

How Society Responds to Desires of Childless Couples: Japan's Position on Donor Conception

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Introduction

Medical technologies used for infertility treatments have made tremendous advances since *in-vitro fertilization* (IVF) first appeared in 1978. In Japan, the first IVF baby was born in 1983; lately more than 10,000 babies are born annually, thanks to IVF.

Assisted Reproductive Technology (ART)¹, including sperm, egg or embryo donation and/or surrogate reproduction, are being used in industrialized countries as well as in emerging economies.

In Japan, ART was long regulated only by the guidelines authored by the Japan Society of Obstetrics and Gynecology (JSOG), the registration and reporting system which controls the practice of ART. However, the guidelines for Artificial Insemination by

Donor Sperm (AID or DI²) were not set by JSOG until 1996, in spite of these technologies having been used since 1948. During those 48 years, the ethical, legal, and social issues of DI were entrusted to each institution offering DI.

This system puts the regulatory responsibility solely into the hands of medical professionals. Further, JSOG has rarely applied penalties for doctors who step outside the guidelines. Having entrusted medical specialists with ART cases, the Japanese government and legislative bodies have been reluctant to address ART issues until now.

Recently, however, there have been several reports of cases in which medical doctors have clinically gone against the guidelines for ART in order to meet the needs of their "patients." The media has also spotlighted stories of people who go abroad, typically to the United States, notwithstanding enormous financial burdens, in order to obtain eggs or to acquire a child

¹ In the Japanese translation of the English term "Assisted Reproductive Technology (ART)," the word "technology" is referred to as "medicine" instead of its literal translation when fully translated. This is probably because in Japan the expression reproductive technology is not well received for being "unnatural." Although there are some variant technologies in ART, I would like to use the acronym ART as either singular or plural in this paper.

² Formerly AID was used widely as the medical term in the world. However, in recent DI offspring activities, they prefer the term DI than AID. One reason is to escape using the word of "artificial." Here, I also use DI instead of AID.

through commercial surrogate reproduction.

The government is now drafting a bill in response to the increasingly dominant opinion that Japan must establish some form of official regulation for ART.

Against this political and social backdrop, I will provide an overview of how a draft of regulatory bill has come about. I will give particular attention to the process of institutionalizing ART since it was first implemented in Japan.

Drafting a bill for Assisted Reproductive Technologies

Arguments for drafting this bill should be directly linked to the society's views of "infertility," which is understood as being inability to conceive a child despite the couple's wish to do so. In addition, reviewing the policies and laws relating to infertility and medicine amounts to examining how family, gender, and ART are being recognized in the relevant culture and society.

What can be regarded as the first success of ART in Japan occurred in 1949 when the first child was born through DI. More than 50 years later, it is estimated that over 10,000 children have been born by means of DI. Since the emergence of Sperm Microinjection, the annual number of DI clients and births has decreased; recipients now number over 1100 annually with more than 110 births per year (Japan Society of Obstetrics and Gynecology 2003)³. But the result of one third pregnancies cases was not reported to hospitals and clinics by recipients.

Table 1. The annual results of DI in Japan

Year	The number of recipients	The number of children
1998	1711	188
1999	1134	221
2000	1350	119
2001	1322	161

In looking back at the first DI cases in Japan, we find that there were some controversies among physicians as well as among jurists. However, Keio University, historically the top provider of DI, claims to have long had its own guidelines for DI which enabled DI-born children to be legitimately recognized by the mother's husband.

Since 1983 when Japan's first IVF child was born, JSOG has limited access to IVF to legally married couples who meet its guidelines, thereby regulating the practice of sperm, egg, and embryo donation as well as that of surrogate reproduction.

Despite these guidelines, some couples go abroad seeking egg donation and surrogate reproduction through various commercial agencies. Unfortunately, reliable statistics on the number of couples and births from services obtained abroad are unavailable.

In contrast, DI was left unchecked until 1996 when a private agency initiated online sperm trading. Strongly opposed, JSOG im-

³ The fact that the JSOG began to make public the yearly success rates of AID 50 years after the first AID was performed in Japan clearly shows a change in the JSOG's views on information disclosure and accountability regarding reproductive technologies.

mediately announced a new guideline prohibiting sperm trading for the purpose of DI in 1997. Nonetheless, this agency continues to do business online.

In 1998, a practicing obstetrician and gynecologist revealed that he had performed IVF on a few women using donated eggs from their sisters; further, one of his patients has already given birth. Found in violation of JSOG's guidelines this doctor was officially expelled from JSOG; he nevertheless continues to practice medicine including ART.

In the legal realm, the Osaka District Court pronounced judgment on the first DI case in Japan in December 1998. In this ruling, the court found for a husband who refused to recognize his child because his wife had used DI without his consent.

These incidents have belatedly propelled the former Ministry of Health and Welfare (now, the Ministry of Health, Welfare, and Labor) to establish the Assessment Subcommittee for Advanced Medical Care of the Health Science Council who in turn set up the Special Committee on Medical Technology for Reproductive Treatment (the Special Committee) in 1998. The Special Committee published "Report on Ideal Reproductive Treatment Using Donor Sperm, Eggs, and Embryos" (The Special Committee on Medical Technology for Reproductive Treatment 2000) concluding that offering sperm, eggs or embryos by a third party without remuneration must be limited to legally married couples unable to conceive with existing infertility treatments. The Special Committee

further states that trading and commercial transactions as well as surrogate reproduction should be prohibited.

The Special Committee rules that nothing should override the six basic principles.

- 1) Priority shall be given to the welfare of the children to be born.
- 2) The human body shall not be treated merely as the means of reproduction.
- 3) Careful consideration shall be given to safety.
- 4) The concept of eugenics shall be eliminated.
- 5) Commercialism in reproduction shall be eliminated.
- 6) Human dignity shall be respected.

Thus, any medical practice infringing upon these principles was to be banned.

Dr. Nezu, the OB/GYN expelled in 1998 by JSOG for practicing ART with specifically egg donations, publicized the first successful case of surrogate reproduction between sisters in 2001 as a protest against the Special Committee's move to ban surrogate reproduction. The doctor was fiercely opposed to surrogate reproduction as a business transaction. Dr. Nezu dismissed the commercial approach or "human trafficking" to surrogate reproduction as carried out in the United States, costs which can exceed ten million yen (Nezu, 2002). This means that the couple should not have to pay for any of the associated costs, nor should the surrogate mother receive any fee.

Recently, his position has been supported from some Ob/GYN for his readmission to the JSOG.

Following the publication of the Special Committee's Report, the Health Science Council set up the Committee on Assisted Reproductive Technology (the ART Committee) to consider drafting a new bill detailing how to enact the Special Committee's recommendations.

The ART Committee adhered to all six recommendations except for a few drastic changes regarding sperm and egg donors and the Donor Conception offspring's right to know the identity of the donor.

Summarized below are the main points of the ART Committee's report.

- * Surrogate reproduction should not be allowed because the birth mother is defined as the legal mother.
- * Donor conception by sperm, egg and embryo donation will be allowed after establishing a public institution to run the system.
- * Donors should be kept anonymous.
- * Sperm or egg donation by siblings should not be permitted.

As can be seen, the ART Committee differed in their view of the donor-conceived offspring's right to access their genetic origin. Recognizing that genetic origins form an essential part of a person's identity, the ART Committee recommended that donor-conceived children have the right to information which included identification of the donor.

In March, 2003 the ART Committee published recommendations for the prompt submission of a bill to the Ministry of Health, Welfare and Labor. However, the bill has yet

to be submitted to Diet even one and half years later.

Here, I will consider the Special Committee and the Art Committee's reports from two viewpoints: the value of having children in Japan and the dilemma faced by couples pondering donor conception.

The ART and the concept of Japanese modern family

Since their introduction, these reproductive technologies have received worldwide criticism for their potential to collapse families due to the need for a third party outside the couple to donate the zygote and the creation of multiple "fathers" and "mothers" for the offspring.

Therefore the bill under preparation stipulates at the outset that only legally married couples are eligible to access ART. This limitation was incorporated into the law without any substantial discussion, even though among the public comments submitted to the ART Committee were several requests to make ART accessible to de facto and common-law marriages.

Now let us look into why ART should be limited to legally married couples. To excerpt from the Special Committee's Report: "This is on the grounds that if a child is born to a single woman or a couple that are not legally married, problems may arise that could adversely affect the welfare of the child since such a child will have only one parent from the outset and its legal status will not be secure." This statement is

intriguing because it mirrors the Committee members' notion of family registration (*koseki*) systems in Japan and of what it means to have a child.

The Special Committee's Report also emphasizes that these trends abroad cannot hold in Japan because in North and Western Europe and North America, there is a high percentage of de facto couples having extramarital children unlike the situation in Japan⁴.

Another area of significance to look at in terms of the concept of family in Japan is the Special Committee's policy which guarantees the anonymity of donor sperm and eggs on one hand, while allowing the donation of sperm and eggs by siblings, etc. The "etc." presumably refers to parents, cousins, or spouses of siblings.

The Special Committee's Report proposes this policy; first, in light of its prohibition of any payment for donation, the draft says, "it is possible that few people will be willing to donate sperm, eggs or embryos except for a sibling, etc. to the recipient, especially in the case of egg donation where the donor must take physical risks." Second, it continues, "considering the fact that the Japanese still attach great significance to blood relationships, it is possible that both the recipient and the donor of sperm, eggs or embryos will desire that reproductive treatment be performed using sperm, eggs or embryos donated by a sibling, etc."

⁴ The total number of extramarital children in 2003 is estimated to be about 21,000, representing 1.9% of the total births.

As for the donation of sperm and eggs by siblings, etc, the Special Committee examined a plan to first allow only donations from anonymous persons and then expand it to allow donations from siblings, etc. This expansion would enable the Special Committee to acknowledge that the importance of blood relationships should be taken into consideration and not necessarily denied. In this way, the new reproductive technologies maintain the traditional sense of family and family structure.

Today, the term "blood relationship" can be expressed as "genetic relationship" in modern terminology. Strictly speaking, however, what is regarded as a "blood relationship" differs from a "genetic relationship." What has been historically considered as "blood" in Japan encompasses a variety of factors more than "genes." Hence, adoption outside "blood" relatives for the purpose of inheriting the "ie", or a family system including patriarchal and paternal ideology, as well as fictitious parent-child relationships have been considered examples of a "blood relationship." I think that the word of blood include not only 'nature' but also 'nurture.'

Now that the traditional system of "ie" is being dissolved, the notion of "one's own child" is becoming prevalent as a new motivation for starting a family. In the past, adoption was the common choice in order to bequeath the "ie" if a couple could not conceive. At present, however, the fact that the legacy of the "ie" has become less important than the legacy of having "one's own child"⁵ which enables husband and wife to confirm

their ties make adoption rare.

It is interesting to point out that the concept of “blood relationship,” which can be paraphrased as the folk view of reproduction, legitimizes the application of advanced medical technologies.

The ART Committee, ultimately, decided for the present not to allow egg or sperm donation by siblings or their partners following the controversy. This current restriction spurred advocates of a sibling-donor system, such as gynecologists, and a representative of patient’s support group for Turner’s syndrome, to argue for allowing sibling donation because the new bill would prohibit remuneration for the donor as well as for commercially based donor banks, thus making donations by unrelated donors difficult or impossible to obtain.

The ART report justified its decision to prohibit egg and sperm donation from siblings or their partners by citing the need to

⁵ In Japan the majority of couples wishing to have a child by infertility treatment wish to have a child born as a result of normal sexual intercourse and pregnancy and delivery, that is, their “own child.” In other words, they do not necessarily wish to use advanced medicine not to mention reproductive technologies which involve third parties (Yanaiharu et al., 1999). In fact, although the statistics for the number of children born by artificial insemination between husband and wife are unavailable, if compared with the number of children born by in-vitro fertilization between husband and wife which reaches 10,000 every year, the number of DI children is small as it stays around 150 every year. This is more obvious from the total annual births in Japan which recorded approximately 1.19 million in 2000.

maintain donor anonymity and the need to prevent the anticipated pressure to donate that childless couples might bring to bear on relatives.

The concept of blood relationship and family ties

As mentioned above, more than 1100 couples undergo DI, resulting in over 110 births annually.

The reasons that some couples choose donor conception is closely connected to their notions of family, their relationship with expanded family, and their knowledge of DI. Many people, not only Japanese, are firm in their belief that a biological link provides a stronger bond and greater affection between children and parents. Although some say couples who choose DI do not care about the “blood relationship,” many DI clients explain that their reason for choosing DI over adoption was to have a genetic tie to at least one side of the family (Noble 1988, Lorbach 2003).

Ando, an Ob/GYN and former professor at Keio University, who first implemented DI in Japan justified introducing DI in Japan by emphasizing that DI is similar to a “half adoption” and thus easier to accept than adoption (Ando 1960). Clearly “half” is better than “whole” adoption, but less desirable than one’s “own” biological children in his discourse.

Thus donor conception is chosen as the second best option. Although people who choose DI seem to have overcome the

traditional perception of the need for a "blood relationship" between parents and children, they still care deeply about the blood relationship and worry about social prejudice toward them as well as their children. This concern leads them to keep the details of their birth from their children.

Telling the truth to DI offspring

Lately, people in some countries have come to believe that children born from donated sperm, eggs or embryos should be able to have access to information about their genetic origins in some countries.

Hewitt, a DI-offspring who was told the truth of her birth in South Wales, Australia, wrote the following.

"My parents developed an environment within our family unit, which was conducive to honesty and openness about everything, especially about donor insemination. I've been very fortunate. I have wanted to know about the man who enabled me to be conceived, my biological father, since the age of twelve." (Hewitt 2001)

Oke, a counselor in infertility in Victoria, Australia pointed out that one of the issues faced by couples using donor gametes, is whether to tell other people, who to tell, and when to tell them" (Oke ed. 1999). Telling others about undergoing donor conception, even in countries where adoptions and step-families are common, personal privacy is thorny because it touches upon such topics as reproduction, sexuality and male infertility.

Here, I would like to show a few examples of countries where the government has implemented a system to ensure DI offspring's right to know about their donor.

Ahead of other countries, Sweden has issued a law concerning DI ahead of other countries, which gives DI-offspring the right to access donor information at the age of 18. Thus the law also requires that the pertinent agency keep the all donor identifiable records for 70 years beginning in 1985.

However, a survey shows that 89% of DI parents have yet to disclose the facts to their children born after 1985 (Gottlieb, *et al.* 2000).

Sweden also revised the law to cover sperm, egg, and embryo donation by IVF in 2003, including the right of donor offspring.

Victoria, Australia introduced the Infertility Treatment Act⁶ 1995 after much study. The government allows the choice of either a so-called "known-donor," meaning identified donor, or an anonymous donor. In addition, since 1998, any donor-conceived offspring have the right to access identifiable information about their donors when they become 18 or older. The state government manages all registration information of the donor, the recipient, and the donor-conceived offspring and offers counseling for all concerned parties.

Although Britain has maintained a donor anonymity policy under the Human Fertilization and Embryology Act (1990), the

⁶ See Infertility Treatment Authority homepage at <http://www.ita.org.au/default.asp?siteaction=home>.

Human Fertilization and Embryology Authority (HFEA)⁷ has kept a registry of information on donors, licensed treatments and children born from donated sperm, eggs, or embryos. When these children reach 18 they may ask the HFEA to confirm that they were born as a result of Donor Conception. They may also ask whether the HFEA Register shows that they are related to the person they intend to marry.

However, Britain changed its regulations about donating sperm, eggs, or embryos in January 2004. Children born as a result of donated sperm, eggs or embryos after April 2005 will be able to access the identity of their donor upon reaching the age of 18. The HFEA reports the reason for this amendment as "...it is acknowledged that ending donor anonymity does involve some risk to the future availability of donors. However, the HFEA does not feel that this practical consideration should outweigh the more fundamental principle that donor offspring should have the right to know their genetic origins" (Human Fertilization and Embryology Authority 2004).

According to a survey in Japan, 97% of DI fathers responded that they have no intention of telling their children about their birth (Kuji 2000).

Looking back at the reasons for not disclosing the facts of the birth, "telling the truth to the child is not necessary because the real father is the man who provides for

and maintains the family" is the most frequent choice (49% in multiple answers). "Letting a child know he or she has no blood relationship with the father may cause problems in family relationships," and "it is pity rather than telling the truth because the child cannot access the information of the donor," "Not telling is a duty of parents," is around 40 percents, repeatedly.

However, the ART Committee recommends that the government establish a new law allowing DI offspring to access information about their donors. Given this legal endorsement, we need to understand the reasons behind DI parents' decision to withhold this information and DI offspring wanting to have in-depth information about their biological origins.

Shimizu showed the results of the survey to 15 women in DI treatment (Shimizu 2004). She described that the responses included: "happiness in having children" (10 respondents); "desire to have a family built on husband and children" (8); "a desire to experience pregnancy and delivery" (10); "importance of parent-child relationship built on the experience of pregnancy and delivery" (3); "parent-child relationship built through years of interactions, rather than mere blood relationship" (4); and "difficulty anticipated in raising an adopted child" (7).

Unfortunately, there are only a few surveys about the attitude of adult DI offspring toward DI and their right to access their information. Further research is needed to enable us to establish a better system to respond to DI issues.

⁷ See Human Fertilisation and Embryology Authority homepage at <http://www.hfea.gov.uk/> Home.

The child-father relationship in DI family

I hypothesize that the secrecy surrounding DI causes tension among family members as evidenced by my interview survey of Ob/GYNs. Interviewees conducting DI described the conflict among the mother, father and their DI child which occurred when the child reached adolescence. In addition, one couple who had used DI, said, "We keep this a supreme secret in our family, especially from our child; we intend to take this secret to our grave" (Tsuge 1999).

Golombok compared DI children-father relationships to those in adoptive families, IVF-families, or natural conception families in Sweden. She found that DI parents, like IVF parents, showed greater warmth toward their children, were more emotionally involved with them, and interacted with them more on a day-to-day basis than the comparison group of natural conception parents (Golombok 2002).

Golombok also offers the following for discussion.

DI mothers showed higher levels of expressive warmth toward their children, possibly because of DI mothers compensating for the imbalance in genetic relatedness. The strong desire to give birth to their own biological children may be associated with their high involvement in parenting when they eventually become mothers. In contrast to mothers, DI fathers were less likely to become involved in serious disputes with their children and, when conflict did occur, they considered themselves less likely to reason

with them.

She explained the reason as follows: Although the possibility that DI fathers are more detached from their children cannot be ruled out, an alternative explanation is that these relatively harmonious families are characterized by fewer and less severe disputes requiring fathers to use reasoning less. The motivation of DI fathers to have children may explain their high involvement in parenting despite the absence of a genetic bond with their child.

This result was obtained from the families with 6-year-old and 12-year-old DI offspring.

As described earlier, adolescence is the period in which children need to decide upon their future life course. Thus more follow-up studies are needed before any firm conclusions can be drawn.

Hewitt (2001) pointed out that according to the results of her questionnaire sheet survey of DI offspring, "the social stigma attached to male infertility has led to the deception of most donor offspring about their true biological parentage". She also added her reasoning that the deception ensures the social father's "masculinity" remains unthreatened but at the expense of the foundation of trust in the parent-child relationships. She quotes from a respondent, "I felt incredible regret that that my father felt afraid to share this information with me. We could have had a very close relationship if he had not been ashamed of his infertility" (Hewitt 2001).

Between these two surveys, we can see the different conclusion by different points of view, from parents' point of views and

children's point of views in DI family.

Because the father-child relationship is linked to the many DI issues, the reason for choosing DI and what couples think after having children should be more thoroughly surveyed. We need to know actual relationship of DI clients and families.

The issue of identity for DI offspring

I would like to show some discourses as the reasons why DI offspring want to know the biological origin.

Hewitt focuses on the identity of DI offspring in her survey. The report which is formed by her survey to DI offspring is entitled as "Missing Link." She described, "Whether donor offspring have felt like a piece of their identity is missing, participants indicated that over 60% had." The frequency of feeling an incomplete identity occurred among only 10% of the participants who chose "rarely" over the possible answers of frequently, occasionally, or rarely (Hewitt 2001).

Cordray who were born in DI and has considered about DI issues from the DI offspring point of views, and wrote about identity of DI offspring as follows:

"Identity is an evolving composite of several factors beyond genes. Neither nature nor nurture is the main essence of identity. Although parental nurture is critical, the influences of teachers, childhoods peers, popular culture and our own ability to reason and create have all played a role in our identity. However, geneticists now claim that

certain genes determine how we respond to environment in ways previously unknown. We are not predetermined to react in a certain way but we are also not complete masters of our fate. However, we are still incomplete without full knowledge of our roots." (Cordray 2003)

The suffering of DI offspring on their identity is emerged socially and culturally on behalf of using a "new" technology. We have to go for better ways to the problem as soon as possible.

Conclusion

Both the Special Committee's Report and ART Committee's Report show a definite belief that indicates its firm belief that having a child is essential to a couple's happiness. However, public comments actually raised several criticisms of this attitude.

Thus, I would like to raise the following question.

Why do couples feel that remaining infertile is intolerable? Most importantly, what do those advocates of infertility treatment consider to be the reasons for an infertile couple's suffering?

The results of my interview research with women who underwent infertility treatment show that the women "suffer from infertility" for manifold reasons which I categorized into the following six (Tsuge 2000):

1. Under the ideologies of "patriarchy" and "motherhood," infertile women or couples are considered deviants.
2. Women lose self-esteem as wives falls

due to their inability to fully express "affection" essential to child-and-parent and husband-and-wife relationships.

3. The inability to "conceive" is perceived as a gender identity crisis among women.

4. Infertility is understood as deviancy (hence, "abnormality") from normalcy because of the absence of the ability of reproduction is innately endowed with.

5. Infertile treatments alienate people from their bodies.

6. Women are expected to keep enduring the discomforts of infertility treatment in accordance with the ideology to the effect that "wishes come true if you keep trying" which women are said tacitly embrace. That understood, what then is infertility treatment?

Infertility can be traumatizing or stigmatizing, especially for males diagnosed with an infertility problem. However, influenced by the misleading belief shared by women themselves and others that it is a women's role to give birth to a child, it is strongly felt by far more many women.

Among those who have tolerated pain and challenged many times spending a considerable amount of time in spite of low success rates, and finally succeeded in having a child by artificial insemination, in-vitro fertilization, or micro insemination, not a few keep their story behind the delivery of their child to the child born and to people around them.

In an earlier paper, I point out that in the process of medicalizing infertility, doctors emphasize that infertility is an "illness" based on my interviews with obstetricians

and gynecologists (Tsuge 1999). It is not the case that doctors are ignorant of the cultural and social implication of infertility. Some, in fact, claim that "infertility is a social illness." Yet these doctors perceive their role is to offer physical treatments in order to treat "illnesses." They argue that the act of solving the problem with technology is for the benefit of patients and that non-medical solutions are not "part of their role."

Medicine is required to "treat" bodies which deviate from normalcy. Everywhere there abound cultural devices which represent the model of "natural bodies⁸." For women, an example would be the measurement and recording of basal body temperatures and menstrual cycles by women themselves; imaging of organs such as the oviduct and the uterus using ultrasonic tomography, or MRI; and measurement of hormone levels.

For men, devices include sperm counts

⁸ The term "natural bodies" carries many connotations as suggested in the analysis presented by Margaret Lock. Reviewing the changing view on the female body, "The medicalized body, therefore, is not only the product of changing medical knowledge and practice, but is at the same time a manifestation of potent, never settled, particularly disguised political contests that contribute to the way in which the female body is 'seen' and interpreted." (Lock, 1993: 331) She draws her analysis on what Donna Haraway's has suggested: "In the late twentieth century the universalized body remains the gold standard of hegemonic social discourse. As a gold *standard*, the natural body is inescapably figured as a convention, i.e., a construction" (Haraway 1989: 355).

per milliliter of semen, sperm motility, and the percentage of deformed sperm. All these can make infertile people realize ever more strongly how “abnormal” their bodies are and slowly alienate them from their own bodies. Here the configuration comes into view in which people confirm that the deviancy of their own bodies from “natural bodies” through medicine and for this very reason they come to seek “infertility treatment” earnestly.

If couples cannot conceive a child after a continued period of infertility treatment, how can they solve the problem? In such cases, there are two choices: either to abandon efforts to become parents, or to consider adoption. Both are hard to accept for modern Japanese. Yet, otherwise they have to continue infertility treatment; there is no other option. That’s the reason why advanced medical technologies are introducing.

Those who failed to conceive continue to explore childless life that they had never imagined before, while reflecting on what infertility means to their life. Some view the matter from the opposite and arrive at the idea that a childless life can also be happy and that the present self-esteem could not have been retained otherwise. With this approach, they confirm that they are irreplaceable beings in society.

It is certainly true that there are those who wish to have a child and choose to receive infertility treatment for this purpose. However, so far medicine and society have provided few alternatives to choose from. What is needed is a society where the value

of human beings is not dependent on their ability to procreate and where all people can accept their own self, not a society where the only solution given is to procreate. The “ethics” currently indispensable to reproductive technologies as of prime importance is to use medical technology by making sure that it does not limit a society’s flexibility and diversity.

Cordray points out the duty of the society toward DI technologies: “...the DI profession has a moral duty to do what is good for all the stakeholders. Society has the duty to restrict this action in order to honor the dignity of all the stakeholders” (Cordray 2003).

I think his points are indisputable with regard to DI offspring. However, does a society which denies DI parents, donors, and their offspring for their lifelong would bring bright world? Or is it really possible to respect individual rights to “coital reproduction” while stringently regulating, “non coital reproduction” and its attendant privacy rights issues? Surely society already controls reproduction culturally, politically, economically.

The most important argument is not how we control the non-coital reproduction but how we can safeguard our rights to reproduce? However, the most difficult conflicts to resolve are those cases arising over the rights of parents and their children. The biggest problem of all may be that neither of the committee reports indicate an understanding of this dilemma.

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References

- Ando, Kakuichi 1960 "*Jinko jusei no Jisshi jotai*" (The Present Performance of Artificial Insemination), in *Jinko jusei no Sho mondai: Sono Jittai to Hoteki Sokumen* (Issues in Artificial Insemination: The Present Condition and its Legal Aspects) edited by Ryuichi Koike, Minoru Tanaka, and Yasuko Hitomi, Hogaku Kenkyu-kai, Keio University, 9-24, Tokyo.
- Codray, Bill 2003 The Best Interests of the Adult Conceived by Donor Insemination, Paper for the Panel Presentation at the Joint Conference of The American Society of Bioethics and Humanities and The Canadian Bioethics Society, Montreal, Quebec.
- Golombok, S., MacCallum, F., Goodman, E., and Rutter, M. 2002 Families with Children Conceived by Donor Insemination: A Follow Up at Age Twelve, *Child Development*, vol. 73, 3, pp.952-968.
- Gottlieb, C., Lalos, O. and Lindblad, F. 2000 "Disclosure of Donor Insemination to the Child: The impact of Swedish Legislation on Couples' Attitudes," *Human Reproduction*, vol. 15, 9, pp.2052-2056.
- Haraway, Donna 1989 *Primate Visions: Gender, Race, and Nature in the World of Modern Science*, Routledge, New York, U.S.A.
- Hewitt, Geraldine 2001 *Missing Links: Exploration into the Identity Issues of People Conceived via Donor Insemination*, Personal Interest Project Completed for Higher School Certificate in New South Wales, Australia, Society & Culture.
- Iizuka, Rihachi 1972 *Jinko jusei no Rinsho* (The Clinical Application of Artificial Insemination), Tokyo: Kanehara Shuppan.
- Japan Society of Obstetrics and Gynecology 2003 *Heisei 13/14 Nendo Rinri Inkai Touroku Chyosa Shou Inkai Houkoku* (Annual Reports of Subcommittee on Registration and Survey in Ethics Committee in 2001 and 2002, http://www.hjsog.or.jp/kaain/html/Rinri/Rinri_report5510.pdf).
- Kuji, Naoaki et.al, 2000 *Hihaiguusha-kan Jinko-Jusei niyori Kyoji ni itatta Dansei Funin Kanja no Ishiki Chosa* (A Survey of Attitudes Toward Men who Had a Child by AID), *Japanese Journal of Fertility and Sterility*, vol.45, 3, pp.219-225.
- Lorbach, Caroline 2003 *Experiences of Donor Conception: Parents, Offspring and Donors through the Years*, Jessica Kingsley Publishers, London, UK.
- Lock, Margaret 1993 "The Politics of Mid-Life and Menopause: Ideologies for the Second Sex in North America and Japan." In *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, edited by Shirley Lindenbaum and Margaret Lock, 330-363, Berkeley: University of California Press, U.S.A.
- Nezu, Yahiyo 2002 "*Nihon no Seishoku Iryo no Genjitsu to Arubeki Sugata: Gentai shujutsu, Higushakan Taigai jusei, Dairi shussan wo Furikaette.*" (The Reality of Reproductive Medicine and its Ideals in Japan: Reflection on Pregnancy Reduction, Artificial Insemination by Donor, and Surrogacy), *Sanfujinka no Sekai* (The World of Obstetrics and Gynecology), vol. 54, 1, 37-46, Igaku no Sekaisha, Tokyo, Japan.
- Noble, Elizabeth 1988 *Having Your Baby by Donor Insemination: A Complete Resource Guide*, Houghton Mifflin Company, Boston, USA.
- Oke, Kay ed. 1999 *Taking Charge of Your Infertility*, Melbourne IVF, Melbourne, Australia.
- Shimizu, Kiyomi 2004 "Survey on the Disclosure of Birth Background to Children by

Mothers who Resorted to Artificial Insemination with Donor Sperm,” in *Proceedings of Workshop for Junior Scholars; Rethinking Science and Medicine from the Perspective of Gender in the Post-Human Genome Project Era*, Frontiers of Gender Studies, The 21st Century COE Program at Ochanomizu University, Tokyo, Japan.

The Special Committee on Medical Technology for Reproductive Treatment 2000 “Report on Ideal Reproductive Treatment Using Donor Sperm, Eggs, and Embryos,” Japanese: <http://www.mhlw.go.jp/shingi/kouseika.html#kousei-kagaku>, English summary: <http://www.mhlw.go.jp/english/wp/other/councils/00>

The Subcommittee on Assisted Reproductive Technology 2003 “Report on Development of the System for Assisted Reproductive Technology with Donation of Sperm, Eggs, and Embryos,” <http://www.mhlw.go.jp/shingi/2003/04/s0428-5.html>

Tsuge, Azumi 1999 *Bunka-toshiteno Seishoku Gijutsu; Funinchiryō-ni tazusawaru Sanhujinkai-no Katari* (Reproductive Technology as Culture: Narratives of Japanese Gynecologists Regarding Infertility Treatment), Shorai-sha, Kyoto, Japan.

Tsuge, Azumi 2000 “*Seishokugijutsu to Josei no Shitai no Aida*,” (Rethinking New Reproductive Technology and Woman’s ‘Natural Body’), *Shisou* (Thought), vol.908, Feb. 2000 (Special Volume on Politics of Biosphere: Life, Body, Social Sphere), 181-198, Iwanami Shoten, Tokyo, Japan.