Paru dans *International Journal for Technology Assessment in Health Care*, vol. 5, n° 4 (1989), pp. 639-657.

GIVING, RECEIVING AND REPAYING : GAMETE DONORS AND DONOR POLICIES IN REPRODUCTIVE MEDICINE[1]

Abstract *: Current practices of donor recruitment for medical fertilization procedures are analysed in the light of Marcel Mauss' essay on the gift in primitive societies. In this perspective, donor policies seem primarily designed to spare infertile recipients the obligation to recognize the donor's contribution to these procedures , thus avoiding the kinship issues which they raise. Questions of meaning concerning donation, social recognition of the donor's role, and clarification of the relational issues underlying fertilization procedures are nevertheless essential elements in establishing their social legitimacy.*

Marcel Mauss' essay on the gift in primitive societies, which analyses the apparently voluntary and spontaneous exchange of certain types of goods in terms of a threefold normative structure - the obligations to give, to receive and to repay - (31), is often used as a framework for analysing the donation of body organs or fluids for various uses in medical practice (19;37;39). The acts of giving and receiving, with their respective difficulties, are frequently examined in these studies; less attention, however, is focused on the third obligation : that of offering something in return[2].

[1] A first version of this paper was originally written as a background paper for a European Community Commission working party, preparing a report on the Ethics of Reproductive Technology. I wish to thank all the Committee members, and in particular Jonathan Glover, for their comments as well as for their permission to publish my material separately, since it was finally not used as such in the report. I also wish to thank Sally Cook Socia, Joachim Marcus-Steiff, Gwen Terrenoire, Judith Lorber and several anonymous reviewers for subsequent readings, suggestions and detailed critiques, which helped me arrive at this final version.

[2] Simmons et al. (37) do deal with the difficulties faced by live donors or by the family of cadaver donors when gratitude in some form is not expressed by the recipients or, in the case of anonymous cadaver donors, by the medical team.

Because of the nature of the gift - a vital body part - and its circumstances, which tend to create an assymetrical relationship between the giver and the receiver, it is supposed that reciprocation is impossible, or at least unfeasible. Using the example of gamete donation for medical fertilization procedures, I would like to argue that finding a means of fulfilling this obligation to return a gift is the key not only to the survival of these practices, but also to their social legitimacy. In this perspective, Georg Simmel's reflections on gratitude suggest that it is not something of equivalent value which is expected in return, but rather an open acknowledgement of the donor's gift :

> "...gratitude emerges as the motive which, for inner reasons, effects the return of a benefit where there is no external necessity for it. But 'benefit' is not limited to a person's giving things to another: we also thank the artist or poet who does not even know us. This fact creates innumerable connections, ideal and concrete, loose and firm, among those who are filled with gratitude toward the same giver. In fact, we do not thank somebody only for what he **does** : the feeling with which we often react to the mere existence of a person, must itself be designated as gratitude..." (36).

Calling on an anonymous individual to donate gametes for a medical fertilization procedure is rapidly becoming a common solution to certain forms of infertility. The now century-old practice of artificial insemination with donor semen (AID), a means of bypassing the problem of male infertility, seems to have set a precedent for the development of similar practices. Physicians performing in-vitro fertilization have used this idea in resorting to donor oocytes, as well as donor semen, in an attempt to "treat" a wider variety of forms of infertility with this new technique; they are also considering the donation of in-vitro fertilized eggs as a form of prenatal adoption. In this context, a more ancient solution to infertility - surrogate pregnancy - is being publicly revived.

And yet, ever since the first insemination with donor semen in the late nineteenth century (18;24), a major obstacle to the public acceptability of resorting to donors has been the sexually illegitimate connotations of such transactions, as well as their eventual legal complications concerning kinship. Secrecy and the anonymity of the donor, protected by a medical mediator, have been the key elements in this type of procedure: minimizing the donor's contribution and eliminating all traces of his participation has always seemed a positive attitude, permitting the couple eventually to forget the procedure and lead a normal family life. In this perspective, the donor's

rights and interests seem negligeable, given the momentary nature of his participation.

Thus arranged, these new fertilization procedures create a social - and sociological - dilemma : whereas gift-giving and receiving bind social actors in an ongoing relationship through the mutual obligation to reciprocate gifts, these medical practices attempt to solicit from anonymous individuals an act of generosity in response to the expression of a new social need - that of body cells vital for reproduction - without defining the social tie which would create in this situation an obligation to give and without incurring for the recipients any reciprocal obligations. Because of what the donor has to offer - one of the biological vectors of kinship - his/her very existence is perceived as threatening to the recipients, who base their claim to parenthood primarily on social grounds. Given the complex kinship issues which underlie these procedures, acknowledging the donor's gift appears as an irrational requirement.

Does an analysis in terms of gift-giving actually apply to the donation of vital body cells in reproductive medicine ? In many countries, semen and oocyte donors are paid; it thus could be argued that we are dealing with a new type of commercial transaction - the exchange of gametes for money between a medical mediator and a donor. But Marcel Mauss clearly points out, in his essay on The Gift, that what distinguishes the exchanges he was analysing from regular economic transactions between clans was the nature of the objects being given, received and repayed. These were objects of subjective value, related to the giver's prestige or that of his clan and, as such, were considered to be a part of the giver's own person, to contain his spiritual essence:

> "...in this system of ideas one gives away what is in reality a part of one's nature and substance, while to receive something is to receive a part of someone's spiritual essence. To keep this thing is dangerous, not only because it is illicit to do so, but also because it comes morally, physically and spiritually from a person. Whatever it is, food, possessions, women, children or ritual, it retains a magical and religious hold over the recipient. The thing given is not inert. It is alive and often personified, and strives to bring to its original clan and homeland some equivalent to take its place (31,10)."[3]

[3] See also Chapter II, note 25, and in particular: "These precious objects differ, it is true, from what we are accustomed to consider as purchasing instruments. Beyond their economic nature they have a mystical nature and are talismans or 'life-givers', as Rivers, Perry and Jackson say. Moreover, they have a very general circulation within a society and between societies, but they are still attached to persons or clans (the first Roman coins were struck by **gentes**), to the individuality of their former possessors and to contracts made between moral beings. Their value is still subjective." (31,93)

The obligation to reciprocate such gifts springs from the very fact that, as a gift of the giver's life, it tends to refer back to him. On the other hand, Mauss reminds us that we are not dealing here with exchange between individuals but rather between groups:

> "...it is groups, and not individuals, which carry on exchange, make contracts, and are bound by obligations; the persons represented in the contracts are moral persons - clans, tribes, and families; the groups, or the chiefs as intermediaries for the groups, confront and oppose each other (31,3)."

The obligation to reciprocate, therefore, need not take on a personal form.

I will therefore examine, in this perspective, the problems raised by gamete donation in reproductive medicine, and the ways in which different guidelines for donor recruitment attempt to deal with them. As opposed to the opinion that donor policies give too much weight to the donor's interests (3), I would like to argue that, for the most part, these guidelines are designed primarily to protect the recipients' interests and those of the future child - as these interests are perceived by the medical intermediaries. Only those interests which the donor might have in common with the recipients - such as the avoidance of legal suits concerning parentage - are taken into consideration. Donor policies are rarely formulated in terms of what gamete donation might mean to the donor himself - or for that matter, to society. Can a society ask some of its members to contribute voluntarily to a procreative procedure without appropriately defining and recognizing this contribution? I contend that the social issues at stake in medical fertilization procedures resorting to donor gametes all stem from this deliberate creation, for medical purposes, of a social and procreative role not meant to entail parental rights[4].

One cannot, of course, put all types of donation on the same footing. In the first place, each type of donation (semen, oocyte, embryo, and the special case of surrogacy) involves different degrees of physical risk. Semen donation, for example, is not a medical but a sexual act as it involves masturbation; in this sense, therefore, it implies no physical risks for the donor. However, oocyte donation, whether by laparoscopy (a surgical procedure), by ultrasound probe, or by the flushing out of a fertilized egg from the womb after artificial insemination (the latter, both ambulatory procedures), all include certain risks, including in the latter case, the risk of an unwanted pregnancy for the donor. Surrogacy involves all the obstetrical and other

[4] My hypothesis can also be applied to medical fertilization procedures **without** donor gametes; for although the physician, given his profession, is apparently engaged in a therapeutic procedure, he is, strictly speaking, involved in a procreative act, since the procedures **do not cure** infertility.

medical risks normally associated with pregnancy and childbirth. In other words, the internal location of women's reproductive organs makes donation of any kind by women a greater risk to their physical integrity and, in the case of surrogacy, a more total and long-term involvement of the donor's person in this act. Policies with respect to donors must therefore take these differences into account.

However, donation is not a purely physical act; semen, oocytes, embryos, pregnancy, and children are all strongly charged with meaning in most if not all cultures, and exchanges of these substances, roles or persons are admitted only in socially prescribed relationships. Individuals thus make an important psychological and social decision in resolving to give away something which is usually perceived as belonging to them, socially and psychologically linked to personal and sexual identity, as well as to family relations. Potential donors must therefore be given a chance to consider their motivations, as well as the possibility that they might at some future time regret this act, interpeting it as a loss, as contrary to their interests or to social and psychological integrity. This seems all the more important in the present context, since neither adequate legal provisions nor social norms defining this type of situation exist.

Because semen donation is the area in which both reflection and practice are the most advanced, I will use these donor policies as a basis for discussing the various issues raised by gamete donation. Oocyte and embryo donation are not yet current practices; nevertheless, some guidelines are being experimented with, often using semen donor policies as a reference. I will therefore explore these guidelines in an attempt to analyse the specific problems raised when resorting to women donors. The surrogate mother will be included in the analysis as a special type of woman donor; for, in fact, heated controversy over this type of reproductive transaction has brought the different donor issues clearly out into the open.

Finally, the problems regarding gamete donors cannot be studied separately from those regarding the recruiting agent, who is, for the most part, a medical intermediary (physician, hospital service with or without cryopreservation facilities, a semen bank, etc.). The intermediary exists, among other reasons, to ensure the anonymity of the gamete transfer - perceived as being in the interests of all the parties involved. The intermediary sets the rules for gamete donation, either by an explicit donor policy concerning recruitment, screening and compensation, or through a series of customary practices which have been adhered to over time. The soliciting agent therefore necessarily structures the context within which potential donors will or will not be motivated to give.

Recruitment and Compensation

Once the principle of a medicalized donor transaction is accepted, the first problem is one of recruitment: where and how is one to find a sufficient number of donor candidates ? In the case of artificial insemination with donor semen (AID) which, until recently, has been practised secretly by physicians in private consultation, the most expedient and discrete solution has appeared for many years to be soliciting among medical students. Not only were they a population of presumably healthy and intelligent young men close at hand, it was supposed that, as students of medicine, they would more readily understand the purpose of the request.

This type of solution has been severely criticized by some, as AID becomes a more widespread and publicly recognized solution to male infertility (3;9;10). In the first place, it appears as a type of eugenic solution, based on social criteria: physicians are choosing young members of their own profession as the most physically and intellectually fit candidates for semen donation (3,14). This, of course, is a questionable supposition, if it in fact reflects the recruiting agent's prime motivation. Secondly, by recruiting donors from a restricted population, the physician's choice is narrowed, often resulting in the repeated use of the same donors. This tends to increase the future risk of consanguineous marriages between children conceived with semen from the same donor. However, those who defend this recruitment method argue that the medical student population is mobile and constantly changing, thus creating a built-in protection against consanguinity. Finally, the recruiting situation in itself tends to create undue pressure on the potential donor to consent, if the solicitor is a donor's superior, or is eventually capable of influencing his future career; the potential donor may therefore not be given appropriate conditions for reflection before acting. The fact that, in this context, the donor is almost always remunerated indicates that semen donation is defined in advance as a commercial transaction, when in fact its meaning for the donor - and for society - may be totally different. Therefore, although medical students may, as a group, be an easily accessible source of semen donors, the soliciting structure does not necessarily protect the donor's interests (or for that matter, the recipients' and the intermediary's interests, as we will see later, in discussing screening).

An alternative solution to this type of recruitment has been proposed by the French Federation of CECOS (Centre d'Etude et de Conservation du Sperme) semen banks (9;11;33). They have attempted to recruit donors among the general public. To this purpose, they have used magazine articles, radio and television programs, and in 1984, a nation-wide publicity campaign. Recipients have also been asked to become involved by soliciting family and friends for donations to the CECOS banks; these particular donations, however, are not used for the soliciting couple, as the principle of anonymity prevails. The purpose of this mode of recruitment is to

increase and diversify the donor population, as well as to promote public involvement and consequently social recognition of AID as a legitimate solution to male infertility.

In fact, the CECOS banks have formulated an ideological basis for their donor policy, whose express intent is to transform this procreative transaction into a morally and socially acceptable act. Conceptualized as a "gift from one couple to another" (don de couple à couple), semen donation should not only be a gratuitous act, it should also ideally be the altruistic gesture of a married couple, who have children themselves and are therefore capable of empathizing with the plight of the infertile couple. In practice, the single most important criteria is paternity (in other words, the potential donor himself must have at least one healthy child, whether he be married, single or divorced) (10,212). Nevertheless, CECOS ideology formulates what it believes to be appropriate donor motivation; in other words, it defines an obligation to give.

Although this system has avoided some of the major pitfalls of recruiting among medical students (restriction to one social category, repeated use of the same donors), it has run into other difficulties. The very first and most important has been an inadequate supply of donors. This is partly explained by CECOS policy, which limits the number of pregnancies per donor to five, so as to practically eliminate the risk of consanguinity. It can also be partially explained by the reluctance of recipient couples - who remain the major source of donors - to solicit donations in their immediate social environment, as they usually wish to keep recourse to AID a secret. In fact, this mode of recruitment has been criticized by some as a source of undue pressure both on the recipients and the donors: the recipient couple may feel obliged to find donors in order to have access to treatment; their friends and relatives may in turn feel obliged to donate semen as a favor to the soliciting couple. In any case, the question remains as to why the CECOS ideological proposition, well-aired by the media, seems to appeal more to potential recipients - whose demand for AID has increased constantly during the last fifteen years - than to potential donors[5].

Most critics of this recruiting system suggest that the problem of an insufficient number of donors could easily be solved by offering an adequate and proven incentive: money (7;33, 223-224). Others suggest that one cannot expect a person to donate something so personal, if he does not receive some benefit from his act (2;12;13;21). Besides the personal satisfaction that the donor can derive from an

[5] In 1973, the first CECOS bank received 278 requests for AID; ever since 1982, demand has stabilized to around 3000 requests per year. As for donors, their number has increased gradually from about 50 donors in 1973 to approximately 800 per year since 1982. However, the number of donors per year has been far less stable than the number of requests for AID, and in 1985, there was a 25% drop in the number of donors. Also, only 2/3 of potential donors have "utilizable" semen, i.e. a sufficient number of normal and mobile sperm which can stand freezing (CECOS statistics presented at annual meetings of the Federation; also 10;11).

altruistic act, it appears important that the receiving agent express his gratitude (and ultimately that of the recipients) through some concrete form of compensation (not necessarily financial). In other words, unselfish concern for the welfare of others does not preclude some form of social recognition.

One of the French CECOS banks at Necker Hospital, which did not originally belong to the Federation, initially paid its donors - for the most part single medical students. After entry into the Federation, they were obliged to stop paying their donors, as gratuitous donation is an unconditional principle of the CECOS banking system; however, they were allowed to continue recruiting single men without children. A study of their donor population before and after entry into the CECOS system does show a decline in the total number of donors after payment ceased; however, this was compensated by a diversification of the donor population (8). The small amount originally paid to the donor (50 FF) hardly appears as an incentive, even though it could be attractive to a student population. Nevertheless, the study does seem to suggest that the absence of remuneration renders semen donation more difficult or less attractive. Is this because lack of payment automatically obliges the donor to question his motivations ? Or is this simply because, without some form of compensation, donation appears to some potential donors as a loss ?

Donor motivation has thus particularly preoccupied CECOS physicians, who offer no payment for semen: what, other than money, will motivate men to donate semen ? Studies by psychologists working in association with these French banks (2;12;13;21;23;29) have revealed four regularly recurring types of motivation in CECOS semen donors: the donor's sensitivity to the problem of infertility, usually linked to the existence of a childless couple in his immediate surroundings; confirmation of the donor's own fertility; an attempt to compensate for some loss in the donor's own family (death, divorce, abortion, wife's sterilization, etc.); previous donating behavior in other areas (in particular, blood donation : a high percentage of semen donors are also blood donors - in one bank as many as 60% (8)). The first motivation seems largely determined by the mode of recruitment used by these banks: requests coming from the recipient couple and media attempts to sensitize the public to the dilemma of the infertile. The next two factors indicate that the donor's motivations are strongly related to feelings and events in his own reproductive life course. The last factor suggests that, in any case, some groups are more "donation prone" than others. Who are they and why do they donate ?

An exploratory study of attitudes towards AID and semen donation among 75 blood donors - 52 men and 23 women - (32;34) indicates that not all male blood donors perceive semen donation as a comparable and thus feasible act for them. Those blood donors who objected to the idea of donating semen (10 out of 52) had a primarily genetic conception of semen: because semen carries those genes which will determine physical - and some say character - traits of the child to be born, it is a

personalized susbstance which cannot be given away anonymously. The child's appearance ultimately permits the identification of the donor, who remains the "real" father. Thus, by giving away his semen, a donor is either depriving himself of a child which is actually his, or simply becoming a father against his will. Many of the men in this group were single and did not have children; a few expressed the intent never to have any.

Those blood donors who were not opposed to the idea of donating semen (19 out of 52) did not perceive it as such a personal and inalienable substance. To them, semen is like blood, a vital substance which can be given away without entailing a loss for the donor, as blood and semen are both constantly produced by the body. Just as blood donation can save lives, so semen donation can save a couple whose infertility problem has brought them to the brink of divorce. The semen donor can thus bring aid and comfort to those who do not have children, without in any way curtailing his own capacity to have them; on the contrary, if anything, semen donation confirms his own fertility. Almost all the men in this group were married and had children.

Many blood donors (21 out of 52), however, were quite ambivalent about the idea of donating semen: although eventually perceived as an act whose ultimate goal seemed positive, semen donation, which requires masturbation, was too often associated with juvenile, homosexual or adulterous behavior. These men also mentioned, as a deterring factor, their wife's eventual disapproval. They were thus quite reticent about engaging in what appeared to them as illegitimate sexual behavior. The majority of the men in this group, whether married or single, had "as yet" no children; for this reason, they also seemed uncertain as to whether they should be imagining themselves as potential donors or potential recipients.

Semen donation can therefore have different meanings for different men at different stages of their lives, particularly with respect to their own procreative history or intentions. When a material reward is not available to explain one's act, the donor may feel compelled to reflect on the meaning he attributes to this altrusitic action. As the blood donor study indicates, many men may perceive semen donation as a loss of their own progeny, or as a strongly forbidden, socially reprehensible sexual practice. Trying to undertand one's motivations can then be a strong deterrent to semen donation. Remuneration, when used to short circuit this obstacle, can in the long run be an unethical means of obtaining donor consent, even if in the immediate circumstances, payment does solve a problem of semen supply for AID. On the other hand, the lack of some form of compensation (not necessarily financial) could appear as an absence of social recognition for the donor's role. The fact that compensation of some sort is a key issue in the controversy over donor recruitment suggests that society does have a debt to clear with the donor.

Anonymity

In semen donation, where the physical risks incurred by the donor are non-existant, the major ethical problems with regards to the potential donor is ensuring that he is not unduly pressured by money, persons in authority or close affective ties into giving semen away against his will. This has necessarily brought questions related to recruitment and compensation to the foreground.

In the case of oocyte donation, which is often not paid[6], the terms of the recruitment debate are different. The medical risks of laparoscopy, ultrasound probe, and embryo flushing are not negligible and, because of these risks, it is the principle of anonymous transactions which is questioned: it is thought that many women would not undergo surgery unless the beneficiary is a relative or close friend (20). In fact, in one of France's first in vitro fertilization (IVF) services at Antoine Béclère Hospital, some couples come to their first consultation with a relative or a friend who has agreed to donate her oocytes for their benefit. Interviews with these potential oocyte donors has shown that strong affective ties usually exist between the two women, motivating the one to help the other to become a mother (5). In some cases, however, especially when the potential donor is a younger sister or cousin, it appears that a certain amount of family pressure has been brought to bear on her decision (5;37,286-337).

This IVF hospital service has tried to transpose the CECOS model for semen donation to oocyte donation, thus incorporating the principle of anonymous transactions. The couples arrive with their prospective donor, but the IVF service proposes an anonymous exchange with another couple's donor. This proposition was accepted by half of the couples, even though it is not certain that this one-to-one anonymous exchange does actually avoid the supposed negative side effects of knowing the oocyte doonor. The couple can always consider their donor as the woman who made the wife's pregnancy possible, even though indirectly.

In other IVF services, physicians have preferred asking a woman already undergoing these procedures for her own benefit to donate some of her ova (or in some cases, embryos). This model for oocyte donation, first used in Australia, arose as a solution to the problem of what to do with "extra" eggs. IVF patients receive hormonal stimulation, so that more than one egg will be released during that cycle; however, more eggs are usually retrieved than can safely be reimplanted at one time. The IVF patient therefore does not incur any supplementary physical risks by

[6] In the United States, some oocyte donors, particularly those undergoing embryo flushing, are paid; the arguments developed above on compensation can therefore be equally applied to these cases.

donating, and the physician avoids performing unnecessary procedures on a woman who needs no medical treatment. However, the donating patient could eventually regret her gesture, if the receiving patient becomes pregnant and she does not. Now that the cryopreservation of these eggs after fertilization makes them available to the same woman for reimplantation at a later cycle, physicians may have to opt for alternative models of oocyte donation(4).

Therefore, whereas the risk involved creates a situation in which knowing the recipient makes oocyte (or embryo) donation an apparently more acceptable procedure, this absence of anonymity can create problems of rivalry or hostility between the two women, especially if the donor is a close friend or relative who will probably witness the development of the child. This risk appears all the more evident, given the present lack of legal provisions clearly defining the oocyte donor's status.

In fact, anonymity is a controversial matter, not only with respect to oocyte donation, but also to semen donation. In both cases, it is the donor's parental status which remains unclear and which seems to menace the stability of the "artificial" family. The problems raised by each situation are not necessarily similar: whereas legal claims to paternity are most often based on establishing genetic relationship through blood tests, legal claims to maternity are, in many legal systems, based on parturition, and not on the woman's genetic contibution (although this was obviously seen to follow from the fact of giving birth). Therefore, in the case of AID, given existing legal provisions, the mother could feasibly file a paternity suit against the donor, or vice versa, the donor could try to establish his rights as the father of the child. Anonymity is thus often advocated as an indispensable component of the AID procedure, protecting both the donor and the recipients. The oocyte donor's legal claim to status as mother seems shakier, as she does not carry and bear the child. This, however, does not prevent difficulties in the future relationship between the IVF mother and the oocyte donor, if the latter should feel that she has a moral claim to some role or privileged position with regard to the child. In fact, controversy over the desirability of anonymity reveals an underlying lack of clarity, both from a legal and a social point of view, on how the donor's role and social status is to be defined. By depersonalizing donations through the principle of anonymous transactions, questions concerning the donor's reproductive role can easily be avoided.

The Swedish Parliament recently questioned anonymity as an appropriate solution to this problem, by passing a law forbidding anonymous semen donations for two reasons : 1. the AID child, like the adopted child, should have a constitutional right to information concerning biological origins; 2. the new insemination law strictly defines paternity in the case of AID as the married woman's husband, who has given his irrevocable written consent,so that no paternity lawsuits can be filed

against the donor (15;38). Anonymous semen donations therefore do not seem justified.

The immediate effect of this new law was a serious decline in the practice of AID, not only because of a reduction in the number of donors but also because of a decrease in demand. But a recent report (16) indicates that, in many centers, practice has resumed its normal rhythm, with a significant modification of the donor population. Whereas before the law, donors were for the most part single students, today they are mostly married men with children (1,129-134;16,32)[7]. Just as in the case of compensation, the anonymity principle seems to affect donor motivation, though no studies exist at present to explain this change. In any case, whether or not anonymity is retained as a component of the AID transaction necessarily affects the social meaning of semen donation; it is therefore possibly not surprising that the new population of donors in Sweden are men who have personally come to terms with the problem of paternal responsibility.

The new Swedish insemination law does raise the question of the desirability of anonymous donation when it might eventually be vital for the child to know something about his or her biological origins for medical or other reasons. It does not however question the principle of anonymous transactions as such between donors and recipients, as the latter do not have access to this information on the donor. The law therefore seems to adhere to the general consensus that, at least in the case of AID, an anonymous reproductive transaction is to be preferred. Nevertheless, in trying to equate the situations of the AID and the adopted child, the law does give the donor a socially recognized position (he is no longer just anonymous semen), even though this position carries no parental rights. There is no denial of the donor's role in the AID procedure.

If the principle of anonymous transactions is retained, an intermediary becomes essential in all reproductive procedures involving donors. The intermediary is the only one who knows the identities of all the parties involved and must guarantee the protection of this secret. And because of this position as mediator, he is able to exert over these transactions considerable social control.

Screening

For many years, physicians who practised AID in private consultation felt that the best way to protect the secrecy of AID was to make as few demands on the donor

[7] It is interesting to note the similarity of Sweden's donor population, after passage of the new law, with that of the population required by CECOS principles.

as possible. There was at most a cursory medical history and physical examination, and usually all medical records concerning the donor and the AID procedure were later destroyed. As AID became more widely and publicly practised, this type of medical conduct was considered irresponsible, and much attention is now given to the screening of donors and to the keeping of medical records, which permit the physician to control the quality of the semen and of the insemination procedure. Screening and accurate records are also important in that the responsible physician wishes to avoid inadvertently creating medical problems for his clients (i.e. venereal disease, AIDS, etc.) and for the future generation (i.e. malformations, genetically inherited disorders).

What does screening involve ? This, of course, varies from country to country, and according to the way donors are recruited. As a rule, no social criteria are openly imposed as a means of selecting potential candidates - the CECOS semen bank federation (which accepts only men with children, preferably married) being one exception. However, as we have already seen, even when no explicit policy specifies social criteria, the recruitment policy tends to determine the social composition of the donor population.

In a few places, particularly in France, the potential donor must undergo an interview with a psychologist or some other qualified staff member. The usual purpose of such an interview is to give the potential donor a chance to consider and discuss fully all aspects of semen donation; it does occasionnaly also serve the purpose of weeding out those candidates whose motivations appear to be psychopathological. Such interviews could be criticized as "looking a gift horse in the mouth": if they are used exclusively for screening purposes, interviews could be considered as excessive scrutinizing of a donor's motivations. However, when seen from the donor's point of view, an interview can be an occasion to pause and reflect, making sure that all aspects of donation have been thought out and that no undue pressure is coming from wife, relatives, or friends.

From a medical standpoint, screening tends to be more rigorous where the AID procedure is highly institutionalized, such as in hospital services and semen banks. Besides the usual medical history and physical examination, semen bank and hospital physicians tend to follow through with complementary laboratory tests (blood group, Rhesus factor, semen culture, genetic karyotype, etc.) so as to have a more detailed and accurate profile of the donor. Genetic screening is in some cases extended to the recipient, in order to avoid the chance combination of recessive genes.

The obvious purpose of such screening is to avoid transmitting infections to the recipients and genetic diseases or malformations to the child. Nevertheless, excessive preoccupation with a donor's biological characteristics could transform reproductive techniques into eugenic practices. Little attention has been given to this

point, because overt eugenic initiatives appear to be so easy to condemn (i.e. the Nobel prize winners' bank, which requires high I.Q. of its donors, on the debatable premise that intelligence is exclusively a genetically-transmitted characteristic). In fact, subtle eugenic attitudes are, to a certain extent, an integral part of the medical precautions taken in the interest of the future child: this, of course, is an obvious corollary to the development of genetics and bio-medical practices permitting the detection of genetically-inherited disorders. A very fine line, therefore, distinguishes at some point prophylaxis from eugenics: the whole difficulty with screening is trying to determine where exactly this might be. As fertilization procedures, genetics, and related bio-medical practices develop, there will most probably be a tendency to multiply the medical precautions which seem necessary to guarantee the good outcome of a reproductive procedure, i.e. a healthy child. There is always a danger of slipping into an eugenic attitude towards childbearing, eventually transforming medical fertilization procedures into preferential means of conception, because accompanied by a series of controls on the biological and genetic make-up of the child. The social value of the donor's contribution would here be reduced to the biological quality of his (or her) gametes.

Does the donor have an interest in the screening ? Not directly, it would seem, although he may wish to be informed of test results, thus obtaining information on his present health, fertility and genetic background. This might be perceived as an indirect form of compensation. On the other hand, the donor may consider this information as of no use to him (for example, in the case of married men with children). In fact, the only aspect of donor screening which appears to have primarily the donor's interest in mind is the interview, and this obviously depends on how such an interview is handled. For screening is that stage in which the upcoming fertilization and its outcome are foremost in mind. The manner and the extent to which donor screening is pursued will tend therefore to reflect the medical intermediary's conception of his role and responsibilities in such reproductive transactions.

The Special Case of Surrogacy

What does the term "surrogate mother" mean to us ? Is the surrogate a donor and if she is, what does she give ?

The term surrogate mother implies that one woman is replacing another in her role as mother. This replacement seems to encompass three dimensions: 1. a symbolic sexual dimension,in that the surrogate is accepting to conceive through

insemination with the semen of the sterile woman's husband, thus precluding sexual relations for herself with her own husband or companion; 2. a genetic dimension, in that she is contributing, through her own oocyte, to the child's biological inheritance; and 3. a corporeal dimension, in that she is accepting to gestate and give birth to this particular child which she has nevertheless agreed not to keep. The fact that the surrogate is almost always designated as surrogate mother (and not as donor) indicates that this three dimensional procreative function seems indisputably associated in our society with motherhood.

Not surprisingly, surrogacy so practised is often perceived as abandoning one's own child. This has led some advocates of surrogacy to propose what they feel is a more acceptable and less difficult version for the surrogate: the child she is to carry should be conceived in vitro with the recipient couple's own sperm and ova. Such an arrangement does in fact eliminate the genetic component, and tries to attenuate the surrogate's symbolic sexual involvement, thus reducing her role to that of gestation and parturition (but also complicating and medicalizing a relatively simple procedure). In this more streamlined version of surrogacy, the term "mother" continues to turn up: in French, the surrogate is defined more strictly as a "carrying mother" (mère porteuse). But we also find terminology which depersonalizes the surrogate, such as the idea that she thus becomes a "human incubator" (6;27) - an archaic prefiguration of ectogenesis ? Maternity seems therefore to be the most closely associated in our minds with its visible physical components - gestation and parturition - which nevertheless also appear as its most fragile link, since these can be perceived as mechanic, replaceable functions.

It is thus difficult to compare the problems raised by surrogacy with those raised by gamete and embryo donations: whereas the surrogate is using part or all of a procreative potential which she cannot alienate, to give birth to a live child for someone else, gamete and even embryo donors are giving away part of their procreative potential so that others may use it for the purpose of bearing children (fertilization, implantation and consequently the birth of a live child cannot be guaranteed). However, because most opponents to gamete and embryo donations tend to perceive these gestures as the loss of a donor's own progeny, considering surrogacy as donation at a more advanced stage (when the child is there) may provide us with new insights into the ethical problems raised by these reproductive transactions. All the more so in that surrogacy seems to attract, in a condensed form, all the objections usually levelled against one or another kind of donation.

1. **Recruitment and Compensation** : In those countries where surrogacy has developed as a practice[8], an intermediary - usually legal in the United States, medical

[8] Since this article was written, the French government has outlawed agencies or associations which

in France - often acts as a facilitator in bringing together surrogate and infertile couple. The intermediary generally takes charge (directly or indirectly) of recruiting potential surrogates, usually through some form of advertisement (i.e. newspaper ads). Sometimes the couples will try to find a surrogate themselves, but only rarely is a sister or a close friend solicited; in the latter case, there is usually no intermediary - except eventually for a physician who performs the inseminations when self-insemination is not used.

In advertising for a surrogate, an important sum of money is explicitly or implicitly part of the proposition. This aspect of surrogacy is severely criticized by many who feel that payment will tend to attract women in financial need, inciting them to use their reproductive potential as a means of earning money. Correspondingly, the soliciting couple will necessarily be of higher social standing - all the more so in the United States, where the legal intermediary's fees must also be paid. This creates an assymetric relationship, in which the surrogate is vulnerable to exploitation (but in which, once pregnant, she is also in a position to exploit the couple's desire to have a child).

Would there in fact be candidates for surrogacy if no payment was offered ? Philip Parker, a psychiatrist who has conducted a study of potential surrogates (35; see also 1,198-200;22;30,246-255), claims that for 90% of these women, payment is a key motivating element. However, it is not the most important one: some women enjoy being pregnant, others hope to compensate for some past birth-related loss, such as an abortion, giving up a child for adoption or having been oneself an adopted child. In any case, the relative importance of payment tends to diminish as the pregnancy evolves and the relational aspects of carrying a child for an infertile couple come to the foreground. Two French journalists, Marie-Ange d'Adler and Marcel Teulade (1,159-228), came to similar conclusions after interviewing surrogates both in France and in the United States: financial needs were almost always at the basis of a woman's initial motivation to become a surrogate, but the key sustaining element seemed to be longing for friendship, the desire to establish a close relationship with the future parents of the child. Women receptive to the idea of surrogacy seem therefore propelled by a mixture of financial and emotional needs which they seek to satisfy through surrogacy.

Proponents of this practice usually feel that, despite the risks of commercialization and exploitation, it is not possible to ask a woman to devote a part of her life to give birth to a child for someone else, without receiving some concrete form of compensation - if for no other reason, because pregnancy and childbirth involve costs (maternity clothes, doctor and hospital bills, etc.). This compensation is sometimes perceived as a salary, as payment for work done for another; for others, it

---

promote and organize recourse to surrogates for infertile couples. Although surrogacy as such has not been declared illegal, the practice has apparently declined.

is a gift, an attempt to reciprocate the surrogates's generosity (1,160-162,192-195;6,28;30,269-270,289). Salary or gift: each perspective gives a different meaning to the reproductive transaction between the surrogate and the infertile couple: in one case, it becomes a market transaction in which bearing and giving birth to a child is perceived as work, as salaried labor; in the other case, it becomes a gift relationship, in which each party tries to respond to the other's needs. However, in both cases, compensation is usually being offered as a means of terminating the relationship, closing off a debt contracted with the surrogate.

This temporary and partial nature of the relationship between the surrogate and the soliciting couple is sometimes reinforced by the existence of a contract which specifies the manner in which the transaction is to occur. In some countries, such as France, the law prohibits the regulation by contract of exchanges involving non-commercial objects. Because it involves a child, a surrogacy contract would probably be considered nul and void, meaning that either party could break the agreement without incurring legal pursuits: the surrogate could eventually keep the child (her rights as birthing mother being protected by present legislation); or the recipients could refuse the child or, what has not yet happened or been considered, they could decide not to pay the surrogate the promised sum. In the United States, the recent Baby M case (Whitehead vs. Stern), involving the refusal of a surrogate to give up the child to the contracting couple, brought a key legal issue to the fore: is such a case to be treated as a contract dispute or as a custody battle between two parents ?

At the outset of the trial, a trend seemed to be set in the first direction: an agreement had been made which the surrogate was obliged to respect. The child was forcibly taken from her and placed in the custody of the contracting couple, the Sterns; the surrogate, Mary Beth Whitehead, nevertheless continued to refuse payment. The ruling by Judge Harvey Sorkow of the New Jersey Superior Court on March 31, 1987 sanctioned this interpretation of the conflict which determined its outcome: the Sterns were awarded custody of Baby M and Mary Beth Whitehead's parental rights were terminated. But a year later, on February 3, 1988, the New Jersey Supreme Court overturned this decision and based its ruling on family law. Given the "best interests of the child" (an argument seemingly related to the Stern's higher social and economic standing), the Sterns were able to maintain custody of Baby M. However, the termination of the surrogate's parental rights could not be founded solely on the existence of a previously signed agreement to do so; and the preceding trial had provided no other legal justifications for depriving Mary Beth Whitehead of her parental rights (17;25;26;40).

This case clearly illustrates the importance of the meaning society attributes to such transactions. If surrogate agreements are to be considered as contracts in which, so to speak, mutual "delivery of goods" must be ensured, surrogacy is necessarily transformed into a commercial transaction; even if no money is actually involved in

the exchange, legal considerations of kinship are voluntarily being excluded from a situation which involves a child. If, on the other hand, they are recognized as procreative transactions involving a transfer of parental rights, simultaneous reciprocity no longer appears as the appropriate means of acknowledging the surrogate's gift. If not individual, some form of social recognition must be found, and this implies confronting and clarifying kinship issues.

As things stand today, the possibility of entering into an agreement with a surrogate does seem to depend, in most cases, on the existence of some form of monetary compensation: payment is a key motivating element for most surrogates and appears to the contracting couple as a means of eliminating their indebtedness to the surrogate. Compensation nevertheless projects the surrogate agreement into a contractual sphere which tends to obscure the kinship issues raised by such a transaction; it also tends to devalue the surrogate's gesture, since the financial pressures which may have motivated her decision to assume a surrogate pregnancy can be used against her in an eventual custody dispute.

2. **Anonymity** : The principle of anonymity is respected in many surrogate agreements, such as the ones we have just described. This fact necessarily presupposes the existence of a legal or medical mediating agent who supervises the transaction and attempts to ensure its good outcome. However, because surrogacy involves an extended physical and emotional investment on the part of the surrogate who, moreover, often wishes some form of contact or support from the future parents, the anonymity principle is not always pushed to its absolute limits. Thus the surrogate may receive phone calls or letters from the couple for whom she is carrying the child, and the couple may sometimes be present at the birth. Nevertheless, in France, the name and address of the recipient couple, in other words, the future whereabouts of the child, are never revealed to the surrogate.

Noel Keane's agencies, which handle surrogacy transactions in the United States, do not favor total anonymity. Both surrogates and couples are given an occasion to interview several prospective candidates, so that each may select the person(s) with whom they feel most comfortable about setting up an agreement to "work together". Nevertheless, their agreement almost always explicitly stipulates that, after the surrogate has given up the child, she will not try to locate or establish contact with it (1,196;30,274-275). In other words, secrecy about the child's future whereabout remains a fundamental requirement even in non-anonymous transactions.

Here it is obviously the recipients and not the "donor" who seek the protection of the anonymity principle. In fact, whereas some surrogates readily accept to be photographed and interviewed, recipients rarely do. In any case, it is more difficult for the pregnant surrogate to conceal what she is doing and she may not wish to do

so. However, surrogates may explain away their recent pregnancy to their children, friends and neighbors by telling them that the child died at birth[9] - also a radical way of putting an end, in their minds, to their role as mother to that particular child.

The contracting couple's effort to protect their anonymity suggests once again that the basic issue being avoided in surrogacy agreements is the clarification of kinship relationships, and in particular, those of the surrogate with regards to the child. For does not the surrogate have a legitimate claim, in most legal systems, as mother of the child ? What would happen if the surrogate were to raise this question at some future point in time ? Would her claim be valid and what would it be based on: genes, pregnancy, parturition...? Even if she does renounce to her status as mother of that child, does she have any other rights to social recognition for her role in bringing that child into being ? What form should this social recognition take ? Does the nature of the surrogacy agreement imply further obligations between the surrogate and the couple after the birth of the child ? Most of these questions can be avoided, as we have already seen, by transforming the relationship with the surrogate into an exchange of gifts of "equivalent" value or into a market transaction with payment for services rendered. Should this not be enough, the anonymity of the future parents makes it difficult for the surrogate to locate the child.

This deliberate avoidance of the relational issues involved in surrogacy becomes all the more evident when we compare the preceding situations to those rare cases in which anonymity has been totally abandoned. Usually a sister or close friend is asked to fill in as surrogate for the infertile woman; in these cases, no mediating agency and no compensation are involved. Or two parties, having opted for anonymity at the start, will change their minds and establish an ongoing relationship after the birth of the child. The families involved have usually decided to tell the child about the sister's or friend's role as surrogate and each has attempted to find some symbolic form of recognizing the surrogate's relational status with regards to the child: including the surrogate in the family tree as one of the child's two mothers; making the surrogate a godmother; giving the child the surrogate's first name (1,223-229).

What remains problematic is that these represent individual solutions to what is essentially a social problem: defining the kinship status of the surrogate mother. Should any one of the above relationships - harmonious at the beginning - encounter difficulties at a later date, there are at present no adequate legal provisions ensuring the maintenance of the surrogate's new relational status (or for that matter, that of the infertile woman as mother). Kinship issues cannot be solved by individual improvisations, for they are basic social relations structuring a society and must therefore be appropriately institutionalized.

---

[9] Personal communication from Françoise Laborie on research in progress on surrogacy.

3. **Screening** : Very little screening is presently involved in the practice of surrogacy: the difficulty of finding women who accept the idea of carrying a child for someone else discourages most mediating agents from practicing any form of rigorous physical or psychological examinations which might tend to weed out or dissuade too many candidates.

It could nevertheless be argued that some form of screening or counseling might be in the interests of all the parties involved. From the surrogate's own point of view, it would seem indispensable that she be given the necessary time and occasions to review her feelings and reflect on the meaning and implications - for herself and her family - of this pregnancy for another's benefit. She might also want to be assured that her present health condition will not expose her to any particular risks during this pregnancy.

Once pregnancy has begun, however, the surrogate is usually required to accept a certain amount of control over her pregnancy, the obvious objective being the screening of the child. An amniocentesis may be performed during the course of pregnancy and the surrogate asked to submit to an abortion if the foetus has some genetic disease or malformation. A blood test may also be done on the child at birth to make sure that it was in fact conceived with the infertile woman's husband's semen. The surrogate may even be required by contract to acquiesce to a series of restrictions (stop smoking or drinking, accept x number of medical examinations during the pregnancy, etc.). In other words, because the child she will carry is explicitly defined as not being hers, becoming a surrogate implies accepting a certain loss of autonomy during pregnancy: the surrogate may not dispose of herself or of the child during that period in any way she sees fit.

This raises the question as to the nature of the relationship which binds the two parties in the surrogacy agreement, and in particular, that of the surrogate's own rights and interests in a situation which requires a temporary but total involvement of her person for the other party's benefit. The presence of monetary compensation in almost all surrogate agreements tends inevitably to create an assymetric relationship between the two parties, due to the differences in their social and financial standing. Screening, the purpose of which is to control the "quality" of the services rendered (and therefore that of the resulting "product"), necessarily reinforces such assymetry, in which the ultimate risk is the depersonalization of the surrogate. It would therefore seem essential, if the surrogate agreement purports to be a reciprocal relationship between autonomous beings, to accord the surrogate a right to make her own decisions with respect to her body - the course of her pregnancy and childbirth - even though she herself may have decided that the child she is carrying is not hers.

Are Donors Sources of Biological Material or Partners in a Procreative Procedure ?

Despite the recent proliferation of reproductive techniques, the preceding analysis of current practices reveals a basically ambivalent social attitude with regards to calling on donors for medical fertilization procedures. Men and women who are willing to share their reproductive potential with others do exist and are often strongly motivated by feelings or events related to their own reproductive lives. Nevertheless, they are scarce, and those who seek to recruit them spend much time and energy trying to elaborate adequate incentives. But whereas society seems willing to solicit and accept the donor's gesture as useful, it seems equally eager to dismiss, forget or conceal him or her, particularly when the donor's contribution is defined by existing law as giving access to parental rights (essentially the case for semen donation and surrogacy). The donor's existence appears to endanger the stability of the family unit - a threat which seems all the greater, the closer the donor is involved in the process of bringing the child to life.

Keeping the donor at a distance so as to avoid the kinship issues latent in such transactions: this seems to be the main preoccupation of most donor policies and the principal justification for the existence of intermediaries. We have seen how certain uses of compensation, anonymity and screening can allow the donor - and the intermediary - to circumvent questions of meaning. The sexual and relational issues inherent to reproduction are also easily suppressed by presenting fertilization techniques as medical treatment for the infertile (when in fact none of these techniques actually cure the infertile recipient). The principle of anonymous transactions, in particular, allows for a more flexible management of and greater experimentation with what have become depersonalized exchanges of biological material.

As a result, the various options made available through reproductive techniques create a definite confusion with regards to kinship. Different procedures place emphasis on different biological vectors to establish kinship. Thus, in AID, paternity is dissociated from semen donation so as to favor the birthing mother's legal husband; in a surrogate agreement, it is the semen donor who, as biological father, claims the child who is later to be adopted by his legal wife. In IVF with oocyte donation, it is parturition which proves the infertile recipient's claim to motherhood; in a surrogate agreement, in which the child is conceived in vitro with the contracting couple's gametes, genes are expected to determine the "real" mother. The only consistant factor in each of these cases, however, is not biological but social: parental rights are always established in favor of the recipients, since the donor is, almost by definition, giving up rights to the child. Nonetheless, the recipients' desire

and intent to raise a child are never the exclusive basis for attributing parental rights: in each case, there is at least one biological vector - semen, ova, or pregnancy and parturition - which the couple uses to reinforce their parental claim.

This confused preoccupation with the biological vectors of kinship overlooks the fact that procreative and parental roles are, in all societies, the result of socially prescribed relations; in some societies, certain socially-recognized sexual and procreative roles do not necessarily entail parental rights (28). Fertilization procedures with donor gametes present us with a series of procreative propositions posing at least one major problem: how does one deal with the donor's contribution ? Because procedures, such as AID, were originally exceptional and secret, they were not meant to call openly into question norms and values, or legal dispositions concerning the family; hiding the donor's role or even denying his existence thus seemed an appropriate means of making the necessary social and cultural adjustments. But as these techniques become publicly established procreative options, striving for social legitimacy - even if only in cases of infertility, their most modest social objective - procreative and parental roles will have to be distinguished, defined, and appropriately recognized (14). The status and limits of the physician's role as intermediary - not strictly therapeutic in any medical sense - will also have to be more clearly defined. All of this, of course, only if our social goal is, in fact, a practice genuinely founded on the reciprocal obligations of gift-giving between autonomous persons.

REFERENCES

1. d'Adler, M.A. & Teulade, M. *Les Sorciers de la Vie*. Paris: Gallimard, 1986. (Written account of a four-part television documentary, with the same title, on reproductive and gene technology.)

2. Alnot, M.O., Delaisi de Parseval, G., Granet, P., & Da Lage, C. Sperme, don, contre-don. *Le Concours Médical*, 1982, 104 (18), 2915-2918.

3. Annas, G.J. Artificial Insemination. Beyond the Best Interests of the Donor. *The Hastings Center Report*, 1979, 9(4), 14-15,43.

4. Brozan, N. Babies from Donated Eggs: Growing use stirs questions. *New York Times*, January 18, 1988, 1,9.

5. Bydlowski, M. Les ovocytes, aspects psychologiques. *Hormones-Reproduction-Métabolisme*, 1986, 3(3), 160-161.

6. Cadras, M. with the collaboration of Tornikian, J. Docteur Geller: "La mère est un incubateur". *Enfant d'Abord*, 1986, 112, 25-30.

7. Dajoux, R. *L'Insémination, l'espoir*. With a preface by Prof. A. Netter. Marseille: Mediprint, 1979.

8. Da Lage, C., Alnot, M.O., Granet, P., & Delaisi de Parseval, G. Les donneurs de sperme. *Colloque International: Les Pères Aujourd'hui*. Edited by the Conseil Supérieur de l'Information sexuelle, de la Régulation de naissances et de l'Education familiale. Paris: INED, 1982, 68-72.

9. David, G. Les banques de sperme en France. *Archives Françaises de Pédiatrie*, 1975, 32(5), 401-404.

10. David, G. Don et utilisation du sperme. *Actes du Colloque Génétique, Procréation et Droit*. Arles: Actes Sud, 1985, 203-224.

11. David, G. & Lansac, J. The organization of the centers for the study and the preservation of semen in France. *Human Artificial Insemination and Semen Preservation*. G. David & W.S. Price, eds. New York: Plenum Press, 1980, 15-25.

12. Delaisi de Parseval, G. Questions à propos des donneurs de sperme. *Génitif*, 1980, 2(1-2), 15-21.

13. Delaisi de Parseval, G. A propos du don d'organes. *Revue de Médecine Psychosomatique et de Psychologie Médicale*, 1980, 22(2), 165-170.

14. Donchin, A. Reproductive Technology and Moral Responsibility: Redefining Parenthood. *The Tasks of Contemporary Philosophy: Proceedings of the 10th*

International Wittgenstein Symposium. Wien: Hîlder-Pichler-Tempsky, 1986, 265-267.

15. Ewerlöf, G. Artificial Insemination - Legislation. *Current Sweden* (1985), 329, 1-10.

16. Ewerlöf, G. *Swedish Legislation on Artificial Insemination*. Typescript obtained from the author.

17. _____. Excerpts from Decision by New Jersey Supreme Court in the Baby M Case. *New York Times*, February 4, 1988, 14.

18. Finegold, W.J. *Artificial Insemination*, 2nd edition. With a forward by A.F. Guttmacher, M.D. Springfield, Illinois: Charles C. Thomas, 1976.

19. Fox, R.C. & Swazey, J.P. *The Courage to Fail: a Social View of Organ Transplants and Dialysis*. Chicago and London: The University of Chicago Press, 1978.

20. Frydman, R. Don d'ovules. *Actes du Colloque Génetique, Procréation et Droit*. Arles: Actes Sud, 1985, 203-224.

21. Gex, P. & Czyba, J.C. Le don de sperme. *Cahiers Médicaux*, 1982, 7(26), 1627-1629.

22. Goleman, D. Motivation of surrogate mothers. *New York Times*, January 20, 1987, 15-16.

23. Granet, P. Aspects psychologiques du don de sperme. *Aspects Psychologiques de l'Insémination Artificielle*. C. Manuel and J.C. Czyba, eds. Villeurbanne: SIMEP, 1983, 57-67.

24. Gregoire, A.T. & Mayer, R.C. The Impregnators. *Fertility and Sterility*, 1965, 16(1), 130-134.

25. Hanley, R. Father of Baby M Granted Custody; Contract Upheld", *New York Times*, April 1, 1987, 1, B3.

26. Hanley, R. Surrogate Deals for Mothers Held Illegal in Jersey. *New York Times*, February 4, 1988, 14.

27. Hanley, R. Three Experts Say Baby M'S Mother Is Unstable. *New York Times*, February 11, 1987.

28. Héritier-Augé, F. Don et utilisation de sperme et d'ovocytes. Mères de substitution. Un point de vue fondé sur l'anthropologie sociale. *Actes du Colloque Génétique, Procréation et Droit*. Arles: Actes Sud, 1985, 237-253.

29. Huerre, P. Psychological aspects of semen donation. *Human Artificial Insemination and Semen Preservation*. G. David and W.S. Price, eds. New York: Plenum Press, 1980, 461-465.

30. Keane, N. with Breo, D.L. *The Surrogate Mother*. New York: Everest House Publishers, 1981.

31. Mauss, M. *The Gift: Forms and Functions of Exchange in Archaic Societies*. Translated by Ian Cunnison, with an introduction by E.E. Evans-Pritchard. London: Cohen and West, Ltd., 1970.

32. Novaes, S. Le don de sperme vu par des donneurs de sang. *Hormones-Reproduction-Métabolisme*, 1986, 3(3), 153-157.

33. Novaes, S.B. Semen Banking and Artificial Insemination by Donor in France: Social and Medical Discourse. *International Journal of Technology Assessment in Health Care*, 1986, 2(2), 219-229.

34. Novaes, S., Fougeroux, F. L'Insémination artificielle vue par les donneurs de sang. *Cahiers Science-Technologie-Société no 11: Ethique et Biologie*. Paris: Ed. du CNRS, 1986, 185-197.

35. Parker, P. Motivation of surrogate mothers: initial findings. *American Journal of Psychiatry*, 1983, 140(1), 117-118.

36. Simmel, G. Faithfulness and Gratitude. *The Sociology of Georg Simmel*. Translated, edited and with an introduction by Kurt H. Wolff. London and New York: The Free Press of Glencoe, 1964, 379-395.

37. Simmons, R.G., Klein, S.D., Simmons, R.L. *The Gift of Life: The Social and Psychological Impact of Organ Transplantation*. New York: John Wiley and Sons, 1977.

38. Sweden, Committee to investigate the matter of artificial insemination. *Barn Genom Insemination* (Children conceived by artificial insemination). Stockholm: Justitiedepartement, 1983.

39. Titmuss, R.M. The Gift Relationship: From Human Blood to Social Policy. New York: Vintage Books, 1972.

40. _____. To Serve the Best Interests of the Child (Excerpts from the decision by Judge Harvey R. Sorkow). *New York Times*, April 1, 1987, B2.