over. See Appendix A for a detailed description of respondents.

When reporting results, I sometimes change identifying details slightly to preserve the confidentiality of my respondents. During the data collection phase, I stored all signed informed consent forms in a locked box to protect my respondents' participation in the project from being revealed, and I changed any names given in the interviews on the transcripts themselves.

For my interviews with lesbians who are pursuing parenthood, I sought respondents in a variety of ways. There is no way to sample these women in a representative fashion because there is no central database or list of lesbians, let alone lesbians pursuing parenthood. Thus, I utilized a convenience sample of respondents solicited through various means. I emailed recruitment requests to various email list-serves and online social groups geared toward these women. I also attended local events to distribute recruitment flyers and introduce myself to potential interviewees. In addition, I used snowball sampling (Goodman 1961) to locate additional contacts.

During the interviews, respondents were asked general questions about their relationship status and decision to pursue parenthood, as well as questions about the process of conception and experiences with the medical profession. Additional interview topics include how my respondents selected sperm donors, including what characteristics they prioritized, how they negotiated the role of the donor, and how they changed donors, if applicable. I also asked them their opinions about the role of genetics and the environment in child development, the importance of role models of different genders, their family structure, and their experiences with tolerance or lack thereof for their families and relationships.

The respondents for these interviews were between the ages of 28 and 45 at the time of the interview. Most of the women had at least one child under the age of 4 when interviewed. A few interviewees were still planning their reproductive attempts, while others were actively trying to conceive, and a very small number had children aged 4 or over. One of the respondents is African-American, three are Hispanic, one is Middle Eastern, and the rest are white. Although I did not ask for income data, my respondents described their occupations during the course of the interview. See Appendix A for a detailed description of respondents.

Interviews were conducted in English or German, according to the respondent's preference, and all interviews were transcribed by myself or by a professional transcriber. I rechecked every transcript for accuracy and to de-identify the data. I used the qualitative analysis software program *Atlas.ti* to code the transcripts according to major themes that arose through careful, repeated readings of the interview transcripts and associated field notes. I coded the transcripts using simultaneous, descriptive, and open coding techniques during the early rounds of coding, and during later rounds of coding I further coded responses based on respondents' values and the narrative arcs within their interviews (Saldaña 2012). Any quotes that were originally in German but appear in this dissertation were translated by me; my translations were verified by a native German speaker fluent in English. Data were collected primarily in the cities of Berlin and Chicago.

To investigate how local differences affect experiences, I interviewed a smaller sample in additional locations in each country, with the bulk of these interviews being conducted in Munich and Milwaukee. The small number of interviews in Munich and Milwaukee are not meant to draw meaningful comparisons between the cities in each country, but rather to provide verification regarding whether the experiences cited in my main research sites are applicable to a wider geographical context. For instance, the Milwaukee interviews helped clarify that insurance coverage for lesbians using assisted reproduction are not widespread. Similarly, the interviews in Munich aided in analyzing how physicians outside of Berlin responded to the guidelines of the German Medical Association (BÄK).

To provide context for the interview data I collected and to situate my respondents' experiences in the broader discourses of reproduction and family, I performed a content analysis of news articles about assisted reproduction and nontraditional families published between 2010 and 2015. The sources I searched included *Newsweek*, *Time,* the *New York Times*, and *USA Today,* in the United States. In Germany, I reviewed *Der Spiegel*, *Die Zeit,* and *Frankfurter Allgemeine Zeitung*. I chose these sources after reviewing circulation data and public understandings of the political preferences of the newspapers and magazines. I sought to include sources with wide circulation, as well as to include a range of editorial political leanings, without choosing sources that are considered to be overtly political.

Because I was interested specifically in how lesbians pursuing pregnancy through insemination are covered in these two national contexts, I searched for articles from 2010-2015 that included any derivatives of the terms "lesbian" and "sperm" to access the range of applicable data. This yielded just over 100 articles in US sources and over 50 in German sources, all of which I reviewed for relevance. In both countries, well over half of the articles that fit the search terms were deemed to have only tangential relevance and were not analyzed further, while the remainder were reviewed in more depth.

In particular, the content analysis involved reviewing newspaper and magazine articles about reproductive technologies, focusing on *standing* and *framing* (Ferree et al. 2002), as well as the major themes of the coverage. Standing describes who has “a voice in the media” (2002:86), whereas framing refers to groups who have their “central organizing ideas” used in the media discourse (2002:105). By analyzing the major contributors to media and popular discourses on reproductive technologies, I assess how discourses about assisted reproduction compare between Germany and the US. In addition, I reviewed the articles to determine the predominant, circulating images and messages about assisted reproduction and non-traditional families in both countries.

Finally, to assess how fertility clinics market themselves and how they present their ideal clientele, I analyzed the websites of all the major clinics in Chicago and Berlin and the sites for prominent sperm banks throughout Germany and the United States. This systematic assessment of websites provided me with data on how services are described, whether lesbians and single women are explicitly targeted as potential patients, and how families are portrayed by the clinics.

## APPENDIX C: GLOSSARY OF TERMS

American Medical Association (AMA): the largest professional association for physicians and medical students in the United States, with over 200,000 members. Founded in 1847, the AMA lobbies on behalf of physician interests and works for the improvement of public health.

Assisted reproduction: a general term that encompasses all attempts at achieving pregnancy outside of heterosexual intercourse, from the relatively low-tech attempts at alternative insemination (see above) to the most complex reproductive technologies.

Assisted reproductive technologies (ART): procedures that involve the manipulation of sperm and eggs outside of the body as part of a procedure to attempt to cause pregnancy.

American Society for Reproductive Medicine (ASRM): Founded in 1944, this professional organization brings together physicians from different specialties (such as obstetrician-gynecologists, reproductive endocrinologists, and urologists) to promote the advancement of reproductive science and treatment. ASRM is the umbrella organization of which many smaller professional organizations, such as SART, are members.

*Berlin-Ärztekammer*: the State Chamber of Physicians for the city-state of Berlin.

*Bundesärztekammer* (BÄK): the German Medical Association is the top organization of medical self-regulation in Germany. As the joint association of the 17 State Chambers of Physicians (*Landesärztekammern*), it co-ordinates the activities of these bodies and represents the professional interests of more than 400,000 physicians.

*Bundesgerichtshof*: the Federal Court of Justice is one of the high courts in the German judiciary system. Its primary task is to ensure uniform application of law, clarify fundamental points of law and develop the law. Particularly in the field of civil law, legal practice is often guided by its rulings, and it is the highest court for issues of private and criminal law.

*Bundesverfassungsgericht*: The Federal Constitutional Court of Germany is the highest court in Germany. It is similar in function to the Supreme Court of the United States, as it reviews rulings to assess their constitutionality, but its scope is more limited by its strict focus on issues of constitutionality.

Egg donation: the process by which a woman provides one or more eggs for assisted reproduction. The eggs may be fertilized outside the body and then implanted into the uterus of a recipient.

Embryo: the stage of development generally considered to be from one to eight weeks after fertilization in humans (preceded by "zygote" and followed by "fetus").

*Embryonenschutzgesetz*: the Embryo Protection Law is a German law regulating assisted reproductive technologies. Its main purpose is to prevent the misuse of reproductive technology for the creation of human embryos and to protect human embryos from improper use, for example for research purposes.

Fertilization: the merging of sperm and egg, which creates a zygote (which can develop into an embryo and eventually a fetus).

Gamete: a reproductive cell (sperm or egg) that is able to fuse with another reproductive cell during fertilization.

*Grundgesetz*: the Basic Law is the constitutional law in Germany. Issued in 1949, it originally only applied to West Germany, but it became the constitution for the entire country with the re-unification of 1990.

Heterologous sperm: sperm donation in which sperm is taken from a donor other than the husband or partner of a woman with whose egg fertilization will be attempted.

Homologous sperm: sperm taken from the husband or partner of a woman with whose egg fertilization will be attempted.

Human Fertilisation and Embryology Act (HFEA): The United Kingdom's act of parliament that established comprehensive regulation of assisted reproduction research and practice. The first act passed in 1990, and a revision was passed in 2008.

Intra-cytoplasmic sperm injection (ICSI, pronounced ick-see): the injection of one sperm into an egg outside of the body to cause fertilization.

In vitro fertilization (IVF): the merging and incubation of a sperm and egg outside of the body (*in vitro* means "in glass" in Latin) until an embryo is formed that is then transferred to a woman's uterus.

Intrauterine insemination (IUI): the placement of sperm directly into the uterus using a long, thin tube.

*Landesärztekammer*: the State Chambers of Physicians are the executive bodies of medical self-administration in Germany. Each physician is required to be a member of the chamber of the state in which he practices medicine. Although there are only 16 states, there are 17 *Landesärztekammern,* because the state of Nordrhein-Westphalen has two independent chambers.

Society for Assisted Reproductive Technology (SART): This is the foremost professional organization for providers of assisted reproductive technology, such as IVF. SART focuses on setting standards of care for treatments that use ART.

*Sozialgesetzbuch*: the Social Code is the codification of the German social security laws, including social insurance, child support, social care, etc.

Sperm donation: the process by which a man provides sperm for assisted reproduction. The sperm may be used for fertilization outside the body and then implanted into the uterus of a recipient (such as in IVF or ICSI), or they may be deposited into a woman's vagina or uterus for fertilization within the body (such as in AI or IUI).

sperm washing: the process of separating sperm from the seminal fluid. Sperm banks often offer sperm washing, which they say reduces the chance of an adverse reaction in the uterus and increases the chances of conception.

*Stiefkindadoption*: literally translated as step child adoption, this is the process of having a non-biologically related partner adopt a biological child of a same-sex partner.

Uniform Parentage Act (UPA): first established in 1973 to suggest uniform standards for parentage determinations in custody disputes. This act was updated in 2002 to account for developments in assisted reproductive technologies. The act was written by the National Conference of Commissioners of Uniform State Laws. Adoption of the UPA is done at the discretion of the states.

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