4.2.2 Gamete Donation

Donating eggs or sperm for others to use in reproduction can enable individuals who would not otherwise be able to do so to have children. However, gamete donation also raises ethical concerns about the privacy of donors and the nature of relationships among donors and children born through use of their gametes by means of assisted reproductive technologies.

Physicians who participate in gamete retrieval and storage should:

(a) Inform prospective donors of sperm or ova:

  (i) about the clinical risks of gamete donation, including the near and long-term risks and the discomforts of ovarian hyperstimulation and egg retrieval as appropriate;

  (ii) about the need for full medical disclosure and that prospective donors will be tested for infectious disease agents and genetic disorders;

  (iii) whether and how the donor will be informed if testing indicates the presence of infectious disease or genetic disorder;

  (iv) that all information collected, including test results, will be stored indefinitely;

  (v) what additional personal information will be collected about the donor;

  (vi) under what circumstances and with whom personal information, including identifying information, will be shared for clinical purposes;

  (vii) how donated gametes will be stored and policies and procedures governing the use of stored gametes;

  (viii) whether and how the donor will be compensated;

  (ix) the fact that state law will govern the relationship between the donor and any resulting child (or children).

(b) Exclude prospective donors for whom testing reveals the presence of infectious disease agents.

(c) Obtain the prospective donor's consent for gamete retrieval.

(d) Discuss, document and respect the prospective donor's preferences for how gametes may be used, including whether they may be donated for research purposes.

(e) Discuss, document, and respect the prospective donor's preferences regarding release of identifying information to any child (or children) resulting from use of the donated gametes.

(f) Adhere to good clinical practices, including ensuring that identifying information is maintained indefinitely so that:

  (i) donors can be notified in the event a child born through use of his/her gametes subsequently tests positive for infectious disease or genetic disorder that may have been transmitted by the donor;

(ii) the number of pregnancies resulting from a single gamete donor is limited.

AMA Principles of Medical Ethics: I,V

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 7-I-04 Artificial insemination by known donor, amendment

CEJA Report 8-I-04 Artificial insemination by anonymous donor, amendment

Report of the Judicial Council A-83 Artificial insemination

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 7 - I-04

Subject: Artificial Insemination by Known Donor, *Amendment*

Presented by: Michael S. Goldrich, MD, Chair

Upon reviewing Opinions that address HIV/AIDS, and upon further consultation at the Open Forum held at the 2004 Annual Meeting of the House of Delegates, the Council on Ethical and Judicial Affairs (CEJA) has determined that in several instances the specific focus on HIV/AIDS is unjustified. Rather, the focus ought to be expanded to include other blood-borne pathogens. Furthermore, the Council has identified legal language in this particular Opinion that does not belong in such an ethics policy. For this reason, CEJA is amending Opinion E-2.04, "Artificial Insemination by Known Donor" as follows. The amended Opinion will appear in the next version of *PolicyFinder* and the next print edition of the *Code of Medical Ethics*.

E-2.04 Artificial Insemination by Known Donor.

Any individual or couple contemplating artificial insemination by husband, partner, or other known donor should be counseled about the full range of infectious and genetic diseases for which the donor or recipient can be screened, including communicable disease agents and diseases. ~~HIV infection.~~ Full medical history disclosure and appropriate diagnostic screening should be recommended to the donor and recipient but are not required.

Informed consent for artificial insemination should include disclosure of risks, benefits, and likely success rate of the method proposed and potential alternative methods. Individuals should receive information about screening, costs, and procedures for confidentiality, when applicable. The prospective parents or parent should be informed of the laws regarding the rights of children conceived by artificial insemination, as well as the laws regarding parental rights and obligations. ~~If the donor is married to the recipient, resultant children will have all the rights of a child conceived naturally.~~

~~If the donor and recipient are not married, an appropriate legal rule would treat the situation as if the donor were anonymous: the recipient would be considered the sole parent of the child except in cases where both donor and recipient agree to recognize a paternity right.~~

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* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

Sex selection of sperm for the purposes of avoiding a sex-linked inheritable disease is appropriate. However, physicians should not participate in sex selection for reasons of gender preference. Physicians should encourage a prospective parent or parents to consider the value of both sexes.

If semen is frozen and the donor dies before it is used, the frozen semen should not be used or donated for purposes other than those originally intended by the donor. If the donor left no instructions, it is reasonable to allow the remaining partner to use the semen for artificial insemination but not to donate it to someone else. However, the donor should be advised of such a policy at the time of donation and be given an opportunity to override it. (I, V) Issued June 1993; updated December 2004.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 8 - I-04

Subject: Artificial Insemination by Anonymous Donor, *Amendment*

Presented by: Michael S. Goldrich, MD, Chair

Upon reviewing its opinions that address HIV/AIDS, the Council on Ethical and Judicial Affairs (CEJA) has determined that in several instances the specific focus on HIV/AIDS is unjustified. Rather, the focus ought to be expanded to include other blood-borne pathogens. For this reason, CEJA is amending Opinion E-2.05, "Artificial Insemination by Anonymous Donor." The amended Opinion will appear in the next version of *PolicyFinder* and the next print edition of the *Code of Medical Ethics*.

E-2.05 Artificial Insemination by Anonymous Donor.

Thorough medical histories must be taken of all candidates for anonymous semen donation. All potential donors must also be screened for infectious or inheritable diseases which could adversely affect the recipient or the resultant child. Frozen semen should be used for artificial insemination because it enables the donor to be tested for communicable disease agents and diseases ~~HIV infection~~ at the time of donation, and again after an interval before the original semen is used, thus increasing the likelihood that the semen is free of ~~HIV infection~~ blood-borne pathogens. Physicians should rely on the guidelines formulated by relevant professional organizations, such as the American Society of Reproductive Medicine, the Centers for Disease Control and Prevention, and the Food and Drug Administration, in determining ~~the interval between the initial and final HIV test,~~ which disorders to screen for~~,~~ and which procedures to use in screening. Physicians should maintain a permanent record which includes both identifying and non-identifying health and genetic screening information. Other than exceptional situations where identifying information may be required, physicians should release only non-identifying health-related information in order to preserve the confidentiality of the semen donor.

Physicians should maintain permanent records of donors to fulfill the following obligations: (1) to exclude individuals from the donor pool who test positive for infectious or inheritable diseases, (2) to limit the number of pregnancies resulting from a single donor source so as to avoid future consanguineous marriages or reproduction, (3) to notify donors of screening results which indicate the presence of an infectious or inheritable disease, and

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(4) to notify donors if a child born through artificial insemination has a disorder which may have been transmitted by the donor.

Informed consent for artificial insemination should include disclosure of risks, benefits, likely success rate of the method proposed and potential alternative methods, and costs. Both recipients and donors should be informed of the reasons for screening and confidentiality. They should also know the extent of access to non-identifying and identifying information about the donor. Participants should be advised to consider the legal ramifications, if any, of artificial insemination by anonymous donor.

The consent of the husband is ethically appropriate if he is to become the legal father of the resultant child from artificial insemination by anonymous donor. Anonymous donors cannot assume the rights or responsibilities of parenthood for children born through therapeutic donor insemination, nor should they be required to assume them.

In the case of single women or women who are part of a homosexual couple, it is not unethical to provide artificial insemination as a reproductive option.

Sex selection of sperm for the purposes of avoiding a sex-linked inheritable disease is appropriate. However, physicians should not participate in sex selection of sperm for reasons of gender preference. Physicians should encourage a prospective parent or parents to consider the value of both sexes.

In general, it is inappropriate to offer compensation to donors to encourage donation over and above reimbursement for time and actual expenses. (I, V) Issued June 1993; updated December 2004.

(Judicial Council – A)

ARTIFICIAL INSEMINATION BY DONOR

Physicians have an ethical responsibility to use the utmost caution and scientifically available screening techniques in the selection of donors for use in artificial insemination. Relying only upon the verbal representations of donors as to their health, without any medical screening, is precarious. The donor should be screened for genetic defects, inheritable and infectious disease, Rh factor incompatibility and other disorders that may affect the fetus. When the physician is not equipped to fulfill these responsibilities, the services of a skilled medical geneticist or other appropriate specialist should be sought.

Since the identity of donors ususally should not be available to recipients or the offspring that may result, the risk of inadvertent inbred and serious undesirable genetic and biological consequences should not be ignored. Physicians have an ethical and social responsibility to avoid the frequent use of semen from the same sources.

IN VITRO FERTILIZATION

The technique of in vitro fertilization and embryo transplantation enables certain couples previously incapable of conception to bear a child. It is also useful in the field of research directed toward an understanding of how genetic defects arise and are transmitted and how they might be prevented or treated. Because of serious ethical and moral concerns, however, any fertilized egg that has the potential for human life and that will be implanted in the uterus of a woman should not be subjected to laboratory research.

All fertilized ova not utilized for implantation and that are maintained for research purposes shall be handled with the strictest adherence to the Principles of Medical Ethics, to the guidelines for research and medical practice expressed in the Judicial Council's opinion on fetal research (2.07), and to the highest standards of medical practice.

B. INTERPROFESSIONAL RELATIONS WITH NURSES

(Reference Committee on Amendments to Constitution and Bylaws, page 313)

HOUSE ACTION: ADOPTED

Physicians and nurses must work cooperatively together to provide optimum patient care. The Judicial Council has adopted the following opinion on Interprofessional Relations Between Physicians and Nurses, and submits this opinion to the House of Delegates.

INTERPROFESSIONAL RELATIONS WITH NURSES

The primary bond between medical practice and nursing is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the orders of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, the physician has an ethical obligation to explain those orders to the nurse involved. Whenever a nurse recognizes or suspects error or discrepancy in a physician's orders, the nurse has an obligation to call this to the attention of the physician. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies when prompt action is necessary and the physician is not immediately available, in the performance of reasonable care a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient. Such occurrences should not be considered to be a breakdown in professional relations.