BELGIAN ADVISORY COMMITTEE ON Bioethics

Opinion no. 67 of 12 September 2016 on the reception of eggs harvested from the partner within lesbian couples with a view to *in vitro* fertilisation (ROPA: Reception of Oocytes from Partner)

REQUEST FOR AN OPINION FROM THE MEC OF ZIEKENHUIS OOST-LIMBURG

The Medical Ethics Committee (MEC) of Ziekenhuis Oost-Limburg (Oost-Limburg Hospital) has put the following question to the Belgian Advisory Committee on Bioethics:

"We are currently receiving many requests from lesbian couples wishing to become pregnancy by donor insemination. Recently, we have also seen an increasing demand to create embryos from the fertilised eggs of one lesbian partner which are then transferred into the womb of the other lesbian partner by way of In Vitro Fertilisation (IVF). […]
The question we are putting to the Committee is: "Is it 'ethically' acceptable to perform IVF with its inherent greater financial cost and greater risk to health?"

PREAMBLE[1]

We are setting out on the assumption that providing fertility treatment (including *in vitro* fertilisation or IVF) to lesbian couples is acceptable and that egg donation is acceptable. This opinion focuses on the specific question: should IVF treatment be performed to fertilise eggs of one partner with donor sperm before being transferred into the womb of the other partner? In the scientific literature, this treatment is referred to as 'Reception of Oocytes from Partner' (ROPA)[2].

With this concise opinion, the Committee seeks to clarify the ethical debate.

PRIOR CLARIFICATION

1° Medical and non-medical grounds. ROPA may be performed on medical and non-medical grounds. It may well be that the woman who is planning to get pregnant has genetic or medical reasons not to do so using her own eggs. For instance, she may face a heightened risk of a genetic disease, or she could be aged 40 or above. It is also possible that the woman who is donating the eggs shows medical contraindications for pregnancy. In this case, ROPA gives her the opportunity to become a genetic mother nevertheless. In which case, she will not be using a conventional surrogate mother. Instead, her partner will carry the child following egg donation and IVF. It will be immediately obvious that the dividing line between medical and non-medical grounds is not always very clear-cut.

[1] This opinion uses the following abbreviations: MAR (medically assisted reproduction); IVF (*in vitro* fertilisation); IUI (intra-uterine insemination) and DI (donor insemination).
[2] Marina, S., Marina, D., Marina, F., Fosas, N., Galiana, N., & Jove, I. (2010) 'Sharing motherhood: biological lesbian co-mothers, a new IVF indication'. *Hum Reprod*, 2010, 25 (4): 938-941.

2° Donation. Use of the right terminology is crucial. The question is whether or not the ROPA application is to be considered as a donation[3]. On the one hand, it could be argued that the woman is a donor, as it is not she who will be getting pregnant. On the other hand, it could be said that this is not about donation, as the woman who is donating her eggs is using her eggs to achieve her own child wish. Moreover, if this transaction is referred to as a donation, this makes all men donors as they are 'donating' to their partners (as worded in the relevant European regulations). A practical implication thereof is that this partner, and consequently all men, would need to be screened as a gamete donor. Which appears unreasonable, as such rules cannot be imposed on couples.
In summary, it appears that, if we consider the couple to be a unit, the partner cannot be considered as a donor.

3° Legal context. Belgian parentage law already provides for ROPA as a parental project to establish specific parentage rules. The Act of 5 May 2014 establishing the descent from the co-mother sets out that a co-motherhood bond is established on the part of the partner from the time the child is born, regardless of whether or not the partners are married. This Act does nothing to alter the status of legal motherhood, which continues to remain determined by childbirth, not by the child's genetic descent. The Act takes a different approach to the way it defines the 'second' descent by allowing the co-mother to establish her parental relationship with the child if this link arises from a parental project, pursuant to an agreement for medically assisted reproduction as set out in the Act of 6 July 2007[4], and complies with a number of requirements which differ, depending on whether or not a marital relationship exists between the co-mothers[5].

ANALYSIS OF THE MAIN ARGUMENTS

1. Medical risks of IVF versus donor insemination (DI)

Compared with DI, the use of IVF entails greater risks for all those involved.

For the woman donating the eggs, there are risks involved in the stimulation. However, these risks are controlled, provided the right stimulation protocols are adopted[6]. For the woman looking to get pregnant, the egg donation in itself also involves a risk of complications (pregnancy-induced hypertension, pre-eclampsia) during the pregnancy[7]. Finally, negative effects (low birth weight) of egg donation on the

[3] For an in-depth analysis of the possible analogies to clarify the use of ROPA: see Pennings G. (2015) 'Having a child together in lesbian families: combining gestation and genetics'. *Journal of Medical Ethics* 42: 253-255.
[4] Just as a reminder: the involvement of such a centre is required for each ROPA.
[5] For an in-depth analysis of the legal context: see *annex to this opinion.*
[6] Devroey, P., Polyzos, N. P., & Blockeel, C. (2011). An OHSS-free clinic by segmentation of IVF treatment. *Hum Reprod*, 2011, 26 (10): 2593-2597.
[7] Younis, J.S. & Laufer, N. (2015) 'Oocyte donation is an independent risk factor for pregnancy complications: the implications for women of advanced age'. *Scand J Public Health* 32: 24-29.

children's health have been reported[8].

None of these risks as such stand in the way of accepting IVF outside the context of ROPA.

2. Cost-effectiveness of IVF versus DI

An argument against performing IVF is that it comes at a greater financial cost to the community. The cost-effectiveness of IVF versus DI has been a matter of contention for years. However, the general trend seen in the guidelines appears to put DI forward as the first course of treatment[9]. If the woman fails to get pregnant after various DI attempts, the medical staff may switch to IVF. This shows that IVF is not a radically different category but an alternative treatment. The cost argument is much less relevant in the ethical case discussion once the team has deemed that ROPA is the most advisable course of action in light of the socio-familial situation.

3. Psychological grounds for ROPA

The woman receiving the eggs does not need egg donation, where the term 'need' is understood to mean 'not genetically or medically indicated'. If a woman, who has good eggs available to her, were to ask for egg donation under different circumstances, she would be refused donor eggs as she would be unable to furnish good grounds to warrant this wish. The crucial point therefore remains: do the partners in lesbian relationships have good grounds?

As foremost psychological grounds, lesbian couples cite the wish to strengthen the partner relationship, to enhance the degree of equality between the partners, build a shared biological bond with the child, and to carry a child of the person they love[10]. This forms part of a wide range of actions, all of which are aimed at strengthening the relationship.

[8] Malchau, S.S. et al. (2013) 'Perinatal outcomes in 375 children born after oocyte donation: a Danish national cohort study'. *Fertil Steril* 99: 1637-1643.
[9] National Institute for Health and Care Excellence (2013) 'Fertility: assessment and treatment for people with fertility problems'. *NICE Clinical guideline* 156.
[10] Machin, R. (2014) 'Sharing motherhood in lesbian reproductive practices'. *BioSocieties* 9 (1): 42-59.

REPLY FROM THE COMMITTEE TO THE REQUEST FOR AN OPINION

Within the Committee, two standpoints exist in respect of ROPA.

Some Committee members are of the opinion that the difference between IVF and DI is surmountable, both in terms of cost and effort, and that the lesbian couple should decide for themselves whether they wish to go for ROPA.

Other members of the Committee are in favour of giving first priority to DI when acceding to a lesbian couple's wish to have a child. These members too consider ROPA to be acceptable, albeit not as the first option.

The general consensus within the Committee is that the decision whether or not to accept to treat a lesbian couple in order to enable them to have a child depends on the degree of empathy with the medical, psychological or socio-familial grounds for an egg transfer.

Furthermore, the Committee is of the opinion that both women (i.e. the woman set to undergo the hormone treatment for egg donation as well as the woman set to carry the child after the performance of ROPA, not after DI), need to be comprehensively informed of all the benefits and drawbacks of IVF. They will be required to sign a contract to start the IVF treatment, in compliance with the aforesaid Act of 6 July 2007 on medically assisted reproduction.

In conclusion, the Committee wants to point out that, in compliance with article 5 of the aforesaid Act of 6 July 2007, every fertility centre is free to refuse to perform IVF treatment under the conscientious objection clause.

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The working documents are kept on file at the Committee's Documentation Centre where they are available to be consulted and copied.

The opinion is available to be consulted at **www.health.belgium.be/bioeth**

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Annex to the opinion no. 67 of 12 September 2016 on the reception of egg cells harvested from the partner within lesbian couples with a view to in vitro fertilization

only available to be consulted in French and Dutch at **www.health.belgium.be/bioeth**
(annexe à l'avis n° 67 – bijlage bij het advies nr. 67)