

III. Gamete and embryo donation

ESHRE Task Force on Ethics and Law*

These pages contain guidelines and other articles compiled by ESHRE Special Interest Groups and others, and agreed by the ESHRE Executive Committee. They are not submitted to journal peer review.

Ethical considerations concerning gametes and embryo donation are discussed. Basic principles are outlined, focusing on the issues raised by the meaning of genetic links, regulation and the necessity for taking into account the welfare of the child. Relevant specific aspects concern anonymity, compensation for donation and the consent, screening and assessment of donors and recipients.

Key words: anonymity/ESHRE/ethics/gametes donation/payment

Basic principles

Infertility is a particular health problem. Gamete and embryo donation may be the only solution to remedy the lack of female and/or male gametes, enabling the accomplishment of a parental offspring without a genetic link. It may also be applied to avoid the transmission of genetic conditions to the offspring. The result is intended to satisfy a desire for a child which is more important than treating the infertility.

Gamete and embryo donation is a sensitive subject because it challenges the genetic filiation of the family, which is the central unit of most societies. The practice is based on the premise that the genetic link has no intrinsic characteristics. The rights and obligations connected to a genetic connection is a matter to be decided by society, usually by means of legislation. Given the absence of a fixed meaning, it is ethical to enable families to be created in this way. Because reproduction is also a matter of public interest (both legally and socially), society has the right to regulate and control gamete donation; for instance, in some countries oocyte donation is evaluated differently from embryo donation, and embryo donation is subject to even stricter regulations than gamete donation.

For the large majority of the donations, the collaboration of the medical profession is needed. This contribution implies the responsibility of the health professional, as a professional and as a private citizen. In addition, it is at all times essential to take into consideration the welfare of the future child.

Particular ethical aspects

Anonymity

Double track

There is no single ideal solution to the problem of anonymity. Several different rights are at stake: (i) the right of autonomy and privacy of the parents; (ii) the right of privacy of the donor; and (iii) the right of the child to know his/her origins.

These rights cannot always be simultaneously respected. Therefore, the double track is proposed as the solution which constitutes the best balance of all interests, taking into account the specific context of donor anonymity. In this procedure, the donor can choose to enter the programme as an identifiable or as an anonymous donor, and the recipients can opt for an identifiable or an anonymous donor. The proposed system frames the choice about the anonymity or identifiability of the donor, like the decision as to whether or not to keep the donation secret, within the right of parental autonomy regarding the organization of their family.

It is understood that this system will not solve all the problems. It is, for example, likely that there will be a lack of donors wishing to relinquish anonymity. Moreover, some people who know of their donor origins will have no access to identifying information on the donor. Regardless of the donor's position on anonymity, in all cases the donor should be traceable when there is a genetic problem in the offspring.

Known donation

A known donor differs from an identifiable donor in that he or she is known to the recipient at the moment of conception or treatment. In the case of an identifiable donor, the identity of the donor is released to the offspring when they have reached maturity. There is no objection *per se* to known donation, either by friends or by family. No evidence is available, at present, that donation by friends has generated additional problems, but careful counselling of both donor and recipients is indispensable. The counselling should focus on

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possible future conflicts due to changing views on the rights and obligations toward the child. As far as familial known donation is concerned, there is no evidence of negative effects of donations by a sibling of one of the parents. However, transgeneration donation is a matter of concern because of the difficulty of defining the status of the child within the family. There is a need for more knowledge from long-term follow-up research on these children.

Payment

In principle there should be no payment for the donation of biological material. The intrinsic value of a gift, a way of showing solidarity, is higher than the positive utilitarian consequences of paying and obtaining more material.

This does not exclude reasonable compensation for the effort of the donor. This compensation should not mean inordinate profit, which would deter generous unpaid donors, entice people who would not otherwise donate, or incite them to withhold information, which might be relevant for the safety of the donation. Furthermore, an excessive payment would seriously challenge the very notion of informed consent by the donor.

There are, however, many countries where this gratuity is not applied. In some countries, a pragmatic solution is proposed. An exchange of services within the context of infertility treatment seems more acceptable as compensation than direct payment for reproductive material, which we consider to be unethical.

Recruitment and screening of donors

Implication counselling is mandatory at the time of recruitment before screening. Screening is necessary in order to protect the recipient and the future child. Psychological evaluation of the general abilities and intellectual capacity of the donor candidates is also necessary.

Known genetic age-related risks imply that sperm donors should be <50 years old and oocyte donors <35 years. For known donation a higher limit is acceptable if the recipients agree to the increased genetic risk. In these cases, the recipients should be offered the possibility of prenatal diagnosis if a pregnancy occurs.

The experience of parenthood increases the awareness of the meaning and implications of gamete and embryo donation and is therefore strongly recommended to the donor. The donor has a moral obligation to obtain the consent of his/her partner to the donation.

Advertising in order to recruit donors is best performed by an independent, non-profit-making body whose duty it is to promote donation at the national level, based on the principle of solidarity and excluding financial incentives.

Minimal information about the donor concerning appearance, education, profession, social background and motivation for donating should be recorded.

Assessment and screening of recipients

Implication counselling is mandatory at the time of assessment. The counselling should particularly focus on the interests and

welfare of the future child. The family history of the recipient should be looked at in order to ascertain whether the donor needs to be screened for recessive diseases.

The recipients have the right (or strong interest) to reserve sperm of the same donor for further pregnancies.

Medical indications

Gamete donation is indicated when there is no possibility of pregnancy without this technique, when other treatments have failed or have a minimal chance of success, or if there is a risk of transmission of a serious genetic disease if preimplantation genetic diagnosis is neither feasible nor acceptable.

Psychosocial indications

There is public debate on the acceptability of the use of gamete donation in circumstances where the infertility is caused or explained by psychosocial factors, such as with lesbians couples, single women and post-menopausal women. There is no consensus on the psychosocial indications for gamete and embryo donation. Some professionals do not consider the recipients' motivations to request this technique as valid. Various societies reflect their appreciation of these issues in their national legislation.

Safety

Screening of gamete donors must be implemented in order to avoid the transmission of serious disease to both recipients and offspring. It is, for instance, essential to cryopreserve sperm in order to exclude the risk of HIV transmission. This risk is lower for oocyte donation and therefore it is considered acceptable in some European countries to not cryopreserve the embryo before transfer. HIV, Hepatitis B and Hepatitis C status should be investigated.

Gamete donation must be practised in centres which go through a process of accreditation and regular controls.

Information registers concerning donation must be kept for 50 years in order to enable the traceability of the donors and to fulfil the possible need for information about the donor.

The child

At every step of the process, it is important to take into consideration the welfare of the child. The child has a right to all the information that the donor has provided and to general data on the donation.

Informed consent

The process of information giving, with counselling concerning the implications of donating or receiving gametes, is essential to enable the donor or recipient to give his/her informed consent. This process demands time and the possibility of continued interaction. Special attention should be given to the fact that donating and/or receiving gametes has long-term implications and that the perception and evaluation of the people involved concerning the donation and/or reception might alter with personal life events. The donor should realise that the meaning that he/she attaches to the donation may not coincide with that of his/her direct social environment and of society at large.