Belgian Advisory Committee on Bioethics

Opinion No. 27 of 8 June 2004 on sperm and oocyte donation

Initiative submitted on 13 July 1998
for the purposes of analysing ethical issues relating to assisted reproduction

Request for an opinion of 16 November 1998
from Mr M. Colla, Minister For Public Health and Pensions,
on "ethical issues relating to reproductive medicine", and more especially points 4 to 6 of this question (see introduction below)

Content of the opinion

Introduction

This opinion supplements two opinions previously adopted by the Committee on assisted reproduction, namely Opinion No. 6 of 8 June 1998 on the ethical bases for optimisation of the services offered by and operating criteria governing in-vitro fertilisation centres, and Opinion No. 19 of 14 October 2002 on the use of frozen embryos.
This opinion focuses more especially on certain questions raised on 16 November 1998 by Mr M. COLLA, Minister for Public Health and Pensions, namely:

"4. With the advent of artificial insemination and in-vitro fertilisation procedures the notion of 'surrogate mother' appeared. This new concept referring to the woman who bears a child wished for by others, is currently not governed in Belgium by any overall rules and regulations.
Should there be a set of regulations, and if so how should these be envisaged?

5. In reproductive medicine, use is made of sperm, oocyte and embryo donation. Are these three forms of donation comparable? In other words, should they be regulated in the same way?
Are there situations in which such donations should be disapproved of?
Should donor anonymity be preserved in all cases?
Is a central sperm, oocyte and embryo 'bank' needed in order to guarantee a wider selection base for donors?

6. Recently a woman was fertilised with the sperm of her deceased husband.
Is this ethically acceptable? And if so, under what conditions?"

The specific questions posed by Minister Colla implicitly raise others. This is why the Advisory Committee on Bioethics has chosen to extend its opinion to all the ethical and legal aspects of gamete donation procedures.
On account of the very different inconveniences and physical risks involved in the donation of oocytes, on the one hand, and the donation of sperm, on the other, and also due to the differences that emerge between relations of maternity and paternity, the opinion will deal with these two types of donation separately. The issue of embryo donations, that of surrogate mothers and that of insemination using the sperm of a deceased partner will not be dealt with here, but will be the subject of separate opinions. Each chapter will first describe the current practices and formulate an ethical assessment. A final chapter will summarise the opinion and present the Committee's recommendations.

I. THE CURRENT LEGAL FRAMEWORK

1. The situation of the centres for assisted reproduction in Belgium

Assisted reproduction is not regulated as such in Belgium, contrary to the situation existing in other countries. The use of assisted reproductive technology raises a number of questions to which we propose answers in the chapter containing legal recommendations.

Nonetheless medical practice is subject to procedural regulations offering guarantees of quality.
On the one hand, the federal legislation of 1999 adopted in the framework of the "reproductive medicine" care programme lays down standards for approval of hospitals authorised to carry out assisted reproduction. The actual approval of these hospitals falls under the remit of the communities[1].
On the other hand, self-regulation is developing within the medical community itself through the professional code of ethics of the "Orde van Geneesheren-Ordre des Médecins"

This situation is such as to accord considerable autonomy to the different centres in the respect of each person's philosophical convictions. Therefore the varied range of services offered by hospitals in practice makes it possible, in the absence of any legal prohibition, for all applicants to gain access to assisted reproduction: married and unmarried couples, heterosexuals and homosexuals, Belgian and foreign single women.

Access to assisted reproduction, which used to be restricted on account of the high cost of resorting to this technique, has been facilitated since provision was made for a reimbursement of in-vitro fertilisation laboratory procedures by the Ministry of Health under the Royal Decree of 1 July 2003. However, neither sperm donations nor oocyte donations are reimbursed. Moreover, neither women who donate their oocytes nor the doctors who remove them have legal protection for these practices.

2. Assisted reproduction and the law on persons: subjective rights of persons in respect of the human body and parts of the human body: the "rights in view of one's status as a person"

Alongside the legal protection of the human body in the framework of Human Rights enshrined, in particular, in the Constitution, it is worth mentioning, within private law and more especially within the law on persons, the "rights in view of one's status as a person" which aim to guarantee legal protection of the physical, psychological and moral elements that make up a person: the human body and its parts, privacy, the name and image of the person, and his/her voice, honour and good reputation.
The legal protection provided by this category of laws serves both to prevent and punish attacks on an element of the person (e.g. making use of another person's body

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[1] In 1994, the French Community transferred the exercising of this competency to the Walloon Region and French Community Commission of the Brussels-Capital Region.

or parts of that body) and to control the use of elements of the person for specific ends (e.g. organ and tissue donations).

Characteristics of rights in view of one's status as a person

Rights in view of one's status as a person are *universal*: they belong to each person on account of his or her status as a human being. They are *absolute*, not in the sense of them being unrestricted, but because they can be used against any other person (*erga omnes*).

Rights in view of one's status as a person are also *inalienable*. The legal concept of 'disposal' indicates the specific right of the owner, not only to use and render cost effective (e.g. by renting out) the things that belong to him, but also to alter them, give them a different use and finally to destroy them or dispose of them (e.g. by selling them). The 'inalienability' of rights in view of one's status as a person is thus understood as meaning that these rights are on a par with "things that are not for retail, and may therefore not be the subject of any transactions" (Article 1128 of the Civil Law). In the second half of the twentieth century, the inalienable nature of the human body came under attack under the influence of the development of biotechnologies, the fragmentation of the human body and the possibilities of using elements of the body for scientific research and therapeutic purposes.

Up until the Second World War, the subjective rights of the person as regards his body and parts of his body aroused scant interest in the legal world. In the second half of the last century, on the other hand, national and international law paid more attention to the human body. It was in the wake of the sadly famous experiments on human beings carried out in the Nazi concentration camps in Germany, most notably, that an appropriate protection of the person based on 'human dignity' appeared, enshrined in numerous national and international texts[2]. The right to integrity of the body and the right to physical immunity[3] are a response to the fear that *others* might determine what would be done to our body.

Growing concern for autonomy as regards one's own body

In the same period, people became more aware of their autonomy, and their right also to make decisions about their own body. It follows on from this that people began to treat their bodies with greater freedom and wished to take their own decisions (self-determination) regarding family planning, contraception, termination of pregnancy, dying with dignity, and the request for euthanasia. Simultaneously the notion grew that the human body is not inalienable without further ado: the person may make arrangements determining that parts of his or her body shall be used for therapeutic reasons and for scientific research. Since these arrangements call for the intervention of a medical expert, this determination on the part of the person in question regarding

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[2] *At international level*:

European Convention of Human Rights (Articles 3 and 8: the right to integrity of the body; Article 4: the right to physical immunity); Universal Declaration of Human Rights (1948), Article 22; Convention of Rights of the Child (1989), Article 39; Title, Preamble and Article 1 of the European Convention for Bio-medicine; Preamble of the international conventions on the civil and public rights of citizens, also as regards economic, social and cultural rights (these two conventions dating from 1966).

On national level: see in particular the Constitution, Article 23; the law of 22 August 2002 on Patients' Rights, Article 5.

[3] European Convention of Human Rights, Article 3: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment" and Article 8: "1. Everyone has the right to respect for his private and family life". In Belgium: law of 22 August 2002 on Patients' Rights, Article 5.

the use to which his body will be put necessarily involves him freely giving his informed consent[4]. This requirement is given international legal recognition[5]. In Belgium, this was recently established by Article 8 of the law on Patients' Rights. Moreover, the person may also make parts of his body available for altruistic reasons, to save the life or health of other people, in the form of donations (see the law of 13 June 1986 on organ removal and transplantation). The possibility of making one's body available for commercial ends is still prohibited in Belgium[6]. Article 5, 3 of the law of 11 May 2003 on *in vitro* embryo research explicitly forbids "the use of embryos, gametes and embryonic stem cells for commercial ends", as does the aforementioned law of 13 June 1986.

3. Assisted reproduction and the right of filiation

3.1. On legal paternity

3.1.1. Within a married couple

- Artificial insemination and IVF with embryo transfer do not involve any difficulty legally speaking if they are carried out using the husband's sperm: legal filiation coincides exactly with biological filiation in the same way as if the child had been conceived naturally.[7]
- In the event of insemination using a third-party donor (A.I.D), the husband is automatically the father of the child through the effect of legal assumption of paternity.

  The question of ascertaining whether the husband may subsequently be authorised to contest legal paternity by basing himself on the scientific proof that he is not the child's biological father is solved by Article 318, §4 of the Civil Code which states that "*the petition (contesting paternity) is inadmissible if the husband agreed to artificial insemination or to an act aimed at reproduction, except if the child's conception cannot be the consequence thereof*".

  However, the law does not stipulate the form in which this consent should be given, or the way in which each of the partners may claim the proof thereof.

3.1.2. Within a common-law couple

- In the case of artificial insemination and IVF with embryo transfer from the common-law husband to his common-law wife, recognition of paternity is

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[4] The question of knowing whether this agreement can include restrictions (in terms of preference or exclusivity in view of certain groups or situations) remains open in the current legal framework.

[5] See Charter of the Patient Hospital User (Article 3,4,5), approved at the 20th plenary meeting of the EEC in Luxembourg in May 1979; Declaration on the Promotion of Patients' Rights in Europe (Amsterdam, 1994), Articles 3.1 to 3.10, approved by the WHO's Regional European Office; European Convention of Human Rights and Biomedicine (1996), Articles 5 to 9; Directive 2001/20/EC of 4 April 2001 on the application of good clinical practices in the conducting of clinical trials on medicines for human use, Articles 3 to 5.

[6], The question of the legality (or otherwise) of the commercialisation of the body in the framework of prostitution is not considered in this opinion.

[7] This scenario is mentioned for the sake of completeness from the legal point of view. However, it should be realised that in terms of assisted reproduction medicine, we only talk of insemination with donation in the hypothesis of a third party intervening who is not one of the originators of the parental plan.

subject to the prior consent of the mother and/or the child[8]. In the event of refusal, the man wanting to recognise the child may appeal in order to obtain from the court the right to recognise him by proving that he is the child's father.

- In the case of insemination using a third-party donor (A.I.D) within a common-law couple, various difficulties may arise regarding the establishment or contesting of the common-law husband's paternity, difficulties that may lead to discrimination vis-à-vis the child.

a. In the event of the mother's and/or child's refusal to consent to recognition by the common-law husband who wants to recognise the child conceived with the gametes of a third person, this common-law husband will not be able to prove that he is the father of the child and, with the legislation as its stands at the moment, his application could be rejected even if the two parties agreed to the A.I.D. In this case, no paternal filiation would be established.
b. If the common-law husband refuses to recognise the child conceived despite his agreement to A.I.D., it will be up to the mother to prove that her common-law husband behaved as the father of the child to be born during the prenatal period in order to legally establish his paternity, in the absence of which the child will be without paternal filiation.
c. If the common-law husband himself is married to a woman other than the mother, the deed of recognition must be approved by the court[9] and the wife may oppose the approval by proving that her husband is not the father of the child. In this situation, the child will not have any paternal filiation either.
d. If a common-law wife who gives birth by means of A.I.D. is herself married, the child's father is presumed to be the common-law wife's husband. Recognition of the child by the common-law husband may only occur in specific conditions where a legal separation of the couple is under way, if divorce has been pronounced, or in the case of a dissolution or annulment of the mother's marriage[10].

Finally, the Committee points out that in the case of a child born by means of A.I.D. within a common-law couple, there is no text comparable to Article 318, §4 of the Civil Code prohibiting the common-law husband to contest his paternity when he has agreed to artificial insemination or to an act aimed at reproduction.

3.1.3. Within a female couple or in the case of a single woman

As regards the establishment of paternal filiation of a child born by means of A.I.D. to a single woman or within a female couple, no recognition of paternity may occur without the consent of the mother and/or the child[11].

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[8] Article 319, §2 and 3 of the Civil Code and jurisprudence of the Court of Arbitration. Several private bills have also been tabled, amending Article 319, §3 and 4 of the Civil Code.

[9] Article 319b of the Civil Code.

[10] Article 320 of the Civil Code.

[11] Article 319 of the Civil Code.

3.1.4. Absence of legal obstacle to the establishment of the donor's filiation

It should be pointed out that in the current legislation, no legal provision opposes the establishment of the sperm donor's paternity if the latter's identity were to be revealed and the child had no established paternal filiation or the legal conditions were fulfilled for his paternal filiation to be able to be contested. We shall come back to this later, in the chapter presenting recommendations.

3.2. On legal maternity

In the case of the donation of oocytes, the establishment of legal maternity does not pose any problem in principle, regardless of whether the donor is known or anonymous, since the legal mother is the woman who gives birth to the child (Article 312 of the Civil Code). However, in theory at least, an action contesting the maternity could be bought by the child or the biological mother. However, this action will be opposed by a demurrer if there are facts in proof in conformity with the birth certificate[12].

4. Secrecy regarding the means of conception. Donor anonymity

The anonymity of the anonymous donor, which is applied in all the centres for assisted reproduction, is guaranteed by Article 458 of the Criminal Code: the doctor who has responsibility for keeping and supplying gametes is obliged to maintain professional secrecy vis-à-vis third parties. The parents may not reveal to their children the way in which they were conceived. However, application of the provisions of the law on Patients' Rights, in terms of the child's right of access to his own medical records or those of his deceased mother, risks divulging the secret about the way he was conceived and any information on the donor. To the extent that the law establishes that the doctor is obliged to refuse access to the records in order to protect the privacy of third parties, the question is raised as to whether he should respect the wishes of the deceased mother and/or hide any information on the donor. These latter points will be discussed below.

5. International texts

1. Article 8 of the European Convention on Human Rights which forms part of Belgian substantive law and stipulates that "*everyone has the right to respect for his private and family life"* has been invoked several times before the European Court of Human Rights in *contexts alien to assisted reproduction* to justify the right of a child to find out about his origins and to establish his double filiation. Nevertheless, some feel that the refusal to allow the child to discover his biological origins does not constitute interference in someone's privacy and that if there was such interference, this would be justified in

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[12] "Facts in proof" constitute proof of filiation by assumption when the following conditions are met: the child bears the name of the person from whom it is said he descends; this person has treated him as his (in particular by providing for his maintenance and education); and he is considered as such by the family and by society.

paragraph 2 of Article 8 of the Convention, provided this interference "*is in accordance with the law*" and is "*necessary for ... the protection of the rights and freedoms of others*", a balance having to be found between the child's rights and the third person's rights.

2. Article 7 of the United Nations Convention on the Rights of the Child which recognises that every child has "*as far as possible, the right to know and be cared for by his or her parents*" and Article 8 of the same convention which establishes the obligation for the State to protect and, if necessary, re-establish the fundamental aspects of the child's identity. However, these texts do not seem to provide a solution to the problems concerning assisted reproduction since the term "*as far as possible*" leaves States a margin of judgement, and because the term "parents" is not defined from the point of view of the new techniques of assisted reproduction. Some feel that the term "*parents*"·refers to the biological parents, whilst others feel that it can only refer to the socioeducational parents.

II. SPERM DONATION

A. Current clinical procedures

1. Indications for and accessibility of sperm donation

At the moment, sperm donations are carried out in the following situations: to overcome male infertility in a heterosexual couple, to replace the partner's sperm if he is carrier of serious hereditary diseases, to overcome certain immunological incompatibilities responsible for repeated miscarriages and deaths *in utero*, to enable a woman living in a homosexual couple to procreate without having relations with a man, and finally to enable a single woman to procreate without having relations with a man. It should be noted that the number of heterosexual couples in need of donor sperm for reasons of male infertility is now small since the availability of intra-cytoplasmic sperm injection (ICSI[13]). Consequently, the proportion of female couples has increased substantially within the group of recipients.

In Belgium, no law forbids sperm donation. The fertility centres themselves define the forms of donations that they agree or refuse to carry out. The differences between centres depend on philosophical and psychological options that these centres may take as regards the ethical legitimacy of the donations. All the centres offer candidate recipients psychological counselling in order to be sure of the free consent of the partners in the couple, and the stability of their reasons, as well as those of a single woman. Other countries apply varying standards. In France, for example, the law reserves artificial insemination with donor sperm for heterosexual couples, whilst the United Kingdom, Spain and the Netherlands accept A.I.D. among female couples and single women. The result of this is that many French women have themselves inseminated outside France.

2. Sperm banks

In Belgium, sperm banks have developed spontaneously to meet the needs of the infertility treatment centres. If *in vitro* fertilisation treatment is involved, the services must meet strict and monitored criteria (Royal Decree of 15/02/1999). When artificial insemination *in vivo* is involved[14], any gynaecology department is able to carry it out, and may therefore establish a sperm bank. It therefore currently proves to be impossible to register the number of these. Whilst these banks are not subject to specific rules, they do strictly adhere to the rules of "good medical practice" and the "guidelines for gamete donation in Europe". Apart from these criteria, we do not know any other criteria that the banks use to select donors.

In Belgium, sperm banks usually accept insemination in 10 families per donor. Indeed, some couples ask for the intervention of the same donor for the child or children they wish to bring into the world after an initial successful donation. In the Netherlands, 25 births per family are accepted. According to the scientific data, these figures imply a risk of consanguinity that is substantially lower than the risk of accidental consanguinity in the population.

In France, sperm banks are regulated. They are subject to a central body (CECOS), which controls the recruitment of donors and the use to be made of the donations. Donors are only accepted in France if they are already married or living in a stable relationship with a partner, and have children. This rule does not apply in Belgium.

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[13] In some cases of male infertility, a single spermatozoon is injected into the oocyte in the laboratory.

[14] Artificial fertilisation *in vivo* consists in inserting the spermatozoa into the vagina without using *in vitro* fertilisation techniques.

When the donor lives with a partner, he is urged to ask for the latter's agreement, but the reality of this agreement is not verified by a written document, as it is in France.

Sperm banks are experiencing difficulties in recruiting donors, both in our country and in all countries where sperm donation is free, even though a compensatory fee is paid (II.B.2.5). Moreover, the centres' experience shows that the percentage of donors whose sperm is of good enough quality to be used is declining.

It is difficult to gain a clear idea of the reasons why people donate sperm when they are not paid for it, since these vary considerably. Solidarity with other men and the desire to help them certainly exists. We also find the desire to have a symbolic fatherhood and, sometimes, the wish to compensate for certain psychological traumas. Amongst many men, however, the reluctance to have children whom they will know nothing about and sometimes the fear of inadequate legal protection, as is currently the case (see I.3.1.4), clash with their desire to donate.

Finally, for medical reasons (tracing the donor in the event of a disease of genetic origin in the child, for example), a register of donors and recipients of donations is held by each sperm bank. The precautionary measures guaranteeing confidentiality of these registers may vary from one centre to another.

3. Secrecy vis-à-vis the child

Generally speaking, it is felt that her only the parents or the woman bringing up the child have the right to reveal to him the artificial insemination procedure by means of which he was conceived, or to choose not to do so. Obviously in female couples or in the case of a single woman, any secret will not relate only to the procedure, artificial or not, by which conception took place. Experience shows that the very great majority of heterosexual couples in fact opt for secrecy. The reason most often cited is the wish to maintain the image of a normal family in the child's eyes, and to avoid him having to deal with questions about his origins. Other more complex aspects no doubt come into play in certain cases, such as the desire to avoid revealing male sterility, and the fact that a sperm donation is still tainted with the perceived meaning of "adultery under medical supervision" which is not easily assimilated for all couples. Paradoxically, many couples feel that the desire to keep the means of conception secret from the child does not imply that this information should also be kept secret from other members of the family or friends, which may lead to the secret being accidentally revealed at some later stage.

4. Donor anonymity

In Belgium, the common practice seems to be to maintain the donor's anonymity. The primary objective of this option is to protect donors from any subsequent claim on the part of the recipients or the children born of their donation. Secondly, donor anonymity also meets the wish of most of the people or couples receiving the donations, who thereby want to maintain their own privacy and avoid any interference from the donor in the child's upbringing.

The donor in principle renounces in writing all legal rights and duties resulting from use of his gametes for reproduction, and therefore renounces the possibility of finding out who the recipients are. However, in the law as it stands at the moment, it would not be possible to use this renunciation as an argument of defence against the recipients and the child, were the donor's identity to be made known. The recipients sign a similar document, under the terms of which they undertake not to do anything to trace the donor.

Nonetheless, some donors agree or wish to remain identifiable, just as some female recipients wish to know the donor. There are also cases, albeit rare, of recipients calling on the services of a donor they know, who is not necessarily a member of their family. These latter situations are sometimes found in female couples, or among women who have not been able to form a stable relationship and want to have a child before they reach forty. It should be noted that, in these cases, the process of freezing the sperm is still necessary for reasons of medical safety. Moreover, in these situations, the agreement between donor and recipients should be particularly clear and make provision for all the terms and conditions governing relations between the different persons involved.

In France donors are always anonymous. In the Netherlands, a law promulgated on 22 April 2002, due to enter into force in May 2004, establishes an ‘Institute of Artificial Fertilisation Data’. This must keep all the data concerning donors and recipient mothers. Data concerning the donor are quite detailed, including information on his education, level of studies and profession. When a child has reason to doubt his natural origin, he could ask for non-identifying data to be sent to him from the age of 12, and identifying information from the age of 16. The donor may oppose this on valid grounds.

Intra-family sperm donations very rarely occur in our culture. In other cultures, such as in Japan, intergenerational donations from father to son occur more often. The main reasons for these practices are knowledge of the donor, genetic kinship and continuation of the family line. Little is known of the psychosocial dynamics of these cases.

5. Non-identifying information

Non-identifying information is data on the donor that do not enable third persons, and therefore recipients in particular, to discover his identity. In the United States, where gamete donations are the subject of a transaction, a number of sperm banks offer the couple or recipient women a catalogue listing all the available donors. The data provided on them include ethnic origin, colour and type of hair, colour of eyes, skin colour, blood group, size and weight, profession or chosen course of study, areas of interest, hobbies, sports and religious denomination. Detailed profiles are also often provided, tracing the donor’s medical history and describing his personality, together with information on his physique, social position and the education of his parents, grandparents, brothers, sisters and any children. In some cases, a (robot) "photo" of the donor, a text written by him, a tape recording and a video film are available in exchange for a fee. For the latter information, the boundary with identifying data on the donor is extremely nebulous.

In our country, although many parents ask for non-identifying information on the donor, these data are not collected and are not given to them. However, the sperm banks seek to avoid an overly great dissimilarity between donors and heterosexual recipient couples on several parameters: size, colour of eyes and hair, and skin colour.

In exceptional cases couples want - or agree to - a donor of a different ethnic origin than theirs, most often because no donor of the same origin is available. For example, there are hardly any donors of Asian or African origin in Belgium. The choice of a donor of a different ethnic origin than that of the couple is only accepted when no donor of the same ethnic origin is available.

In our country, the donor does not in principle receive any information or exercise any control over the people to whom his donation will go. Neither is he informed of any births that may have taken place from a donation he made. However, some sperm banks explicitly ask the donor for his agreement to his donation also benefiting female couples. Other banks do not request this authorisation.

A number of sperm banks seem to be organised along the lines of blood donations, an analogy that is apparent in the procedural rules. The organisers clearly feel that donors and recipients should adopt the conduct and the type of relations that prevail between donors and recipients in the case of blood donations. This formula does not correspond to the real meaning that donors and recipients give to sperm donation. Indeed, for most of them, the conception of a child has a completely different psychological, social and ethical value.

B. Ethical problems

Some members of the Committee first wish to make a general remark. They stress that in the donation of gametes, and more generally in very many cases of assisted reproduction, we find ourselves before a question of health that is not vital, but which verges more on a "medicine of desire". They do not feel that the "desire to have a child" should be supported "at all costs". In their eyes, public funding in this field should also be examined in relation to the injustices that are carried on in our country and towards developing countries.

In the field of gamete donation, two paradigms emerge which colour the ethical choices in a great many aspects of these practices. This is chiefly applicable for sperm donation, and to a lesser degree for oocyte donation[15].

a) The gamete donor perceived as a "medicine"

In this viewpoint, the donor is assimilated to the corporeal material he offers: he or she is a means of solving the fertility problem facing a couple.
The donor is not taken into consideration as a person, and the donation does not introduce a third person into the family. Selection of the donor is based exclusively on the control of the quality of the genetic material. Attention focuses basically on the family case history, from the point of view of genetic disorders, and on the tests for sexually transmitted diseases. The donor's file must be kept on account of the need to contact him in the event of medical problems occurring in the children. Neither the identity of the donor nor the non-identifying information is relevant in this perspective. The donation comes to an end immediately after having been effected: the donor has no involvement, either with the recipients or with any children born from his donation. Furthermore, neither the recipients nor the children have questions to ask about the donor.

b) The donor as partner and assistant

Here the donor collaborates in solving the problem of infertility experienced by the couple or the woman. His gesture is voluntary and altruistic. Consequently, the donor should have the information necessary to decide whether he or she wants to provide his or her support to the parental plan. Payment is not accepted, only a compensatory fee is the sign of recognition of his gesture. A donation should be received with gratitude, this being manifested by the donor being treated with respect, bearing witness explicitly to the importance of his contribution (both on the part of the team

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[15] G. Pennings, "An ethical analysis of assisted reproduction using donor gametes", PhD dissertation, Free University of Brussels, 1999.

of doctors and nurses and on the part of the recipients), and by the donor being given information on the future of his donation (for example information on the number of children born thanks to his contribution). He must also agree to different aspects of the procedure which make his gesture a real aid to people. This means, *inter alia*, that he must provide accurate information on his health, on himself and his family, and that he must respect the agreements established with the other party. Some recipients regard it as necessary for the donation to come from good people with values. The donor's contribution thus goes beyond the mere provision of corporeal material, for the donor as a person comes into play. Donors and recipients define the forms that their relationship shall have. This relationship often goes hand in hand with the importance that donors and recipients will attach to the (identifying or non-identifying) information that should be passed on to the child. If it appears important for the descendants to have certain information on the donor, the latter should be prepared to communicate it if their donation is to continue to have the meaning of an aid.

These two basic orientations will be re-encountered, in varying degrees, in the solutions proposed to the various ethical problems to be dealt with below. Several of these problems apply equally to sperm donations and to the donation of oocytes. We will therefore not repeat them in the chapter on the latter kind of donation.

1. Ethical questions concerning the family as a sociocultural institution

The use of the gametes of a person who will not subsequently be involved in the child's upbringing raises a number of fundamental questions concerning parentage and the formation of the family. Anthropology shows that no human institution is entirely determined by the biological elements that form its base, but that it is always also a conventional – and partly arbitrary – cultural and social construction. Thus the family has adopted very diverse means of organisation over history and in different societies. However, and in our society among others, the relationship of parentage has generally founded its sociocultural legitimacy on the biological bases of the family. The metaphor of "blood ties" is a good illustration of this.

Furthermore, the institution of the family plays a major role in the constitution of societies. It determines the civil identity of the citizens, as well as the affective and cognitive traditions through which each person will subjectively form the feeling of his identity. The family also continues to play an important role in the handing down of property and the passing on of social roles, even though this function has sharply diminished over the last hundred years.

Faced with novel conception procedures, two ethical questions appear. The first involves ascertaining the degree to which the family's natural biological establishment is necessary for its formation and, therefore, the stability of its functions in the processes of identification and transmission. The second question, a corollary to the first, involves ascertaining whether the legitimacy of the relationship of parentage must be sought by preference in this natural base, or, on the contrary, in the fact of assuming responsibility for a child's upbringing.

Outside the Committee, some members of our society feel, generally for religious reasons, that the natural base of the family is indispensable and should always be respected. For them, the fact of disassociating reproduction from sexuality, for example, raises questions about the function of the family and the meaning of parentage, and jeopardises them. They think that the intervention of a gamete donor constitutes too great a threat for the exclusivity of the relationship linking partners, and for the bonding and procreative dimension of sexuality, which leads those who hold these opinions to reject all recourse to techniques of assisted reproduction.

Without going as far as that, some members of the Committee stress that the intervention of a gamete donor undoubtedly severely tests the relational dimension of sexuality and, therefore, of the couple and the family. However, they are of the view that a couple may, in all conscience and honesty, deem it legitimate to use this technique, but that this decision can only be assimilated if the couple's relationship is extremely stable, and remains as close as possible to the natural relationship. For these members, therefore, the reproduction technique should be reserved for stable heterosexual couples. These members also consider that recourse to this technique is ethically legitimate because it has a therapeutic character, i.e. if there is an infertility problem or a serious genetic problem.

Other members defend a different position. They feel that the family tie is determined by the fact of a person having the intention to bring up the child. In most cases, the genetic parents foster this intention. However, the genetic tie is neither a necessary condition nor a guarantee ensuring the real assumption of responsibility for the family tie. The genetic tie is of secondary importance in relation to the psychosocial tie which is created between an adult (or adults) and a child during the latter's upbringing. Even from society's point of view, it is the quality of this educational tie that counts. The important point is thus the intention and capacity of the person or persons to assume responsibility for the child's upbringing. The choice of living on one's own or with a partner and the sexual orientation of the couple (heterosexual or homosexual) cannot, in their view, offer any definitive answer to this subject, either in a positive or negative sense.

2. Ethical problems concerning the procedures for sperm donation

2.1. Indications for and accessibility of sperm donation

A number of - at times difficult - questions are raised as regards the ethical responsibilities of the various players involved in the donation of sperm: What criteria should the sperm banks and fertilisation centres use in the selection of donors and recipients? What are the rights and duties of the recipients and donors? These questions partly fall within the ambit of respect for ethics as applied in society. Partly, also, they involve the future child's interests and rights and the interests and rights of the future parents who are asking for a donation.

2.1.1. The conditions laid down by the *in vitro* fertilisation centres

Some centres currently only agree to carry out artificial insemination with donor sperm (A.I.D.) for stable heterosexual couples. They feel that certain individual requests do not offer the necessary guarantees for the child's full development on account of the context in which the future parents are living. Some members of Committee regard this stance as legitimate. Other members of the Committee, on the other hand, see some of these exclusions – to the extent that they regularly relate to female couples or single women – as containing a discriminatory stance prohibited by the law, because they concern people's sexual orientation.

Faced with this divergence of opinion in our society, the members of the Committee feel that each centre may determine the group of patients it agrees to take charge of, but that this freedom may not have the effect of systematically excluding certain people from access to assisted reproduction. If such were to be the case (which is not the current situation), the State would have to see to it that centres existed with sufficiently varied choices.

2.1.2. The balance of the recipient couple

In our culture, a number of people experience male infertility as a lack of virility. Even though this assimilation is rationally inaccurate, account must be taken of the possible existence of this idea in certain couples who decide to resort to A.I.D. These people may also feel that the experience and legitimacy of paternity is strongly attached to its natural biological aspect. Thus, to varying degrees from one couple to another, the positions of male partner in the couple and of paternity towards the child may be weakened by the sperm donation procedure. The man may not feel wholly the father and may have difficulties completely assuming his paternal role. A similar difficulty may appear in the child when he is informed of the means of his conception.

The insecurity felt by many women when confronted with the decision to use a donor should not be under-estimated either. Clinical experience shows that they are often reluctant, both in respect of the symbolic “adultery under medical supervision” that a sperm donation may represent, and as regards the fear of their partner having difficulties in the future accepting a child conceived in this way.

These questions need to be taken seriously into account during the counselling prior to a decision to go ahead with A.I.D. by donor, in order for the couple’s consent to be genuinely well informed.

2.1.3. The type of family in relation to the child’s interest

Differences of opinion appear as regards access to A.I.D. for different groups of women: female couples, single women and fertilisation occurring after the father’s death[16]. These differences concern what people see as being necessary to the healthy development of the child, on the one hand, and on the other hand the respective importance they attach to the rights of the parents and those of the children.

For some members, the new possibilities offered by assisted reproduction risk occasioning a slide towards a “medicine of desire” in which the future child’s interests are not sufficiently taken into account. They recall that the child depends wholly, as regards its very existence, on the decision to reproduce taken by the adults begetting it. This asymmetry in the possibility of asserting its interests calls for an especially careful concern on the part of the parents for the good of the child.

Other members, on the other hand, have confidence in people who want to have a child. They insist that parents generally take their decisions with the innermost conviction that they are making the best choice for the child, and all the more so when they have wanted its birth. These members do not see any reasons, a priori, for suspecting the parents’ intentions, or therefore for questioning respect for their autonomy.

Female couples

Two opposing positions here reflect the confrontation between two conceptions of the right of parentage and the conditions necessary for the child’s good development.

Some members of the Committee recall that the right of people to establish a family is a wholly important expression of people’s right to their autonomy, but also of the right to equality, and a conquest of the freedom of persons. They thus claim that the plurality of types of family should be accepted, distinguishing the biological parent,

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[16] This specific point will be covered in a subsequent opinion.

the legal parent and the socioeducational parent, each being able to choose the structure of parentage in which he intends to reproduce, with or without the aid of science. They recall that no human society is wholly determined by biological events and that parentage is in fact afforded its legitimacy through culture.
These members of the Committee add that the reliable existing studies on the development of children brought up by female couples do not show any difference between these children and children brought up by heterosexual couples. Nonetheless, a greater number of more far-reaching studies should be carried out to confirm that in such conditions the child's wellbeing is not jeopardised. Among these members of the Committee, some consider that for children brought up by a single woman or by a female couple, it may be more important one day to be able to refer to the sperm donor. They advocate the establishment of a two-track policy (see below) which would enable single women and female couples to choose a donor who accepts the removal of anonymity.

Other members of the Committee defend a conflicting position. They recall that the distinction between man and woman is a biological constant and that all societies establish two genders on account of the sexual characteristic of the species to which we belong and which enables reproduction. Whilst acknowledging that everyone has the right freely to choose the way they live their sex life, and conceding that homosexual couples are neither more nor less capable than others of bringing up a child, they put the child back at the heart of the debate. In this perspective, they feel that giving homosexual couples the status of parents would amount to denying the importance of the difference of the sexes, which is an essential aspect in the construction of identity. It therefore appears to them to be essential for a child to have two parents who are of a different sex.
More specifically, they fear that the child of a female couple would be stigmatised by society, particularly in his school environment. Those advocating authorised parentage for lesbian couples point out that it is precisely this stigmatisation that has to be combated, and that moreover this is gradually diminishing in our society.

In the face of these divergent opinions, the members of the Committee think that a law prohibiting A.I.D. in female couples should not be promulgated. Such a law would not respect the diversity of opinions existing in our society. It would also risk leading to a kind of "reproduction tourism", as is already observed from France.

For the rest, longer and more far-reaching studies are needed to clarify the matter of the child's real interests.

Single women
Generally speaking, the fertilisation centres have the experience that requests for artificial insemination made by single women are often problematic. The situations and motivation of women living on their own are many and varied. Some of these women foster inordinate expectations regarding the child to be born, a child whose job it may be to give meaning to its mother's life. The lack of an adequate relational network or the existence of ambiguous relations with a partner often lead the centres to refuse to carry out insemination.
Relatively little is known of what has become of children brought up by women who have asked for A.I.D. when living on their own. Some members feel that for its upbringing it is necessary for the child to be faced with two adult educators, in a relationship referred to as "triangular". In the absence thereof, its wishes are opposed,

in the form of a duel, with those of its single educator, without a third position being able to arbitrate in the conflict. The comparison with mothers who bring up their child (or children) on their own following a death or separation, for example, is not very relevant since they did not originally have the intention of taking on this responsibility on their own. In many of these situations, the father is still present, either on account of his maintenance obligations and visiting rights, or, even without that, as an existing figure or one that has existed.
The few known studies (relating to a very small number of cases) do not show any specific difficulties among children brought up by single mothers and conceived by artificial conception.

Some members of the Committee thus feel that it is not ethically responsible to carry out artificial insemination in single women.
Other members, on the other hand, accept it straight away. They are nonetheless of the view that in-depth counselling and a detailed psychological assessment are needed among single women requesting artificial insemination.

2.1.4. Conditions laid down for or by the donor

In addition to meeting various criteria of good health, the donor is requested to present a balanced personality and the abilities required to take a free and well-informed decision. For these reasons, and on account of the specific nature of the donation (contributing to the birth of a child), only people of age are chosen as donors. In the view of some, it is desirable for the donor already to have fathered a child, in order for him to be in a better position to give his informed consent.
A specific ethical question is raised as regards what is termed “*direct donations*”: the decision made by a donor to reserve his donation for a particular category of recipient. Some donors could thus, for example, reserve their donation for heterosexual recipient couples and refuse to have it used for female couples, or the reverse. Two positions are expressed in this respect in the Committee.

Some defend the idea that the donation is a voluntary act on the part of the donor, who should be free to make his choice and lay down his conditions. Indeed, a donor has a right to decide on the use to be made of parts of and products of his body, a corollary of every person’s recognised control over his own body.

Others, on the other hand, feel that the choice by the donor of the use to be made of his donation risks attacking the principle of equality and implies the acceptance of a discriminatory criterion condemned by society. General ethical principles, such as equity and equality, make it possible, for example, to argue that the distinction founded on sexual orientation is inadmissible.

We can note, finally, that *personalised* donations to a woman or a couple are very rare in our culture. We have little data on this subject.

2.1.5. Conditions laid down by recipients

An ethical question is raised as regards the criteria that recipients may demand in the selection of the donor from whose donation their child will be born.
The bulk of recipients want to receive the donation from a person belonging to an ethnic group similar to their own, and the centres respect this request. Indeed, it is felt that this request is not founded on an attitude of discrimination, but is for the good of child in facilitating his adaptation in his family. On the other hand, the deliberate request made by a recipient couple to call upon a donor from an ethnic group other

than their own would risk contravening the principle of equality of all human beings regardless of race, and should not be accepted.

Exceptionally, when no donor from the same ethnic group is accessible, the donation from a donor of a different ethnic group could be accepted.

More generally, the scope of the other information requested by the recipients will be dealt with below in the question of non-identifying information.

2.2. Secrecy towards the child. The child's right to know how he was conceived

The choice of secrecy means that the parents do not inform the child of the fact that his or her conception was obtained by artificial insemination. The question of whether or not to reveal to the child the identity of the donor (anonymity) is different and will be covered in the following section (see 2.4.).

In our society, cultural habits continue more often than not to ascribe "real" fatherhood to its genetic origin. Socioeducational paternity is perceived as carrying less weight and less legitimacy. Experience shows that, for that reason, the large majority of heterosexual parents do not reveal to their child the fact that he or she was born of a sperm donation. They fear the donor as being perceived as replacing the social father and the latter feeling diminished in his role of husband and father. They want to protect the child from psychological and social problems, and thus protect his relationship with his socioeducational father.

The situation as regards maintaining secrecy as to the conception is obviously different for single women and female couples[17]. Indeed, in these cases, the child will necessarily wonder about his origin on the paternal side. The choice then, depending on the wishes of the women in question, is to make reference to a fictitious encounter with a man, or to explain to the child his/her conception by insemination with donor sperm.

2.2.1. Ethical and legal questions

Keeping the way he/she was conceived secret from the child first of all raises legal questions. Opinions on the rights of the child vary appreciably at international level. They are enshrined in various laws on gamete donation, anonymity and the preservation of secrecy. In the international context, reference is often made to Article 7 of the United Nations Convention on the Rights of the Child, which gives the child "as far as possible, the right to know and be cared for by his or her parents", and, in a conflicting sense, to Article 8 of the Convention on the Protection of Human Rights and Fundamental Freedoms of the Council of Europe which guarantees respect for a person's private life. However, the interpretation of these articles is not unequivocal and offers each State the possibility of giving them a different content.

The main divergence of opinion lies in the definition of parentage. Indeed, both the donors of gametes who are the biological parents of the child and those who bring up the child can legitimately be considered as parents. It therefore does not seem reasonable to interpret these texts in the sense of banning parents from keeping the child's real origins secret from him/her. Apart from an unacceptable intrusion of privacy, such a prohibition would imply the right for the child to oblige his/her parents – more often than not the father – to submit to tests aimed at tracing genetic

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[17] The case of male couples does not come into play here, since this involves the intervention of a surrogate mother. This will be dealt with in a subsequent opinion.

paternity, with all the risks this would entail for the peace of the couples and families [18].

An additional legal question has been raised here since the entry into force of the law on patients' rights, authorising any person to request a copy of his or her medical records. The doctor may refuse to hand over these records if he feels that doing so would be contrary to the patient's interests, or would call into question the interests of third parties without their consent. It thus has to be decided whether an artificial insemination forms part of a person's medical records or not, be it the recipient's records or the child's paediatric records. Some members of the Committee who are opposed to secrecy – and are consequently more often than not opposed to donor anonymity – feel that these data should appear in the medical records passed on. On the other hand, the members who advocate the parents' right to keep the form of conception a secret are obviously of the view that this information should not be divulged. In fact, as outlined above, most parents do not tell their children that they were born thanks to an artificial insemination. For these members, data concerning this insemination should therefore not form part of the communicable information of the medical records, under pain of illegitimate intrusion into the parents' private life.

2.2.2. Psychological aspects

Keeping secrecy vis-à-vis the child as regards his or her genetic origins could have consequences for his or her psychological development. Assessments of this risk differ.

Some argue that the existence of a secret in a family or between people who are closely related can harm relations with the child and the latter's development. This idea is based on certain cases of family or psychoanalytic therapy in which it appeared that relational problems, and even sometimes pathological disorders, came from the existence of a secret in the family. This secret led to hesitations and things left unsaid when certain subjects were tackled, creating in the child a feeling of danger, but also unreliability on the part of his or her parents. Due to the very nature of these problems, there are of course no studies permitting a statistical demonstration of the clinical facts.

Moreover, the testimony of people who later learned of their donor origin shows that this can lead them to suffer serious identity crises and can cause a rupture in the relationship of trust between them and their parents. The accidental revelation of the secret is experienced all the more negatively on account of it not having been revealed voluntarily. The psychological trauma for the child intermixes several factors. The first is to cut him off, in part at least, from the historical tie through which he thought he was linked to the continuity of a family. The second concerns the very fact of secrecy: was there something – bad or shameful – to be hidden from him? The third is to alter the bond of trust as regards the truth of what his parents say, a tie underpinning trust in the true nature of their affection. On account of the very personal nature of this kind of situation, there is no valid information on the percentage of children who develop serious problems further to accidentally finding out about the donor origin of their conception.

Others stress, however, that there is no formal evidence at the moment to prove that keeping the means of conception secret has a negative effect on the development of the children concerned, or on relations in the family, when the secret is kept. They also emphasise that it is difficult to determine whether the children born by donor

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[18] We know that blood tests carried out at birth sometimes show an incompatibility with the legal father's blood group.

insemination would also experience problems if they were told of the situation at a young age and then grew up with this information.

Finally, some recall the growing importance of genetics in healthcare and the increasing number of genetic tests. The risk of a person discovering, after a genetic test, that his social father is not his genetic father is becoming greater and greater due to progress in medicine. These tests could therefore threaten the keeping of the secret in the long term.

As can be seen, the arguments are not absolutely decisive either in favour of secrecy or in favour of it being disallowed.

For some, the child's rights, the risks of problems he runs in the event of a by chance revelation of the secret, and the positive value of frankness in the educational ties lead to parents being encouraged to reveal to their child, at a young age, the manner in which he or she was conceived.

For others, the keeping of the secret is a choice that parents make, and signifies their desire to protect family unity and completely exclude any interference from a third party. This choice must be well informed, and parents should therefore be informed during counselling of the problems liable to arise should they decide to keep the secret. However, out of respect for their autonomy, they should be given the freedom of this choice, even if it is felt that a different attitude would be better for the family and the child. As in the framework of genetic counselling, at the end of the day it is up to the parents to decide on the behaviour to adopt vis-à-vis the child to be born.

Summary with regard to secrecy

The members of the Committee feel that there are no sufficiently strong arguments to enforce the removal of secrecy from parents who wish to maintain it. The right that the child can be acknowledged as having to find out the way in which he/she was conceived seems to be less strong than the parents' right to choose the kind of upbringing they want to give their child, and their right to protect their private life. Furthermore, they feel that the legitimacy of parentage is based more strongly on socioeducational parentage than on genetic parentage.

Certain arguments could be cited to qualify this position of the members of the Committee.

The first is that, if the parents should remain masters of the choices they make, the same goes for the medical institution. The latter has a public character and the argument of protection of privacy does not arise for it in the same way. The doctors and nurses do not have the same rights and duties as the parents towards the child whom they help bring into the world. However, it should be recalled here that the doctors and nursing staff are bound by professional secrecy which is of a public order, and indispensable in ensuring the patients' relationship of trust. Violating professional secrecy vis-à-vis applicants for artificial insemination would, for the members of the Committee, have more negative effects than the obligation to reveal to the children the way they were conceived. Apart from a worrying weakening in the public's trust in the reality of professional secrecy, there could be a fear, for example, of applicants for artificial insemination turning to small-scale practices which could imply health risks, or engaging in "reproduction tourism" to countries whose laws afford them better protection.

The second argument, in addition to the importance accorded to children's legal and psychological rights to find out about the way they were conceived, could relate to their future health. It is probable that knowledge of the genetic make-up of diseases will become increasingly important in diagnoses and therapies in the future. We are faced with an uncertainty here. At the moment, it seems that direct genetic analysis using the patient's cells will suffice in most cases, and it will not be necessary to go back to his/her ascendants, but the issue cannot be settled.

The third argument is that other countries, for example the Netherlands, have adopted laws authorising the child, from a certain age, to find out about the way he/she was conceived. These laws themselves, however, remain very qualified. Only children who have reasons to doubt their origin are considered. In this case, the obligation to reveal to the child how he/she was conceived does not rest with the parents or the doctors and nurses, but a legally established third body that has access to the data, but also judges the pertinence of the request. Finally, the distinction is maintained between the right to find out the method of conception, accessible from the age of twelve, and the right to find out the identity of the donor, accessible from the age of sixteen and under stricter conditions.

The members of the Committee are anxious to stress, finally, the importance of the decisions taken by the recipients and the donors. They take these decisions in the current context of the agreements that are offered to them. It would not be admissible for a change in the law modifying these agreements to be applicable to those who have already started a process of insemination on the basis of the current agreements. It is essential that all the players in assisted reproduction take their decisions in full knowledge of the conditions imposed upon them, and with a genuine trust in these.

2.3. *Anonymity*

Anonymity consists in the donor on the one hand, and the recipient and the child, on the other hand, not knowing their respective identities and not having any right to this information. A distinction can be established between strict anonymity and the *identifiable* donor, who remains anonymous for the recipient until the most distant moment in the life of the child, the moment when the latter could find out the identity of this donor. It should be recalled that sperm banks in any case keep a record of the respective names of the donors and recipients in order to be able to trace the origin of any medical accidents that may arise in the conception or development of the child. In the case of anonymity, these registers should be subject to particularly rigorous protection.

Most countries currently guarantee the anonymity of the donor, but we are seeing a clear slide in recent years towards the extension of the possibilities for a removal of donor anonymity.

The position adopted vis-à-vis anonymity is in large part linked to the recognition – or not – of the child's right to find out his genetic origins or filiation. As a rule, rights sanction interests. Acknowledgement of the fact that the child has this right does not automatically imply that he has the right to obtain the identity of his genetic parents in all circumstances. The interests of his parents, the recipients, and those of the donor must also be taken into account. Three attitudes can thus be envisaged. The first does not grant the child the right to find out his origins. The second grants him the right and has this right prevail over those of the other persons involved. And the third compares the child's right with that of the other persons involved and attempts to find a qualified position.

2.3.1. In favour of the maintenance of anonymity

Arguments concerning the interests of the different parties involved are advanced in favour of the maintenance of anonymity.

- Protection of the donor: in theory the donor renounces all legal rights and duties stemming from the use of his gametes during reproduction. Any interference in his private life by the recipients or the child is excluded. Let us recall that in this hypothesis more than in the following ones, the necessary legal provisions should be taken to ensure that this renunciation can be used as evidence against the recipients and the child even if the donor's identity is revealed by accident.
- Protection of the private life of the recipient parents: for those who defend anonymity, the recipient family should have the possibility of developing independently of any interference from a third party, both in their relationship as a couple and in their relations of parentage. In this case, it must also renounce any recourse in respect of the donor. It must be possible for this choice to be definitive. It is therefore important that it be well considered during the pre-decision counselling.

Anonymity modifies the very nature of the donation, which becomes more impersonal and is considered more as biological or genetic material making it possible to solve a problem of sterility in the recipients. The relational dimensions of a donation between humans are minimised as far as possible. Moreover, this position wholly prioritises the educational relationship, in the family and for the child's development, over and above the genetic biological relationship.

- On the child's side, finally, those who are in favour of anonymity feel that there is no consensus on the question of ascertaining whether it is in the child's interest to know his genetic origin. If, coupled with anonymity, the means by which he was conceived is kept secret (see above), the child will consider his social parents to be his genetic parents and it can be supposed that he will not suffer any harm.

2.3.2. In favour of the removal of anonymity

According to these members, the child's right to be given the information on his origin should prevail over the rights of the other interested parties. Certain international rules on rights of the child recommend it, at least if "the right to know his parents" is interpreted as meaning the genetic parents rather than the socioeducational parents. According to this option, the authorities should take measures enabling the child to retrace his genetic origins. In fact, these members feel that knowledge of the genetic origins is necessary for the formation of identity and is essential to be able to know oneself and situate oneself in the social structure. Genetic parentage is thus deemed to prevail over socioeducational parentage.

From a qualitative point of view, the main consequence of the removal of anonymity lies in the possibility of personal contacts being made between the donor, the recipient(s) and the child/children born thanks to the donation. However, an important distinction needs to be made here between the donor identified at the moment of donation, and the *identifiable* donor whose name the child may find out later, if he wishes. In countries where the legislation provides for this possibility, the step may be taken from the age of 16 or 18.

Most of those who are in favour of the removal of anonymity suggest confining themselves to the identifiable donor. This, for example, is the position adopted by the recent Dutch law, which stipulates that, as of May 2004, all donors must be identifiable. In this case, the donor may not have any contact with the child until adolescence. The relationship between parents and child can in this way develop without any interference from the donor, which is what most recipients prefer. It also seems that this is a necessary precautionary rule. Thus, for example, if we refer to certain lawsuits in the Netherlands opposing female couples and their known sperm donors, it seems that the agreements concluded at the beginning regarding the relationship with the child are not always respected.

This option has the advantage of enabling the child to whom the parents have revealed the fact that he was conceived thanks to a sperm donation, one day to consult the donor. For children brought up by a single woman or by a female couple, this possibility seems particularly important: Some members of the Committee stress that in these cases, the child does not have a paternal substitute.

Finally, the removal of anonymity restores the donor's status as a human being and avoids him merely being considered as the supplier of biological material. The supporters of this option thus feel that there is a better respect for the value and dignity of the human partners in the donation.

One possible consequence of the removal of anonymity concerns the reduction in the number of candidate donors, to the point where there may even be a lack of donors. Taking into account the possibility of children going in search of their genetic parent, a proposal consequent to the removal of anonymity aims to limit the number of recipients benefiting from the same identifiable donor (three to five families). This therefore means that more donors would be needed to help the same number of recipients. Moreover, the fact of being identifiable could reduce the number of candidate donors. Those advocating the removal of anonymity feel that such arguments are weak and irrelevant in the face of the ethical and social principles at stake, in their view, in this question.

2.3.3. Mixed position (two-track policy – weighting of interests)

The supporters of this position acknowledge that the child, once of age, has the right to find out about his origins and regard this as a real right that should be respected, but which should be weighted by being balanced against the rights of other parties concerned: the donor's right to the respect for his private life and the parents' right to their autonomy. The recognition of the child's right to the information on his ascendants does not mean that this right surpasses, without weighting, the rights of the other people involved if a conflict were to put them against each other. Thus, the parents' right to keep the way in which he was conceived secret from the child is still recognised as being of priority. Even those countries that accept the removal of donor anonymity upon the child's coming of age (and consequently consider the donor's right to respect for his private life to be subordinated to the child's right) still feel that the parents may, by virtue of their autonomy, decide whether or not to reveal to the child the fact that he was conceived thanks to a donor and thus, a fortiori, the latter's identity.

The two-track policy implies a double choice: the donor can choose to be identifiable or to remain anonymous, and the recipients choose to receive the sperm of an anonymous or an identifiable donor. This system is used in a number of sperm banks in the United States and was applied in the Leiden Fertility Centre until the Dutch law mentioned above was revised. This mixed position creates a system making it possible, in principle, to better respect the rights of all the interested parties, but by creating a hierarchy between their rights. The recipient couple is free to opt to keep the method of conception secret. It can be recalled here that this can also be the case of single women or female couples. Although the parents decide that they will reveal to the child, at a particular time, the fact that he was born thanks to a gamete donation, they are free to choose an identifiable donor or not. This right takes precedence over that of the donor, since it is the recipient couple that chooses whether the donor will be identifiable or not. It takes precedence over the child's right (at least until he comes of age), since the parents choose whether or not to keep the information secret from the child and/or whether to choose an identifiable donor or not. Furthermore, the donor is still free to choose his status, to be identifiable or not. Finally, in some countries, such as the Netherlands, the adolescent child or a child of age still has the possibility of finding out who the donor was if he advances sufficient reasons, and the donor agrees.

Given that, in the framework of this system, the two parties (donor and recipient) in principle make an irreversible choice before fertilisation even takes place, it is essential to ensure that there is good counselling on the potential implications of these choices, especially for the child.

The advantages of this system are as follows:

It offers a range of choices to the parents as regards their plan to have a child. Obliged to choose between a known or anonymous donor, the recipients will reflect better on the choice they make. They will have to adopt a clearer position regarding whether or not to keep the child's origins secret from him. The position of the donor will be subject to greater reflection, both by the donor himself and on the part of the recipient parents. Indeed, currently neither the donor nor the parents really have to envisage the donor's position now and in the long term, since donor anonymity is applied almost automatically by the fertility centres.

This system makes it possible to view the child and his wellbeing by taking into account all the relations within his family, and not by considering him as an isolated individual holding certain rights. In general, it is felt that the child is happy when he is living in a family which has created its own cohesion in the various aspects of its relationships.

The autonomy of the parents and of the donor is respected as far as possible. Indirectly, this respect also implies the acceptance of a moral pluralism as regards the formation and structure of the family: there is no single correct way of forming a "good" family.

The choice between the two possibilities would make it possible gradually to collect objective observations on the effects that anonymity or knowledge of the donor has on relations between the parties and on the child's development.

Finally this system would enable the number of donors to be maintained or even increased. The information available leads us to think that in the event of the obligatory removal of anonymity, the number of donors would be reduced to around 20% of the current number. Now, it is important to maintain a reasonable number of donors. This argument may be considered as relative, but the negative consequences inherent in the observance of a rule must be taken into consideration. If the sperm banks were not able adequately to deal with the requests made by recipients, there would be a risk of the latter resorting to clandestine circuits, or having to go abroad. Aside from the problems of public health and social discrimination that this could lead to, children's rights and protection would not be better respected, since the clandestine circuits do not offer any guarantees.

Among the members of the Committee, we find the three options, in favour of anonymity, in favour of banning anonymity and in favour of the mixed system.

The members of the Committee are keen to add two general recommendations:

- *Regardless of the system adopted as regards anonymity, attempts must be made to ensure that the persons involved in artificial insemination be guaranteed the stability of their choices over time. In such matters, it cannot be accepted for* a posteriori *changes to be made to agreements entered into.*
- *Regardless of the system adopted, including the case of anonymity being lifted, any tie of filiation between the donor and the child should be excluded. This would distort..*

2.4. Non-identifying information

It is recalled that non-identifying information refers to data on the donor which is insufficient for him to be identified by third parties, and therefore by the recipients. This information may be very general: the donor's type of physique, stature, colour or type of hair. It may also embrace details of the donor's personality, such as is applied in the USA: his tastes, life choices, philosophical options, a recording of his voice and even a robot photo.

Several questions are raised here, which have ethical implications.

The myths about the importance of genetic factors

Some couples imagine, under the influence of currently fairly widespread preconceived ideas, that a human being is almost entirely determined by his genes: physically, psychologically, and - if pushed - as regards his philosophical options. This conviction is scientifically incorrect. In the first place, the genetics of the child are determined by those of the two parents, and not solely by those of the gamete donor. Secondly, the educational, physical, psychological and cultural environment will orient the ways in which this genetic potential finds expression. Finally, the idea of strong genetic determinism risks entailing a denial of the role of freedom in human lives. It tends to take away responsibility from the parents as educators, whilst the child finds himself enclosed in a destiny over which he does not exercise any power. Finally, the emphasis placed on genetic filiation runs against the importance accorded to socioeducational filiation in the concept of parentage. The socioeducational importance is precisely what legitimises the recourse to artificial fertilisation in families, and renders this successful. Some members therefore regard it as essential that, in respect of requests for non-identifying information made by the recipients, the counselling take care to dispel this belief in a "genetic whole".

Other members feel that the question of non-identifying information does not have to raise such suspicions. The request for information on the donor may express the very normal desire to form an image of the man who is providing his assistance to the realisation of the desire to have a child. Moreover, it may just as easily occur that the assurance of a conformity of genetic characters plays a role in the choice of a partner among people wishing to reproduce naturally.

The child's position in the face of the parent's wishes

For some members, the desire to receive non-identifying information on the donor could constitute an obstacle to the development of the child's autonomy. The parents' wishes as regards the future of their child motivate their commitment to bring him up and to want the best for him. However, it is equally necessary for the parents to remain open to accepting the original and unexpected aspects that every child will develop. The child's access to his adult autonomy depends on the quality of the welcome given to these unexpected developments. A reasonable limit must therefore be found to the non-identifying information offered on the donor, to the extent that wanting too many details would risk confirming that it is legitimate to desire a "customised" child and to lock the child into a prefabricated image. No doubt no regulation will be able to determine a priori the limits needed to protect the child's "unexpected aspects". However, consultation between sperm banks and gynaecology and obstetrics departments, and the experience of counselling carried out with recipients, may lead to reasonable procedures.

Other members feel that these considerations are completely irrelevant. Disapproval of "the customised child" only aims to show the legitimate desire of recipient women in an unfavourable light. One underestimates the demands made of women asked to be inseminated by a donor about whom they would not be able to know anything. They would be expected to show a blind trust in the doctors and fertility centres. Knowledge of non-identifying information, and the possibility of making choices on the basis of this information is, in the view of these members, one of the improvements in the procedures thanks to which the interested parties, and first and foremost the women, gain more control and power over the whole process. Applied to natural reproduction, the reasoning according to which this information would lead to a “customised child” would lead to the conclusion that people who want a child should not know anything about each other for fear of failing to respect their child’s autonomy.

As regards the respective roles of the recipients and the medical staff in these choices

Some members emphasise the right of the recipients to maximum respect for their autonomy. It is therefore solely up to them to fix the scope of the information they wish to receive, obviously after counselling enabling them to take a well-informed decision.

Other members of the Committee feel that respect for the autonomy of the recipients should also make way for the role and responsibility of the teams of doctors and nurses in the assessment and passing on of the information on the donor. The doctors and nurses regard themselves as emotionally invested by the future parents in the quality of the educational tie that will bond parents and child, and as wholly committed to this, not just as technicians but also as human beings. The team of doctors and nurses therefore has its role to play in the choice of the scope of information imparted.

Whilst the first group sees a risk of paternalistic intervention in this participation of the doctor and nurses, the second sees it as a responsibility of the medical staff.

Additional considerations

Some feel that if the recipients want a very detailed picture of the donor, the latter also becomes a human figure very much present in their minds. There would therefore be a contradiction in simultaneously wanting him not to assume any role as partner in the child’s conception by remaining anonymous. There would also be an asymmetry between the detailed psychological presence of the donor’s image in the parents’ minds, and the secrecy that would be maintained vis-à-vis the child as regards his origin. In such conditions, it would be reasonable to call upon a known donor in order not to continue with this kind of ambiguity.

Others think that the request for non-identifying information and the possibility of choice that this gives rise to, are justified by the desire not to depend totally on other people. The recipients are the first people concerned by the donation. It therefore goes without saying that they will endeavour to have their say and to keep control in the procedure.

Practical possibilities

Finally in this question of non-identifying information, account must also be taken of the practical possibilities. Having to fill out questionnaires always calls for an effort on the part of voluntary donors, of whom not too much can be demanded. Very detailed information in medium-sized or long questionnaires can only be requested if the donors are paid, as happens in the USA. The donation of gametes then forms the subject of a transaction. In Europe, we are still opposed to this commercialisation for the reasons that will be discussed in the following chapter.

From the child's point of view

The question of non-identifying information must also be raised from the point of view of the child. At the moment, little is known about the nature of the information concerning the donor whose children, informed by their parents, would like to access. Such research would be necessary in order better to determine the non-identifying information that can be usefully collected. The dissemination of the information which would form part of this minimum profile would then be a condition required by the sperm banks for the donor to be able to proceed with the donation. This minimum profile could also be supplemented with other data, the forwarding of which would have been authorised by the donor.

From the donor's point of view

Finally, it should be recalled that non-identifying information hardly undermines the donor's privacy, if at all, bearing in mind that the link between the donor as a person and the recipient as a person is broken by the maintenance of anonymity. Any desire for contact, and any risk of a claim or legal dispute, should therefore be ruled out, and the legislation should be adapted in such a way that any inconvenience that results for the donor in giving non-identifying personal information is clearly lower than the advantage that this information could have for the recipients and the child.

2.5. Reward and payment. Commercialisation

It will be recalled that, as for blood donations, most European countries prohibit payment for corporeal material.

Several ethical reasons may be advanced to back this rule.

The symbolism of human dignity

Payment for parts of the human body or products of the body leads to the consideration that the body may, in respect of some of its parts, be detached from what underpins the human person's dignity. Now, this person and his dignity are symbolic structures essential to the composition of any human society and to the quality of the relations established in it. Among the elements that form this symbolic edifice, the body plays a very important role as a source of the experience and identity of any human being. In our European traditions, many are those who fear that detaching certain parts of the body from this symbolic structure, as objects of commerce, would weaken the structure as a whole. In a society in which technological and commercial objectivisation weighs heavily, they see this as implying a risk of the concrete supports of the symbolism of respect for people gradually being reduced. This is why they want to ban any and all commercialisation of the human body or its parts and products[19].

The effects of commercial profits

Payment for human body parts would generate profits and thereby create a pressure to agree to it, which would distort the freedom of decision on the part of the least well off. Payment in exchange for the donation would run counter to the altruism and

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[19] It is recalled that the question of the legality – or otherwise – of the commercialisation of the body in the framework of prostitution is not covered in this opinion.

solidarity which promote the quality of relations between humans in a society. It prioritises the strongest over the weakest. If we cannot blame the destitute for wanting to sell parts of their body in order to help their family, we cannot accept the social organisation creating situations of distress that lead to such situations. The latter must be corrected through solidarity, and not through the marketing of parts of the body.

Practical aspects of gamete donations

In this respect, we could also fear that the idea of making a profit might push candidate donors to hide essential medical information. Finally, payment could incite higher bids being made by applicants in respect of the donor's specific characteristics, proportional to the amounts paid.

Sperm donors currently receive a lump-sum amount as compensation for their costs. In order to maintain a clear distinction between compensation and payment, the real costs should be proven. However, bearing in mind the practical difficulties this would entail for donors and clinics, a reasonable lump-sum amount seems acceptable. The National Board of the Order of Doctors agrees to consider a fair compensation for gamete donors. This compensation should be based, *inter alia*, on a reasonable assessment of the time spent and the inconvenience undergone, and may not be conceived of as a payment for gametes. The sperm donor – and to a lesser degree, of course, the donor of oocytes – has travel expenses, is subject to a series of examinations, and suffers a degree of inconvenience. As already mentioned above, it would be desirable for the amount of this compensation to be the same in all sperm banks.

In order to attract enough donors, it is important to give them a certain kind of "reward". According to the traditional rules, a donation is received with gratitude, and is answered with a donation in return. This reward does not have to be financial, but may take the form of dissemination of information concerning the donation (such as notification of whether children have been born of this donation) and an enhanced social recognition vis-à-vis the donor, as is done with blood donors. It is noted that this recognition should already be expressed by a more respectful attitude towards donors than is currently still too often the case on the part of the medical staff of certain banks.

2.6. Quality criteria

A sperm bank must of course make its practice subject to the rules of good medical practice. Donors must be in good general health, and their family history must show them to be free of hereditary diseases. They must also not have any record of having had sexually transmitted diseases or hepatitis.

From this point of view, it is currently felt that it is no longer acceptable to carry out insemination using fresh sperm. After all, the donor may have become infected with HIV and be in the period during which the virus is not detected in screening tests (around two months). The current procedure thus consists in freezing the donor's sperm in all cases, even when the donor is known, in order to ensure a period of "quarantine" enabling its non-contamination to be verified.

The question of the family case history, and in particular that of genetic tests carried out on the donor, poses tricky problems. According to current knowledge, we are all carriers of three or four recessive genetic diseases (i.e. diseases which only express themselves if they encounter the same gene coming from the partner), and many diseases are today shown to have a genetic component. If the family history and the tests are supposed to guarantee that we are free of any hereditary diseases, no-one would be able to reproduce. So in these matters we must be careful about the dream of the genetically perfect child. All normal people have one or other anomaly in their genetic make-up, and the growing accuracy of genetic tests will only result in an increasing number of these that it will be possible to detect. The idea of a perfect genome is thus deeply unrealistic. We must therefore be fairly restrictive: the point of genetic screening is to avoid a donor exposing the family receiving the donation to a significantly higher risk than that run by the population at large. Thus, in some recessive diseases, the presence of the recessive gene is not a counter-indication to the donation, insofar as it can be detected and therefore excluded in the recipient woman, thus avoiding the birth of a sick child.

In Belgium most of the centres carry out a karyotype of the donor and screening for cystic fibrosis, whilst this examination is not carried out in France where it is even refused when requested. This difference in judgement relates to the importance attached to the statistical risk of the disease, faced with the rule of avoiding a trend towards eugenics. Indeed, if this screening is not carried out, the risk of a donor who is a carrier of the recessive cystic fibrosis gene meeting a partner who is also a carrier is 1%. This risk is the same as in the population at large. In our country, however, it is felt that when recipient parents submit themselves to a medical technique in order to reproduce, it is acceptable for them to request additional security.

In Belgium also, particular groups are subject to certain genetic tests, such as the test for thalassemia among donors of Mediterranean origin or the test for sickle-cell anaemia among donors of African origin.

2.7. Specific obligations for sperm banks

The question is raised as to whether, aside from the usual rules of good medical practice, the sperm banks should be subject to specific obligations.

The holding of a register

From a medical standpoint, the holding of a register enabling the identity of the donor to be linked to that of the recipients and the children born of sperm donations is useful or necessary in order to be able to trace the causes of any pathologies that would affect the child’s development.

The existence of such a register would also concern the children’s right to find their biological parent, possibly against the wishes of their socioeducational parents. This question will be discussed below in connection with anonymity and secrecy.

In any case, if such a register were to become obligatory, it would be necessary to stipulate in detail the rules of confidentiality and right of access.

Coordination between banks

The current situation does not establish any obligatory coordination between sperm banks. Better coordination would facilitate progress in certain fields, for example by fostering scientific exchanges. It would make it possible to better determine the pertinent criteria of the medical and psychological characteristics demanded of the donors. It also seems that the number of births accepted from one donor should be the subject of consensus. The situation whereby a donor goes to several sperm banks without mentioning it should also be avoided. And, as the Order of Doctors recommends, the lump-sum compensation given to donors should be made uniform.

The procedures followed by the sperm banks should also be coordinated to some degree with those followed by the centres carrying out artificial insemination. This concerns, for example, the non-identifying information on the donor, which is passed on to the initiators of the parental plan. It also concerns the follow-up procedures set in place by the insemination centres: how are they informed of whether or not a pregnancy is the result of insemination? What information is passed on to the doctor?

In the event of a successful pregnancy, what information will be passed on to the paediatrician who will be monitoring the child? These questions, which are currently solved in varying ways depending on the banks and these centres carrying out the insemination, must also be given new answers in function of the recent law on Patients' Rights. It will be necessary to determine whether the child can or cannot gain access to his paediatric records or his mother's records after her death, and what these records should contain.

For all these reasons, the establishment of a system of coordination and control between sperm banks, and between these and the centres carrying out the insemination is necessary. This question does not (yet) concern donations of oocytes since it is currently very difficult to freeze and keep oocytes.

A central coordination body of this kind would collect the data from all the banks, which the latter would be able to consult. The insemination centres' – and possibly the recipients' – choice would thus be widened, as regards the desired characteristics of the donors. This body could also lay down certain rules cited above and oversee their application.

This does not mean that it would be a good idea to create a central sperm bank for the whole country, on the model that applies for blood transfusion. The multiplicity of banks in fact contributes to a continued philosophical diversity of the players.

III. OOCYTE DONATION

A. Current medical procedures

Medically, the donation of oocytes involves very different procedures and difficulties to those encountered with sperm donations. To donate oocytes, a woman has to undergo hormonal stimulation for various days aimed at bringing numerous ovarian follicles to maturity, and then a small operation to collect the oocytes present.
The risks inherent in this procedure are the same as those undergone by a woman who submits to an *in vitro* fertilisation procedure, namely:

- Problems of imbalance in the metabolism of water and electrolytes. Generally minor when they arise (approx. 1% of patients), these problems may in some cases take on worrying proportions, calling for hospitalisation. The literature even makes mention of fatalities, including in Belgium.
- The rare risk of definitive sterility following the stimulation.
- A risk of venous thrombosis, similar to the risk caused by certain contraceptives (approx. 1/1500).
- Some patients present minor neurovegetative diseases.
- Finally, some donors, when they fail to respect the rule of abstaining from sexual relations during the period of ovarian stimulation, find that they have become pregnant without wanting to.

The question of the responsibility of the doctors who remove oocytes and that of the donor’s insurance is currently unsolved. The donor undergoes a medical treatment without needing it for her health. In the strict sense of the law, such removals could fall under the description of blows and injuries in the event of an accident, since one of the elements of legitimacy of medical acts, namely their necessity for the person’s health, is lacking here. It should be recalled that the law of 1994 on blood donation does not make provision for the donation of oocytes, and that the law of 1981 on the removal of organs explicitly excludes the donation of gametes. Now, it can be felt, in all justice, that it is necessary for the donor and the doctor who removes the oocytes to benefit from the protection of the law as well as an insurance policy.

Cryoconservation of the oocytes is still in an experimental phase. Although some pregnancies have been obtained by this method and the technique is progressing, its clinical application remains limited. The difficulty of freezing mans that it is currently not possible to create oocyte banks. The donation of oocytes thus makes it necessary to use “fresh” oocytes and it is not possible to guarantee totally that the donor is HIV-negative, since at the time of the donation she may be in the initial period of contamination during which AIDS tests still give a negative result. For this reason in some countries, such as France, embryos are created from the oocyte donation, and then frozen for six months. During this period the donor’s HIV-negative status can be checked. However, the freezing followed by thawing of the embryos appreciably reduces the chances of success in *in vitro* fertilisation treatments.

The medical criteria for the selection of donors are the same as those applied to sperm donors: good general health and a lack of hereditary or sexually transmitted diseases. Moreover, most centres limit the age of donors to 35, feeling that beyond this age there is too great a risk of not obtaining oocytes or of the oocytes obtained being of poor quality.

B. Ethical questions

A great many ethical questions are identical in the case of sperm donation and oocyte donation. Due to the medical procedures required and the greater medical risks involved in oocyte donation, some questions raised are specific to this kind of donation.

1. Freedom of decision of the donors

The complexity of the medical procedures indeed means that very few women come forward as voluntary unpaid donors. Candidate recipients are thus most often led to seek a donor from within their family or among their friends.

1.1. Intra-family donation or donations between friends

Most cases involve donations between sisters or between friends.

Other reasons, as frequent as the scarcity of donors, can play a part, such as shared genetics and the non-anonymity of the donor. The donor, a sister or friend, is motivated by her emotional tie with the recipient, the experience of intense suffering that infertility means for the latter, but also by confidence in the knowledge that the child will be brought up well. Some members of the Committee fear that on account of the strong bond existing between sisters, and sometimes between friends, there is a real risk of the donor feeling morally obliged to agree, or even of moral pressure being brought to bear on her. Other members, on the other hand, are of the view that the feeling of a moral duty towards a sister or friend is highly valid, and that personal freedom is not distorted by such feelings. Clearly this difference of judgement cannot be solved at a theoretical level, since the freedom of the people concerned depends on their psychological balance and characteristics of their environment. Only high-quality psychological counselling can, on a case-by-case basis, verify the adequate freedom of the donor and recipient.

Cases are also known of intergenerational donations from mother to daughter and vice versa. These raise specific questions. For some members of the Committee, the intergenerational bond between the people concerned risks limiting their decision-making freedom too much. Moreover, these members fear that the child, a reference for two generations at the same time, might have psychological problems of identity. The intergenerational donation also often raises questions linked to the age of the people involved, questions that will be dealt with below in respect of post-menopausal recipient women.

1.2. Voluntary donors

Whilst the symbolic value of the donation of oocytes is similar to that of the sperm donation, for the woman donating oocytes there are also greater inconveniences and physical risks. Therefore account should be taken, much more attentively than in the case of sperm donation, of the reasons behind such voluntary donations.

Studies show that a very large number of candidates state that they have experienced “reproductive” traumas. These include a miscarriage, an abortion or an unfulfilled desire to have a child. Donating oocytes can in some way be a form of compensating for these traumas. Although this observation encourages prudence, it does not constitute a reason for excluding these candidates a priori. Here, too, the situation calls for experienced counselling. Great care must be taken in excluding donors for personal reasons, but it is also necessary to know how to turn down those fostering overly unrealistic expectations.

1.3. The oocyte sharing procedure

A third form of oocyte donation is oocyte sharing. A woman who undergoes an IVF procedure for problems of infertility agrees to share the oocyte resulting from her ovarian stimulation with a woman applying for oocytes, when more than eight oocytes are collected. In exchange, the woman receiving the oocytes pays for all or part of the first woman's treatment. This practice is frequent in the United Kingdom, where there is practically no reimbursement of IVF by the social security. It is sometimes applied in Belgium.

This method has the advantage of the donor of oocytes not undergoing the procedures of stimulation and removal on account of the donation, but in her own medical interest. The psychological risk for this woman is that of seeing the recipient become pregnant when the IVF procedure has failed for her. The few studies carried out on the subject show that the donors who did not become pregnant after their treatment did not regret their collaboration. Although they may experience psychological difficulties on learning that the recipient has had a child (if they are given this information), a number of donors also find comfort in the fact that the treatment they have undergone has not been entirely in vain.

Furthermore, this procedure raises the question of the unpaid nature of the donation, a question which will be dealt with below.

1.4. Donations in exchange for payment

These are regularly carried out in the United States. At the moment paid donors are offered by Internet web sites. It is recalled that this is contrary to the principle of non-commercialisation applicable in Europe (see II B. 2.5).

2. Donor selection criteria

- As for sperm donations, some insist that the donor should already be a mother and does not want any more children. Because of their experience of motherhood, it is hoped that these women will be better able to take an informed decision. Moreover, in the case of a woman without children, account must be taken of the risk, albeit minimal, of her becoming sterile after the treatment. Motherhood is psychologically of great importance in the life of many women. It could be especially distressing for a woman never to experience motherhood whilst having helped others to reproduce. It seems difficult to therefore turn this into an obligatory rule in the selection of donors, but it is clear that greater care needs to be taken here than in the case of sperm donations.
- A large number of centres stipulate 35 as the maximum age for the donation of oocytes, for medical reasons of prudence. On account of the emotional ties often linking the donor and recipient, and the diversity of the medical situations, it appears difficult to make this limit an obligatory rule.

3. Recipient selection criteria

The general ethical criteria for oocyte donation are the same as for sperm donation, as regards the selection of the recipients (see II. B. 1 and 2.1).

A specific problem is raised here when the woman requesting oocyte donation is *a post-menopausal woman.* This question was cited in Opinion No. 19 on the use to be made of frozen embryos, and reference was made to this opinion.

The menopause is characterised by the fact that oocytes are not produced. A distinction needs to be made here between women affected by a premature ovarian deficiency, from a young age, whether this menopause is spontaneous or has been caused by medical treatments (e.g. anti-cancer treatment), and women presenting a physiological menopause.

Developments such as the freezing of ovarian tissue and the maturation of oocytes *in vitro*, as well as the freezing of oocytes in the future, mean that we can predict women being able to conceive a child from a more advanced age using their own gametes. Currently the possibility already exists for a woman to have embryos from her partner and herself frozen and to ask for their implantation after her menopause.

In these situations, it is the age of the recipient women that poses ethical questions. First of all there is a medical problem regarding the risks for the woman's health. Secondly, opinions diverge as to the capacity of old parents to take on the task of bringing up their children. There could therefore be a conflict here between the parents' right to their autonomy and the rights of the child.

This problem is too complex to be dealt with here, and will be covered in a subsequent opinion.

4. Directed and/or personalised donations

This question was dealt with, in respect of sperm donation, in II. B. 2.1.4. A number of considerations specific to oocyte donation are added here to supplement the reflections made above. Whilst uncommon in the case of sperm donations, directed and/or personalised donations are very frequent in oocyte donation.

4.1. Choice of the recipient by the donor

Personalised donations are donations in which the donor states that she reserves her oocytes exclusively for one specific person. For donations between sisters or friends, this is often the case. Even where there is no family tie, some donors want their donation to go exclusively to a particular person whom they know and trust. In principle, these personalised choices do not raise any specific ethical problems. All people have the right to make a donation to another person whom they choose, provided this gesture does not contravene any legal rules and the ethics applicable in society. However, it is necessary to remain attentive to the relational difficulties that may arise between the donor and the recipient, and in the family dynamics. Confusion regarding the respective roles towards the child may arise. Clear prior agreements between the donor and the recipient are important here, as well as careful counselling.

Directed donations are those reserved for specific groups. For example, they might be subject to the condition that the oocytes are not used for post-menopausal women or for lesbian women. This possibility is not generally accepted for other body tissue donations, such as blood donations and most organ donations. In the field of gamete donation, directed donations are as a rule accepted, on consideration that they have particular meaning for the donors since they lead to the birth of a child. However, directed donations intended to discriminate against certain categories of people could pose a problem, as was seen in relation to sperm donation (II. B. 2.1.4.).

4.2. Choice of donor by the recipients

The bulk of donations carried out in our country are in the form of personalised donations. Clearly the recipient will not choose a donor whose personality she does not like or whose oocyte she would not like to receive. In oocyte donation, the relationship of trust between donor and recipient is essential to avoid any untimely interference by the donor in the recipient couple's relationship and in the child's upbringing.

In the case of an anonymous donation, the conditions that the recipient may stipulate are similar to those relating to sperm donation (II. B. 2.1.5.).

5. Secrecy

Contrary to what one would expect on account of the fact that the donor is most often known by the recipient, the family circle and the child are not necessarily informed of the use of donor gametes or of the donor's identity. However, the couples who resort to oocyte donation seem in general to have fewer problems in passing on this information to their child. This observation is explained, among other things, by the fact that on account of her pregnancy, the woman is making a very considerable biological contribution to the development and birth of the child. Psychologically, the feeling of motherhood and the legitimacy thereof in the woman are founded much more on the fact of carrying the child for nine months than on the fact of genetically supplying her oocytes. The fact of not being able to reproduce via her own genetic material is thus experienced less negatively for her self image than is sterility in men.

The matter of secrecy vis-à-vis the child as regards his origins is thus raised less often in the case of oocyte donation, and in a psychologically less fraught manner. On the ethical side, if the secrecy is maintained, it poses the same problems as in the case of sperm donation (II. B. 2.2.).

6. Anonymity of the donor for the recipient

As indicated previously regarding sperm donation, among donors whose name it has been authorised to pass on, a distinction must be established between donors known from childhood and identifiable donors. *An identifiable donor* is a woman willing to authorise her name subsequently being revealed. This communication is almost always linked to the age and maturity of the child (16 or 18) and almost always occurs at the initiative of the child, when he/she has learnt – accidentally or not – of the circumstances surrounding his conception.

Given the small number of voluntary, unpaid and anonymous candidate donors, candidate recipients are often forced to seek donors in their own family circle or among their friends. In seeking a donor in her own social environment, a recipient woman is free to opt to keep the method of conception and, a fortiori, the donor's identity, secret from the child, but unlike in the case of sperm donation, she knows the identity of the donor, and vice versa.

The fact that the two know each other may, far more often than in the case of sperm donation, lead to obstacles to *the educational freedom of the recipients*. When the donor is known from the outset, as is the case when she is a sister or friend, the length of the relationship between donor and recipient (which may span decades) and the permanent interaction made possible by their proximity, may result in all kinds of conflicts and complications. This is the case, for example, when one of the two parties wants the way the child was conceived to be kept secret from the child. This situation opens up the possibility of various types of moral and psychological pressure being brought to bear. Precise agreements and good supervision from the start of the treatment are therefore vital in order to limit any conflicts as far as possible. A number of indications call for prudence. It can be inferred from various studies that an already substantial minority of known donors feel a degree of responsibility vis-à-vis children born thanks to their donation. This same reason prompts certain donors to opt for a known donation. When the donor is thus more or less present in the child's upbringing, conflicts cannot be ruled out if she feels that the child is not being brought up well. Even more than for the other forms of intervention, the known donation thus calls for very exhaustive counselling and the choice of partners with great maturity. The fact remains that the only basis for a good understanding is the mutual trust linking the two parties.

To avoid these possibilities of conflicts arising, many teams of doctors and nurses recommend the procedure of *crossed donations*, which makes it possible to maintain the anonymity between donor and recipient. If she has a chance of finding a donor but wants to remain anonymous, the recipient may, in agreement with the donor, resort to a system under which a woman A receives the oocytes of the donor found by woman B and vice versa. The donor then knows *for whom* she is making this donation but does not know *to whom*. She is anonymous since the person receiving her oocytes does not know her identity.

Aside from relational questions between donor and recipient, the main ethical question as regards anonymity, as in the case of sperm donation, is that of the child's right to know his genetic origins. We therefore refer to what was said in relation to sperm donation (II. B. 2.3.).

If the parties choose anonymity, the question is raised as to the forwarding of non-identifying information. This question raises the same considerations as those advanced above as regards sperm donation (II.B**.** 2.4.).

7. Reward and payment

The general ethical aspects of payment for gametes were dealt with in relation to sperm donation (II. B**.** 2.5.).

However, the question concerning the acceptability of payment for gametes is raised chiefly in respect of oocyte donation. Due to the lack of donors, the prices offered in countries where payment was deemed acceptable have increased substantially in a short space of time. This payment is wholly against the accepted rule in Europe, under which money may not be made from body tissue and body parts. In view of the excessively high sums offered to candidate donors elsewhere, the freedom of their consent is highly doubtful. Apparently there are many who take the decision for financial reasons. The wish to convince women to donate their oocytes also leads to the fear that the risks and inconvenience that they will undergo may be minimised when they are informed of the procedures.

The members of the Committee also feel that compensation for the costs and inconvenience suffered is wholly acceptable. In order to avoid any exaggeration in the assessment of these amounts, all centres offering oocyte donation should jointly draw up a precise compensation system. Of course it is normal for this compensation to cover medical costs and insurance. Compensation could also be envisaged for the inconvenience experienced (blood tests, hormonal stimulation, retrieval of oocytes, etc.), travel, and time spent.

In the context of oocyte donation, a specific problem is raised. A system on which major differences of view are expressed is that of "*oocyte sharing*". In this system, the woman who herself undergoes a fertilisation treatment gives some of her oocytes to another woman in exchange for payment of part of her treatment. The major advantage of this system is that the donor undergoes the treatment for herself anyway and does not run any additional medical risks on account of her donation. On the other hand she limits the chances of successful IVF since she has a smaller number of embryos. Too few studies have hitherto been carried out on the reasons and socio-economic situation of donors of oocytes in this context to provide a precise picture on the subject.

The ethical question raised here involves ascertaining whether this system of sharing of oocytes should be considered as a form of payment for the donation.

In favour of this system, some advance the following argument: the payment linked to the sharing of oocytes is not of such a nature as to prompt people to make a donation with the intention of deriving any major financial benefit. Donors ‘by sharing’ no doubt agree to make this kind of donation in order to lighten the financial burden of *in vitro* fertilisation treatment, or even in that way to be able to gain access to it. They do not do so “to earn a living”.

For other members of the Committee, “egg sharing” calls into question the voluntary nature of the donation, and contravenes the rules under which any commercialisation of the human body should be refused because it distorts the mutual respect that people owe each other.

To solve this dilemma, some members of the Committee feel that the system of egg sharing should be authorised, within a framework of precise limits. To alleviate the financial pressure that could hamper the freedom under which the donation is made and to avoid the impression of paying for the oocytes, they recommend that the woman who has agreed to give some of her oocytes be able to benefit from a reduction in the costs of the IVF treatment even if the number of oocytes proves to be insufficient to be shared. Since 1 July 2003, in vitro fertilisation has been subject to a new reimbursement system covering the virtual totality of the costs incurred. IVF currently amounts to around €300 to be paid by the patient, with the rest (around €1,200) being reimbursed by the social security. In the future it will be possible to estimate whether, as a result of this, the practice of “*egg sharing*” has diminished.

IV. RECOMMENDATIONS

A. Ethical recommendations

1. General ethical considerations

From an ethical point of view, a number of priorities should be mentioned. The first priority is to ensure that fertilisation techniques do not become a purely technical matter, but retain as far as possible the human character that is right and proper to apply to the passing on of life. The second priority consists in asserting the child's interest. This means that efforts must be made to ensure the quality standards of the sperm bank so that the child's health and quality of life are guaranteed as far as possible. It also means that the desire to have a child and the parents' parental plan must be clearly authentic.

Three general ethical options become clear on these questions in the Committee.

- Some feel that the cultural organisation of parentage and the family cannot diverge too far from its biological foundations, under pain of destabilising the children's psychological formation and the organisation of society. They underline the importance that the presence of both human sexes has in the formation of people's psychological and social identity. They recall that artificial insemination, especially in sperm donation, is a difficult experience for the couple. They therefore wish to see gamete donation reserved for stable heterosexual couples, and only to correct genetic pathologies or serious cases of infertility. They are of the view that many factors stemming from psychopathology clinic and sociology, despite not being statistically proven, prompt extreme prudence as regards the changes that could be made to the structure of parentage and of families, and that these factors authorise a limitation of people's autonomy in their right to reproduce.
- Others, supporters of individualism and egalitarianism, defend an absolute right to reproduce as a conquest of the freedom of one's personal life. They claim the plurality of types of family, making a distinction between the biological parent, the legal parent and the social parent, each being able to choose the structure of parentage in which he intends to reproduce, with or without the help of science. What is important, in their view, is the intention and capacity of one or two people to guarantee the child affection and education. For them, the choice of family structure by the adults does not constitute a decisive factor. They therefore do not regard it as legitimate to oppose gamete donation in female couples of for single women, for example. They think that the only interventions that should be prohibited are those leading to situations where it has been shown, by objective studies, that these could be harmful or dangerous for the development of the children.
- Others do not feel comfortable with this contrast between the affirmation of a single ideal family model, which seems to them to be too exclusive and too 'naturalist', and the emphasising of an almost absolute right to reproduce in the name of autonomy and equality, which seems to them to be too ideological. They want to take account of the child's interest first and foremost, but by exploding the myth that any single type of family is good.

> They think that the diversity of more or less propitious situations should be recognised in function of numerous factors.

The three groups acknowledge that the centres have the right to refuse to contribute to situations that they judge to be too problematic. They thus feel that the medical teams should have freedom of decision allowing them not to accept people for treatment (either for gamete donation or for any other instruction for assisted reproduction) when they feel that the risk of the child facing major difficulties is too great.

These general ethical options are sometimes reconstructed differently in the face of certain cultural convictions present in our society: the importance of the parental function and the role of genetic elements in people's future.

Gamete donation dissociates biological parentage from socioeducational parentage. In our society the idea is still too often prevalent that "real" parentage is of a biological nature. This idea is more marked as regards the man's role than the woman's. The members of the Committee feel that the socioeducational aspect of parentage is at least as important as, or even overrides, the biological tie.

Another common preconception, induced by the advances made in modern genetics, is the thought that a person's destiny is more or less completely determined by his genome. Not only is this idea scientifically inaccurate, but it tends to mitigate the educational responsibility of the parents and reduce the childrens' and adults' freedom in the fulfilment of their destiny.

The members of the Ethics Committee feel that endeavours must be made to combat these two preconceptions.

The donation of gametes breaks the usual link that has traditionally existed between the parents' sexual relations and the conception of the child. Some members of society, generally on account of their religious beliefs, feel that this link can never be broken and thus condemn all gamete donations. No representatives of this position are to be found within the Committee.

2. Specific ethical questions

- Conditions laid down by the centres involved in assisted reproduction and/or by the people donating their gametes

Some centres and some people donating their gametes want these procedures to be reserved only for stable heterosexual couples and to exclude female couples or single women.

Some members of the Committee feel that these practices are acceptable, whilst others see them as harbouring a discriminatory attitude which contravenes the legal rules in force in our society.

It therefore seems necessary for medical teams who carry out assisted reproduction to maintain their freedom to refuse this to people who do not appear to them to be liable to guarantee the suitable development of the child. These judgements are based on complex grounds and always imply a degree of subjectivity. Whilst it is essential for studies to be carried out to help better predict the child's future, these studies alone are not liable to define accurately the criteria for a good family or a good upbringing, and their results may always be open to debate. Finally, our country is characterised by its pluralism and there are many interpretations of the rules of non-discrimination.

For all these reasons, the members of the Committee do not think that it is necessary to intervene in the rules of selection that the centres choose. On the contrary, it would be desirable for these centres to get into the habit of discussing between themselves their experience and the future of the rules they choose.

It should also be ensured that these rules are known and clearly identifiable by the public. The State must also see to it that there is enough variety among the centres and the donors so that anyone wishing to have recourse to artificial insemination is able to fulfil their options as regards their sex life and their conception of parentage.

- Secrecy towards the child as regards the way he or she was conceived

Whilst all the members of the Committee feel that parents have the right to reveal or not to reveal to their children the circumstances under which the latter were conceived, several trends become clear on this subject within the Committee.

Some members feel that the truth is generally preferable, both in principle and to avoid any psychological traumas that would arise in the event of the child finding out his or her origin by chance. It would therefore be necessary for the counselling with the parents to insist on this. Other members see less danger in secrecy, and stress the advantages that children have in being brought up without having to deal with the fact that a third person was involved in their conception.

- Anonymity of the person donating gametes

When the parents have decided to reveal to the child the way he or she was conceived, or in the event of this being revealed by accident, the question of the donor's anonymity is raised. Three possibilities exist here: the donor is known from the moment of conception, he is definitively anonymous, or he is anonymous but is identifiable later, when the child has reached his teens or adulthood.

From an ethical point of view, the choice of donor anonymity or not calls into question the - at times differing - interests of the three parties concerned. The parents may legitimately prefer the donor to be anonymous in order to avoid any interference by a third person in their relationship as a couple and in the child's upbringing. The donor may prefer anonymity in order to protect his private life and to protect himself from any claims. The child, finally, has the right to find out his origin on the basis of his wish to construct his identity and to attach his history to that of his origins.

Opinions differ within the Committee on the way in which these interests should be prioritised.

All feel that it is essential for the donor to know the conditions governing sperm donation from the outset. It is also essential that neither he himself nor others are able to go back on the conditions under which his donation was effected.

Some members of the Committee feel that the parents' right to resort to a donor who will remain definitively anonymous should prevail over the child's right to find out his origins. They recall that nobody has control over decisions taken before he came into the world. The parents should retain their autonomy in all choices relating to reproduction and upbringing. These members accept that some parents prefer anonymity of the donor in order to avoid any interference by the latter, and so that the child is brought up with the feeling of belonging wholly to his family.

Other members of the Committee, on the contrary, feel that the child's right to know his origins should prevail over the parents' autonomy, at least from a certain age onwards. They stress the emotional importance of this in stabilising the identity. They also emphasise the risks of psychological trauma in cases where the secret is revealed by accident, and the fact that this risk only increases with the development of genetic analyses in medicine.

To better balance the rights of each party, many members in the end come down in favour of a mixed solution. The donor could choose to be identifiable or not. The parents could use one or other type of donor, according to choice. Finally, in cases where parents and donor had opted for the latter to be identifiable, the child would in turn have the choice, from a certain age, to get to know the donor (or not) if the parents revealed to him the way in which he was conceived or if this was revealed to him by chance.

It is noted that Western countries differ in the rules they legally enact regarding the anonymity of the donor, with a trend towards increasing the child's right to know his origins. The situation is thus still evolving.

It can be recalled that, irrespective of the solution chosen, it is essential that the adults concerned in the decision to proceed with reproduction by gamete donation be clearly informed of the consequences of their choice. It is also absolutely necessary for the rules that they have chosen to be guaranteed and for it not to be possible for these to alter.

- Commercialisation of gametes

The members of the Committee back the option (generally applied in Europe) of prohibiting the commercialisation of gametes. Their conception of the place of the body in the symbolism of human dignity opposes it, as does the injustice that would prompt destitute people, in particular women, to sell their gametes without genuine freedom of choice. In this respect, the members of the Committee recall that it is not these people that should be reproved, but any society that tolerates an organisation pushing certain people to these situations of distress. Finally, the effect of commercial competition would probably have negative effects on the medical risks specific to donation procedures.

However, the members of the Committee regard it as legitimate for a compensation to be established for people who donate gametes, in function of the inconveniences they undergo and any costs they incur. Clear practices should be laid down on this subject, so as to avoid vagueness and competition between the centres concerned.

The practice of oocyte sharing, by which a woman undergoing an *in vitro* fertilisation procedure agrees to donate some of her oocytes to another woman in exchange for payment of her treatment, is met with differing opinions within the Committee. Whist some feel that this is an acceptable practice which does not really involve commercialisation as such, other members do see it as commercialisation of gametes, and therefore oppose it.

3. Practical recommendations

- *Rules on sperm banks and insemination centres*

Although the large number and diversity of sperm banks and insemination centres favours the patients' and therapists' freedom of choice, and promotes a healthy spirit of competition as regards quality, the members of the Committee observe that coordination on certain points would be necessary between these centres. They therefore do not recommend the establishment of a central bank, but rather the creation of an umbrella coordination body. Certain rules should be obligatory for the banks and centres, whilst others would only take the form of recommendations.

This coordination body would facilitate the exchange of scientific information and the definition of the rules of *good medical practice* in the field of insemination. It would see to it that the public was well informed and that the procedures were transparent, and would also enable a greater choice among the diversity of donors. It would make it possible to define a register of the medical data that would have to be kept by the centres and the rules of confidentiality to be observed in this field. It would have to be able to monitor the correct application of these rules.

- *Counselling of the people donating and receiving gametes*

Many questions concerning gamete donations call for the people involved to make decisions which are difficult on account of personal psychological implications and the consequences they will have in their life, their children's lives and the lives of their nearest and dearest. Before embarking on artificial insemination, gamete donors, but even more so applicant recipients, must therefore have the possibility of meeting experienced professionals with whom they can gain an understanding of, and thereupon gauge, all the implications of their decision.

- *Finally follow-up studies* should be carried out to enable a better assessment of the consequences of gamete donations for all the parties. The members of the Committee insist on the importance of such studies. The lack of hindsight and knowledge makes ethical decisions difficult in many situations. It is the future of parents and children who are increasingly numerous on account of the advances in assisted reproduction that is at stake. Research is therefore a clear ethical duty here.

B. Legal recommendations

The legal recommendations presented below are general indications. Indeed, it is difficult to specify in detail the provisions that the legislator will have to make, on account of the diversity of positions encountered, but also bearing in mind the fact that the four countries bordering Belgium all have different laws regarding artificial insemination and assisted reproduction. As regards the details, these recommendations refer to the full text of the opinion.

All the members of the Committee agree in advocating legal rules to be adopted as a matter of urgency in the field artificial insemination and assisted reproduction.

However, it should be observed that some of these legal rules are of a contractual nature and, as such, are based on individual autonomy of will and freedom of choice. These legal rules will have to be harmonised and in balance with the subjective rights of family law in respect of filiation and parentage. Family law is of a completely different nature to contractual law and fundamental individual rights such as the right to privacy and the right to pass on life, the latter rights interfering more and more with legislation on marriage, filiation and parentage. Indeed, family law is not centred on the individual but on the structuring of the many relations existing within the home and the family. The rights and obligations that make up family law are thus imposed on each of the members of this family.
At a legal level, we come up here against the tension existing between the two trends referred to above (see I.2 and IV.A.1). Currently, in our society, we observe a remodelling of family law to the advantage of fundamental individual rights and rights in view of one's status as a person. In this respect, some members hope that the legislator will ensure the guaranteeing of a *balance between these new rights centred on the individual and those falling under family law which organise the social life of the human being.*

1. The rules of filiation

The Committee feels that the following legislative adaptations need to be made on account of the new situations resulting from practices of assisted reproduction.

1.1. As regards application of Article 318, §4 of the Civil Code, it should be specified how the proof of the husband's consent to artificial insemination or to any other act aimed at reproduction, can be furnished.
1.2. As regards the establishment of paternal filiation of children born of A.I.D.. in common-law couples, the Committee recommends the adaptation of the Civil Code in order to avoid any discrimination (see I. 3.1.2).
1.3. The concern to avoid any discrimination between the children also makes it necessary to extend the rule of Article 318, §3 of the Civil Code to filiation outside marriage.
1.4. The Committee recommends a legislative reform in order to prohibit in all cases the establishment of filiation of the gamete donor to the extent that he did not have the intention to be a partner in the parental plan.
1.5. Since the law of 8 May 2003, people of the same sex have the right to get married. These people may not establish any tie of filiation with the exception of the tie that legally links the child to the woman who brings him into the world.

Likewise, they are not accorded any of the prerogatives of parental authority such as the maintenance of ties with the child in the event of the couple separating, for example.

The members of the Committee are divided on this situation. Some think that they should be acknowledged as holding these rights and that rules of filiation should also be clarified in this scenario.

Others, who are opposed to the birth of a child in a female couple, nonetheless feel that if a child is born in such a couple, the partner of the legal parent should legally be accorded certain parental rights not constituting rights of filiation, on account of the bonds of affection she has with the child.

2. Secrecy regarding the method of conception and donor anonymity

The Committee considers that it is currently not expedient to create a legal framework to regulate the questions concerning maintenance of secrecy towards the child regarding the way he was conceived. It is up to the couple alone to decide whether or not to tell the child that assisted reproduction was used in his conception. In this respect, it feels that it would be advisable to adapt the recent law on Patients' Rights in such a way that, if the decision is taken to maintain secrecy, it is not divulged either by the child's personal records or by his mother's records.

As regards donor anonymity, all the members of the Committee insist that the donor should be protected from any subsequent filiation claim. Moreover, the advocates of anonymity insist that insurance be taken out as regards the medical file in order to protect the donor, whilst those advocating the removal of anonymity (see 2.4.2) or a mixed system (see 2.4.3.) recommend a legal system being introduced to organise this removal and to enable certain data, the communicable nature of which is deemed to be desirable, to be kept.

3. Responsibility and obligations of the sperm banks and centres of assisted reproduction

The members of the Committee feel that it is desirable for the sperm banks and the centres coordinating to be obliged to register with an umbrella body, which will have to be created. The law will have to define the duties and obligations incumbent upon this body.

Various questions must be settled here, concerning both good medical practice and the legal rules having consequences on questions of filiation and anonymity. The Committee will mention here, although not in an exhaustive fashion:

- the type of data that the centres must collect regarding the donors, making a distinction between identifying data and non-identifying data
- the type of register to be held, and according to what rules of confidentiality
- the number of births that may ensue from the donation made by one and the same donor
- the means of recruitment of donors in order to secure an adequate number of them, as well as the terms and conditions making it possible to provide those asking for a donation with a sufficient choice.

4. Non-commercialisation of gamete donations

All the members of the Committee feel that the principle of non-commercialisation of gamete donations should be maintained. The use of gametes for commercial ends is forbidden in Article 5,3 of the law of 11 May 2003 on *in vitro* embryo research.

A suitable compensation is legitimate, however, to compensate the inconvenience and physical risks undergone by donors, and any expenses occasioned by the donation. Stable rules should regulate these amounts so as to avoid competition between centres and a dormant commercialisation.

5. Need for a legal framework for the retrieval of oocytes and the donation of gametes

The Committee is also of the view that a legal framework should be established for the retrieval of oocytes, as exists for the removal of organs, so that a donor of oocytes can benefit from the cover of insurance for medical responsibility in the event of accident without being confronted with difficult disputes linked to the lack of a clear legal framework legitimising these retrievals.

Some members also recommend that the legal deed that follows the removal and which consists in donating one's gametes (sperm or oocytes) be legally legitimised and that the rights and obligations of gamete donors and recipients be specified. In this respect, the principle of non-commercialisation already mentioned in point 4 is one of the essential conditions for this legitimacy. Special attention will also be devoted to the rules protecting gamete recipients from intervention by the donor in their relationship as a couple or in the child's upbringing when they do not want it.

The opinion was prepared by select commission 98/3 – 2002, consisting of:

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The working documents of select commission 98/3 – 2002 – request for opinion, personal contributions of the members, minutes of meetings, documents consulted - are stored as Annexes 98/3 – 2002 at the Committee’s documentation centre, where they may be consulted and copied.