National Consultative Ethics Committee for Health and Life Sciences

OPINION N°110
ETHICAL ISSUES RAISED BY GESTATIONAL SURROGACY (GS)

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OUTLINE

Introduction

In French, the terms "gestational surrogacy" (gestation pour autrui) or "reproductive surrogacy" (procréation pour autrui), coexisted for a long time with various others, only in use before the first laws on bioethics were passed, as were also the expressions "surrogate mothers" or "substitute mothers". But today, the new terminology has prevailed in parallel with relevant developments in medical practices.

The first substitute motherhood initiatives emerged in France in the 1980s, at a time when *in vitro* fertilisation was not practised. They were organised following the creation of two associations whose purpose was to arrange for infertile couples to contact women who would be willing to be inseminated with the husband's sperm, bear a child to full term and relinquish it at birth. In what is now termed "reproductive surrogacy" or "traditional surrogacy", the surrogate was both the biological and the gestational mother of the child and the technique did not require medical assistance. These associations were subsequently banned[1], but the prohibition did not put an end to clandestine arrangements between couples and surrogate mothers. However, the practice was dealt a severe blow by a decision of the Plenary Assembly of the Court of Cassation on May 31, 1991[2], which ruled that the agreement entered into by a woman, albeit for altruistic reasons, to conceive and bear a child and relinquish it at birth was contrary to the public order principle of the non availability of the human body and of civil status. As a consequence of this finding, it was ruled that the child born of a surrogate mother could not be adopted by the wife of the biological father since it would amount to misusing the institution of adoption. Lawmakers in 1994 also declared it a criminal offence to act as a go-between for a couple seeking to care for a child and a surrogate mother (article 227-12 of the *Code Pénal*). They also declared that any agreement for reproductive or gestational surrogacy would be null and void (article 16-7 of the *Code Civil*).

Once *in vitro* fertilisation (IVF) became an effective assisted reproductive technology, it was technically feasible to propose the procedure, using their own gametes, to women deprived of uterine function — either because of congenital malformation or following hysterectomy — followed by embryo transfer to the uterus of another woman whose role would be purely gestational. This truly gestational surrogacy requires the assistance of doctors and biologists: oocytes (eggs) must be harvested from the intended mother, then fertilised using

[1] Civ 1st. December 13, 1989, n° 88-15.655

[2] Rec. Dalloz 1991, p.417, rapp Chartier, awarded after hearing Prof. Jean Bernard, then President of CCNE.

the intended father's sperm with standard IVF or ICSI[3]. Both women undergo treatment to harmonise their cycles. Technically, the procedure can be combined with oocyte donation, in which case three women participate in the reproductive process: the genetic mother (donating oocytes), the gestational mother and the intended mother. It is even possible to use donated sperm and produce a child who will have *in fine* no genetic relationship with the man and the woman who are to become its parents.

In 2004, the subject was not raised in the discussions which led to the passing of a law on August 6, 2004. At the time, it could be assumed that the ban, which included all forms of surrogacy, gestational or reproductive, represented a consensus in France.

In the last few years, however, the issue of legalising gestational surrogacy (GS) has resurfaced. There could be other reasons for this besides coincidence with the possibility of a further revision of the bioethics law. First of all, as CCNE emphasised in Opinion n° 105, there is a growing demand for autonomy within today's society, particularly as regards individual life choices. But the main reason follows on the medical possibility of providing sterile couples with the option of producing children with their own parental gametes, by combining GS and IVF. There is a specific demand on the part of women and couples whose infertility is related to congenital malformation (Rokitansky-Küster syndrome), cancer surgery, postpartum haemorrhage, or *in utero* exposure to diethylstilbestrol (or DES, in particular in the form of Distilbene®). While the number of women concerned may seem fairly small, some members of the medical professions and others expressing an opinion on this subject consider that their circumstances should be taken into account on a case-by-case basis, as an exception to the prohibition of GS[4].

The international context also sets the scene for this renewal of interest. In Europe, gestational surrogacy is prohibited in Germany, Austria, Switzerland and Spain, tolerated in Belgium, Denmark and the Netherlands, specifically regulated in the United Kingdom[5] and in Greece. Moreover, freedom of circulation, together with the development of the "baby business"[6], means that French couples can go for IVF followed by GS to some States in the U.S. and also in countries such as the Ukraine or India, where specialised clinics operate specially for foreigners. When couples return to France with children conceived in this

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3 *Intra cytoplasmic sperm injection,* an *in vitro* fertilisation technique consisting of the introduction by micro-injection of a single sperm into the oocyte, through the zona pellucida

4 See the report of the *Académie de Médecine* referred to previously for precise facts and figures.

5 It is for this reason that the working group heard Dr. Robert Forman, a London gynaecologist, on his experience of gestational surrogacy.

6 Title of Debora L. Par's book, Harvard Business School Press, 2006

fashion, substantiating ties of filiation is not straightforward[7]. CCNE, as was already emphasised in Opinion n° 105, dated October 9, 2008, as a preliminary to holding a States-General discussion on bioethics, continues to maintain that legislative diversity cannot vindicate alignment with the most ethically permissive legislation. Similarly, the fact that such practices exist should not necessarily prompt France into making them a part of its legislation. States should never be required to legislate in the light of a *fait accompli*; the legitimacy of practices is the prerogative of lawmakers themselves.

A large number of bodies have already expressed their thoughts on the issues at stake, ethical issues among them, were gestational surrogacy[8] to be legalised. However, it was incumbent on CCNE to consider specifically a subject which it had already addressed in one of its first Opinions[9] and which is central to its mission, since gestational surrogacy is both an assisted reproductive technology (ART) and a factor leading to far-reaching transformation of family structures. For this reason, the present Opinion will mainly address the issue of whether it is ethically sound to add GS to the list of authorised ART procedures. Clearly, some of the ethical points raised could be extended, *mutatis mutandis*, to reproductive surrogacy, i.e. the procedure which does not necessarily entail the assistance of the medical profession, but although the subject will be mentioned occasionally, it will not be debated in specific terms.

Today's society appears to be divided on whether the current ban should be maintained or should be attenuated by waivers and exceptions to the rule. CCNE's membership is no exception to this divide.

The arguments upheld by the two principal contending groups need to be set out, even though they have already been presented in previous reports on the subject. Once this has been done, the main thrust of CCNE's specific contribution will be an attempt to single out a

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[7] This Opinion does not address the mainly legal issues arising out of the status of these children.

[8] *Contribution à la réflexion sur la maternité pour autrui*, Report by a French Senate working group, n° 421, 2007-2008; *OPECST, la loi bioéthique de demain*, Report n°107, November 21, 2008; R. Henrion and C. Bergoignan-Esper, *La gestation pour autrui*, report in the name of an Académie de Médecine working group, Bull Académie de médecine 2009, p. 583 et seq.; Study by the *Conseil d'État*, *La révision des lois de bioéthique*, La documentation française, May 2009; A. Graf, *Rapport final des États généraux de la bioéthique*, July 2009; Record of discussion by the *Conseil d'orientation de l'Agence de la biomédecine* on September 21, 2009; A. Claeys and J. Léonetti, Information report in the name of the task force on the bioethics law, January 20, 2010, Document of the *Assemblée Nationale*, n°2235 ; P.Cressard and F.Stefani, Position paper by the *Conseil national de l'Ordre des médecins*, (Medical Association) report adopted on Feb. 4, 2010.

[9] Opinion n°3, October 23, 1984

number of common lines of reflection arising out of a confrontation of the points of view being defended, not confining itself to a static listing of contrasts, but reflecting a degree of convergence on the nature and gravity of the issues at stake, beyond the diversity of sensibilities.

I. THE TWO MAIN CONTENDING POINTS OF VIEW

I.1. Arguments for retaining current legislation which prohibits GS

I.1.1. One first set of arguments is based on the premise that GS could put an end to the preponderant role of pregnancy and birth in creating the bond between mother and unborn child which remains present in all forms of assisted reproduction. The legal attribution of motherhood is a corollary of the growing recognition by recent scientific research of the importance of gestation.

When motherhood is deliberately transferred to another woman who is not the one giving birth, the bond which is built up between a pregnant woman and the foetus during pregnancy is disregarded: this complex link, in nature both psychological and biological, with an epigenetic component, is the foundation for early bonding. Numerous social practices are the consequence of these recent scientific conclusions, for instance haptonomy or 3D ultrasound examination.

To thus ignore or deny the effects of pregnancy and of the mother-child relationship on the child's future could well be damaging for the child as well as for the intended parents. Although the child, longed and hoped for by the intended parents, who are furthermore its biological parents, is not in fact abandoned, it is reasonable to wonder whether the period of gestation leaves a permanent mark on a child. Life *in utero* and birth for such a child are the subject of special contractual stipulations, so that the child's perceptions of its background and origins will be essentially different from those of other children, including those conceived by other ART methods. At this point, therefore, it is difficult to accept without any reservation that a child's future is entirely safe from the effects of GS. An underlying impression lingers on that pre-eminence given to the interests of the couple may be given more regard, in this instance, than concern over providing a child with a background and a family history which will be helpful for the construction of its personality.

The same is true of the interests of the gestating mother, caught between two perils: on the one hand, experiencing to the full her pregnancy with the probability that she will become attached to the child and that separation immediately after birth will be painful and, on the other hand, forcing herself to remain aloof from the start of pregnancy. The full extent of the consequences of this hazardous course of action on her psyche and that of the child

remain unexplored at this time. For these women, childbirth marks an ending, not a beginning.

I.1.2. A second set of arguments is concerned with the physical risks of pregnancy and childbirth for the gestating mother, these risks being accepted to satisfy the wishes of others and not her own desire to have a child. French law only accepts such encroachments on physical integrity for the benefit of others in exceptional circumstances and for therapeutical reasons. This is in particular the case of living organ donors.

In truth, GS does indeed give rise to medical risks, some of them life-threatening, for the pregnant woman and the child, and they were fully reported by the Académie de Médecine. They include in particular the risks of multiple pregnancy and premature delivery if transfer is not limited to a single embryo, or caesarean section or postpartum haemorrhage. In such cases, how would the various parties concerned share responsibility? Be that as it may, the fact that the gestating mother consented willingly could certainly not serve as an alleged reason to override the physician's first duty, i.e. do no harm. Even if they are uneventful, repeated pregnancies and deliveries put a strain on a woman's health, both at the time and later in life.

I.1.3. Apart from risk to health, inherent to GS is the possibility of a person's instrumentalisation and commercialisation. Is not the expectation of financial compensation, albeit reasonable and regulated as is the case for "healthy volunteers" in biomedical research, a violation of the principle of free consent? Could it not convert the child into an object for sale? And even when no financial reward is involved, is not a woman who uses her gestational faculties for the benefit of someone else turning herself into some kind of production tool? It is true that even egg donation already represents a significant risk of donor instrumentalisation[10], but the risk is aggravated in GS when a woman's entire body is committed during her months of pregnancy. Furthermore, as intended parents are justifiably interested in having the pregnancy continued to full term, this may constitute a *de facto* contradiction of the surrogate's right of independent decision concerning her own life and the exclusive right of decision she has by law on whatever involves her pregnancy, including the right of termination within legal limitations.

I.1.4. Finally, making use of another woman's womb in order to serve a parental undertaking strikes some sectors of opinion as a radical contradiction to the principle of respect for the

[10] Doctors report that they have observed subordination relationships between egg donors and the recipient couple. Some centres are ready to provide faster service for couples who already have a donor, whose eggs can only be used for other couples in order to respect the rule for anonymity.

dignity of human beings[11], described as neither "demonstrable, exemptible nor disputable"[12], which also enjoys constitutional recognition. Furthermore, the dissociation between sexual relations and reproduction; between fertilisation and implantation; and between genetics and parenthood, already present in other forms of medically assisted reproduction, would be augmented here by dissociation between the various functions of motherhood, uterine and social or even genetic if the gift of eggs combined with GS were to be authorised. Such a development would be the ultimate step away from nature to technology and would be a major anthropological mutation.

I.2. Arguments for authorising GS.

Those advocating a case-by-case acceptance of GS counter the criticisms above, basing their position mainly on the medical nature of the procedure.

I.2.1. These arguments rest on the case for society's commitment to solidarity with women suffering from irremediable and untreatable forms of infertility. In these circumstances, GS appears to be the solution to a distressing physical and psychological condition. Uterine infertility is often experienced as particularly unfair. It affects women "who have everything a mother needs" except a womb, whereas women without ovaries but who do have a womb can benefit from the gift of oocytes and women whose husbands are sterile can benefit from the gift of sperm. In this respect in particular, GS is a logical extension of the management of infertility following cancer treatment. Young women with cancer of the uterus, a condition appearing increasingly early in life, are obliged to undergo hysterectomy. A question they may raise with some justification is why they are left with ovaries when there is no prospect for them of any future gestation[13]. Finally and irrespective of cause, GS which is the sole possibility of solving their problem, is banned by French law so that it is only available to couples who can afford to travel abroad, thus introducing an element of wealth-related discrimination.

I.2.2. Partial legalisation of GS, thus providing couples with an authorised and secure environment for the procedure, would limit clandestine practices, be they reproductive surrogacy by the non medical insemination of the gestational carrier, or going abroad to

[11] See infra 2nd part.

[12] M. Fabre-Magnan, quoted by the Committee for the study of the preamble to the Constitution presided by Mme. Simone Veil, December 2008, p.131

[13] P.R.Brinsden's work (*Gestational Surrogacy, Human Reproduction Update* 2003, 9, 483-496) points out that cancer is the primary indication for gestational surrogacy in the United Kingdom.

accommodating foreign countries where such practices are built on the exploitation of particularly underprivileged women. As to risks run by the various parties to the procedure, although undeniable, if they are better known they can be more easily controlled: it would be possible to take every precaution to ensure that the surrogate's consent is truly free and informed, using for instance similar procedures to those adopted for organ donation between living members of the same family. For this purpose, should be verified in particular the context in which the surrogate gave her consent (altruistic reasons unconnected to financial straits, absence of pressure from friends, family or professionals, awareness of what a pregnancy followed by separation at birth actually represents, awareness of risks to health, due consideration given to consequences on the life of her family, her own children and her partner, whose consent must also be secured, review of all the setbacks that may occur during pregnancy and in some cases lead to requesting its termination. Besides, the British experience as described in the published study[14] would seem to indicate that relations between surrogate and the intended parents are generally trustful, that young children born of GS do not seem to have any particular difficulties and, finally, that gestational surrogates are less predisposed to *post partum* depression than women bearing their own child.

I.2.3. As regards principles, people advocating conditional liberalisation of GS, are inclined to counter arguments based on the dignity of the human person with arguments based on individual liberty, which is also recognised by the Constitution and must be presumed, including for women volunteering to carry a child which is not their own, as long as there is no evidence of psychological or economic pressure. They believe in the existence of altruistic motivation, as is the case for other donated constituents and products of the human body.

For these reasons, those in favour of liberalisation believe that there is a case for legalising GS with limitations, within the framework of reproductive medicine rather than in connection with social demand, controlled by specialist committees, in the same way as prenatal diagnosis or intra-family live organ donation are run. There is no evidence in these proceedings of any mismanagement[15], but upholders of such legalisation consider that

[14] Studies undertaken by S.Golombok (Dev.Psych 2004, 40, 400-411; Journ.Child Psycho Psychiatry 2006, 47, 213-222, Hum Reprod 2006 , 21, 1918,1924) do not reveal the existence of any particular childhood dysfunction. A comparison between children born of spontaneous conception, gestational surrogacy and egg donation at one year of age (published 2004) shows that the only observed difference was increased personal parental investment. These results were confirmed at ESHRE (*European Society of Human Reproduction*) conferences.

[15] NISAND I *Quelques réflexions sur la grossesse pour autrui*. (Comments on gestational surrogacy) *In* Mises à jour en Gynécologie Médicale by J. Lansac, D. Luton, E. Daraï, Vigot, Paris, 2008, p. 121-132.

authorisations should be granted on a case-by-case basis to ensure that the strict monitoring required for an ART procedure to be conducted in full compliance with technical and ethical standards, is in fact observed[16].

1. II. ETHICAL OBJECTIONS TO LEGALISING GESTATIONAL SURROGACY

Despite arguments supporting the view that there should be some exceptions to the ban on GS, legalisation, albeit limited, would still raise ethical issues which would not be completely neutralised by the addition of legislative safeguards. These issues can be ordered into six categories.

2. II.1. No law can prevent the risks it seeks to protect against

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II.1.1. Clearly, regardless of the legislation which could be adopted and however carefully surrogates are selected, they could not be entirely safe from medical and/or physiological complications or setbacks.

The *Conseil d'Orientation de l'Agence de la Biomédecine* (the French Biomedical Agency's steering group), in its review of the subject from the original perspective of what practical problems it would need to address were the legislators to vote in favour of legalisation, expressed a number of reservations. For example, would not perinatal maternal death, a bane which has defied efforts to eradicate it, be even more of a heartbreak if it occurs during gestational surrogacy?

II.1.2. Another point is that legislators' concern for limiting to fair compensation any financial reward would not be an obstacle to clandestine practices. Although altruism is certainly one of the characteristics of human relations, the state of reciprocal dependency created by the very principle of GS is a problem in itself. This is connected to the fact that, as has been noted in every country where GS is legal, the parents come from a higher social level than the carrier and expect a great deal from her. This is an at-risk situation for both parties. On the one hand, the intended parents' generosity may lead them into gratifying

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[16] The two lines of argument presented in this Opinion do not represent exhaustively the full diversity of views on the subject. There are also supporters of liberalising gestational surrogacy for reasons which are not purely medical, in particular so that male couples can become parents. CCNE decided to limit their considerations to the ethical issues at stake in the case of gestational surrogacy as compared to other ART techniques which are already legal. In fact, the question of whether ART should meet all social demands for access or be confined to medical indications applies to all medically assisted reproduction procedures and not just to GS.

more or less discreet demands for reward or gifts. On the other hand, even when mutual trust is present at the outset, relations may become strained, particularly in the event of repeated failure, leading to thoughts of pressure or blackmail.

More generally and unsurprisingly, the adoption of legal and secure GS in the United-Kingdom has shown that such measures are not sufficient in themselves to put an end to non medical clandestine procedures. The acceptance of exceptions, wherever the boundary is set, would exclude some couples because they do not come within the scope of the law, either because they are same-sex couples or because the woman concerned is not suffering from one of the medical conditions that, according to society, justify recourse to GS.

II-1-3- In the eyes of CCNE, it is these possibilities of misuse — inherent to GS — and not a lack of recognition of a couple's wish to give life to a child genetically their own, which motivate reservations concerning legalisation. A couple's ambition to transmit, together with their own family history, physical characteristics or family resemblance, is natural and legitimate. This is why, in many cases, it is one of the factors that motivates a couple to apply for gamete donation so that their child is, at least biologically, the child of one of its parents.

The fact that a couple wants a child which is genetically their own is not, in itself, contrary to ethics. The problem lies in the extreme consequences of this action when couples choose GS. CCNE's view is that this legitimate wish or need is not sufficient in itself to justify recourse to GS.

II.2. GS cannot become ethically acceptable for the sole reason that it takes place in a medical environment

As we have seen, some sectors of opinion would not be in favour of a generalised legalisation of GS, but consider that some waivers based on medical considerations would be acceptable so that in the case of certain very specific disorders or malformations, the wish of infertile couples to have a child is not be left without any therapeutic remedy. However, CCNE's view is that the possibility of infertility indications giving access to GS being medically supervised does not invalidate ethical objections to a woman putting her body at the service of a couple to enable them to become parents. Doubts can also be entertained on the merits of "GS by prescription"[17] rendering acceptable practices that would otherwise be rejected if they had been judged by the yardstick of social acceptance.

[17] The growing use of the more technical sounding acronym (GS), is perhaps a sign that the subject is moving out of the ethical and societal area and into the medical sphere?

As is more generally the case with bioethical matters, ethical issues raised by GS are in substance entirely unrelated to scientific and medical expertise and their applications. The practice has a bearing on the very future of human society and the issues at stake are by no means confined to medical considerations: what parts of the human body can be put to commercial use? To what extent should respect for human dignity lead to protecting that dignity from self-harm without encroaching on human liberty and autonomy? These questions are not related to the medical diagnosis of infertility. They are concerned with the ethical problems which could affect individuals and the community if such practices are put into effect.

Finally, CCNE points out that in Opinion n° 105, referred to above, the Committee emphasised that although the founding principles of biomedicine, in particular the dignity of the human being, the primacy of the child's best interests and the non commercial nature of the human body, are allowed to suffer some exceptions, these exceptions must not be too considerable or too permanent if these principles are to retain any substance. The presence, side by side, of both principles and major exceptions to them is damaging to the intelligibility and sincerity of the law.

It follows that reference to a medical context of management cannot overcome, on its own, the weighty ethical objections to GS.

II.3 Implementing possible legal rules governing GS raises issues which are difficult to solve without prejudice to the interests of individuals

The first rule of law must be to organise social relations while protecting and reconciling the interests of all. GS involves at least three categories of people, the surrogate, the intended parents and the child, so that reconciling all the interests involved is no easy task. Any legislation, even partial, would need to include clauses protecting the filiation of the child born by GS. This cannot be done by simply applying the articles designed for medically assisted reproduction whose purpose is entirely focused on establishment of paternity in the event of third-party gamete donation or embryo hosting[18].

The decisions taken in the two European countries which have specifically authorised GS are enlightening. In the U.K., the woman who gives birth to the child is designated as the mother in the birth certificate and her partner as the father. Transfer of filiation cannot take

[18] Consent to medically assisted procreation with gamete donation, expressed in the presence of a judge or of a notary, blocks any subsequent denial of paternity and enables paternity establishment, despite refusal on the part of a man who has expressed that consent when he is not wedded to the child's mother and he contests paternity (article 311-20 of the *Code Civil*).

place before six weeks have elapsed, during which time the gestating mother may decide to keep the child[19]. In contrast[20], the Greek system stipulates that as soon as intended parents and the surrogate have come to an agreement, a legal document registers the child's filiation in relation to the couple who, from that point onwards, are in sole charge of it. In a way, the procedure can be described as prenatal adoption, the adopters being also the child's biological parents.

The first of these systems is more protective of the surrogate. It does not impair her right to autonomous decisions regarding her pregnancy. It preserves the traditional rule for establishment of maternity, *Mater semper certa est*, while it also preserves the surrogate's right to a change of mind. There is, however, some ambiguity since, while asserting the child's tie of filiation with the intended parents, it implies that the surrogate is also a mother, which undermines the philosophical soundness of the institution. In contrast, legislation on gamete donation takes pains to ensure that donors have no tie of filiation with the child. The general impression is that lawmakers were not ready to accept the consequences of their decision or were recognising GS reluctantly and without enthusiasm. This implied reticence may bring about a sense of insecurity detrimental to bonding within the intended family. A system of this kind could generate conflictual situations focusing on the child, as was the case before 1966 when the law allowed a child to be returned to biological parents even after they had agreed to adoption[21]. If the end result was that the child could not be welcomed into the family of the intended parents, nor by either the surrogate herself or by the surrogate together with her partner, the whole process would be a failure. This might happen only rarely, but is it reasonable to create the possibility?

The second option, enshrined by the Greek legislation, is more radical. The law having authorised GS, its consequences are accepted. It guards against legal uncertainties and psychological changes of heart. But with such a system, doubts come to mind concerning the possibility of reconciling the surrogate's early renunciation of motherhood and her entitlement as a pregnant woman to medical confidentiality or her right to decide on terminating pregnancy, in particular by reason of severe foetal anomaly.

Transferring to intended parents the right of decision to terminate, is explicable by the fact that, *in fine*, they would be bringing up the child, even a severely disabled one, but is this

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[19] A 1985 law was added to by the 1990 *Human Fertilization and Embryology Act* amended in 2008 (www.hfea.gov.uk)

[20] Laws 3089/2002 and 3305/2005; P. Agallopoulou, Droit de la famille 2004, Chron. n°11

[21] This refers to the notorious Novack case, Civ 1ère July 6, 1960, Rec.Dalloz 1960, p.510

compatible with the fact that before birth, the foetus is not a child subject to parental authority, nor is it legally distinct from the person of the pregnant woman?

Furthermore, GS is very difficult to implement in full compliance with the principle of anonymity, even if that anonymity is attenuated as is the case for adoptions. In the circumstances, one cannot help wondering whether gamete donor anonymity, egg donation in particular, could coexist with GS. There would surely be an almost inevitable "domino effect" leading to the elimination of anonymity so that the specific requirements of gamete donation could no longer be complied with. As is well known, among the purposes of anonymity are the conclusive prevention of financial transactions and reinforcing the principle of disinterested donation. If lawmakers had intended to put an end to the anonymity of gamete donation, with reference to the possible need for certain children to be able to access their family history, it should be the result of reasoned decision and not via an indirect effect of the legalisation of GS.

II.4- GS could be a threat to the principle of human dignity or to the symbolic image of women.

Respect for human dignity, a key concept arising from the 1948 Declaration of Human Rights and reaffirmed in a large number of international documents defending human rights and combating barbarity and slavery[22], is founded on the equal value of all human beings. In a Kantian concept, dignity is an intrinsic human quality which prohibits humans from serving as means to an end and having a price. Compliance with this principle is affirmed by French bioethics laws and by the *Conseil Constitutionnel* (Constitutional Council of France)l[23]. Although it is not defined by law, it obligates everyone to respect other people's dignity and is the legal foundation for provisions as widely diverse as those forbidding human trafficking, modern forms of slavery and harassment in the workplace.

However, despite the general consensus in favour of respect for human dignity, there remains a divide between those who believe that this dignity also entails individuals' obligations to themselves, so that they remain "worthy" of their human condition, on the one hand and, on the other, those who consider that insofar as other people's dignity is not harmed, individuals are free to decide for themselves what constitutes their own dignity.

The debate on gestational surrogacy is in part connected to this difference between philosophical standpoints. For those defending the concept of dignity as an intrinsic human value, to be respected not only in others but also for oneself, GS represents an

[22] See the report of the committee presided by Simone Veil on the revision of the preamble to the Constitution, p.119

[23] Decision n° 94-343 DC of July 27, 1994

instrumentalisation of women's bodies and its endpoint is to make children a kind of merchandise, so that for this body of opinion the practice is irremediably in contradiction with respect for human dignity. But for those favouring a more individualistic concept of dignity, this principle cannot lead to passing judgment on the ethical value of gestational surrogacy when it is freely accepted by all those concerned and the surrogate does not consider that the process is disrespectful to her own dignity. At this point, respect of dignity is in opposition with the right of individual self-determination.

Although it must be accepted that French society is not unanimous with regard to what is covered by the principle of dignity[24], within CCNE there are very strong reservations on the repercussions of GS on the carrier, for some by reason of concern for dignity and for others with reference to the image of women. Although it is plausible that some surrogates are acting entirely of their own free will, exception must still be taken to having society accept a form of alienation, however voluntary. Furthermore, there are numerous testimonies to the fact that, with GS, we are approaching the boundaries of free and informed consent: with GS, freedom does not seem to mean the same thing for all the parties involved. If the practice were to be organised, the establishment of "pools" of licensed surrogates[25] would be offensive to public feelings since it would mean that the most physically and morally trying aspects of motherhood would be the burden of one category of women, while the more rewarding part of the task in human terms would be the prerogative of others. The rejection of social acceptance of GS, even for those who defend a more liberal understanding of human dignity, is based also on sociological considerations outlined above, according to which in countries where GS is legal, the social status of surrogates is very notably lower than that of the intended parents.

4. II.5. There are still some unknowns regarding the future of GS born children

The future of all children cannot be anything but uncertain and it would be illusory to aim at guaranteeing an optimal family environment for every child. Moreover, the decision to become a parent must not be subject to society's supervision as a general rule. But in the case of GS, CCNE finds it difficult to pronounce itself in favour of very singular birth conditions that most people would think twice of adopting for themselves.

It is true, as the Committee has already mentioned, that very probably a child born of GS, awaited with eagerness by intended parents, would be welcomed into the world. However, out of the encounter of arguments put forward by the adversaries and supporters of GS, three sets of issues emerge which would lead us to err on the side of caution: without assuming, first of all, that the future child would necessarily suffer any traumatic feeling of

[24] ibidem, p. 128 et seq.

[25] See, in a science fiction context, Margaret Atwood's "The Handmaid's Tale".

loss, misgivings may be entertained regarding the consequences on the child's psychological development of being the subject of an unusual and complex process, and of a transaction, not to say a negotiation, between differing interests. Secondly, in view of the questionings and sufferings of some young adults born of gamete donation, the possibility of an impact in the long term of dissociation between maternal filiation and gestation on the psyche of people born following a GS procedure cannot be dismissed out of hand. Finally, it is permissible to harbour doubts regarding the consequences of the procedure for other children who may be indirectly affected, be they the children, existing or born subsequently, of the surrogate carrier or those of the recipient couple.

It would be wishful thinking to suppose that such matters might be clarified by studies which could only be very limited and would also raise severe ethical problems of intrusion into the personal affairs of families and the privacy of children. Furthermore, when seeking to identify a largely subconscious state of unease, the object of the evaluation is uncertain, as is the methodology.

II-6- The claim for legalising GS is based on a disputable concept of equality before the law

Some of the reservations regarding GS, as we have mentioned several times, are close to those that could be expressed regarding other forms of assisted reproductive technology which are in fact authorised in France. It is also true that it is now accepted that apparent or social fatherhood and motherhood can be dissociated from biological fatherhood and motherhood, since gamete donation is unexceptional.

It is understandable in these circumstances that those in favour of legalising GS point out that failing to alleviate a particular form of sterility would be unfair and contrary to our perception of equality before the law while society and the medical community are making every effort to respond to other types of infertility. As assisted reproductive technology has progressed remarkably, according to the report of a working group of the French Senate[26], the aim here is to "*refrain from aggravating the pain of infertile couples by giving the impression to those who are unfortunate in this respect that all the causes of infertility do not deserve the same consideration*". Infertility, whatever the cause, tends to be represented here not only as a pathology, but also a wrong that the community must put to rights to the fullest extent possible, on an egalitarian basis.

The aim of this legalisation, albeit controlled, of GS would also be to restore equality between the more affluent families, who can afford to circumvent French law by employing the services of a gestating mother in another country which authorises or tolerates the procedure, and those couples who cannot bear the expense.

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[26] Contribution to reflection on maternal surrogacy, previously quoted.

It is certainly true that the development of medically assisted reproductive technology and, in particular, the legalising of third party gamete donation, may give the impression that there is a collective commitment to overcome all forms of sterility which needs to be upgraded in order to respond to the circumstances of women who are unable to carry a child.

But over and above the ethical objections raised above, CCNE considers that care must be taken to avoid giving credence to the idea that any injustice, be it physiological, challenges the principle of equality before the law. While the distress of sterile women arouses feelings of compassion or outrage, it cannot put an obligation on society to organise equality by correcting conditions that nature has compromised. Such a concept would lead to demanding of society that it takes whatever action may be required, without any limitation, to restore justice in the name of equality. It also signifies that there exists a right to have a child, whereas the wish or the need to have children cannot lead to recognising any such entitlement.

Furthermore, this conception of equality has no natural limits. How could surrogate motherhood be denied then to remedy other forms of distress? Considering that any kind of suffering deserves remedial legislation is a path that very soon leads to an impasse, human suffering being both highly subjective and infinitely varied as to its causes.

CCNE also notes that this way of viewing the matter could put unwelcome pressure to bear on infertile couples, could kindle aspirations fraught with the risk of failure, ending in disappointment all the greater for having had to endure wearisome technical procedures that raised great hopes and engaged much effort.

But it remains essential to call on national solidarity to help infertile couples for whom there is no known medical remedy. For this to be done, a first step would be to invest in medical research on the causes of female infertility that are still untreatable and to intensify preventive action against avoidable causes. A second step would be to initiate social reflection on normative discourse concerning female sterility and motherhood.

Conclusion:

Finally, after substantial and collegial reflection, for the six categories of reasons which have been outlined above and for the large majority of the CCNE members, the arguments in favour of keeping existing legislation as it is currently have prevailed over those in favour of legalising this ART procedure, even if it were strictly limited and controlled.

Paris, April 1, 2010

Note to be appended to the Opinion on GS

To a considerable extent, the signatories of this appendix participated in, and agreed with the ethical reflection set out in this CCNE Opinion. They are aware of the risks and excesses which could follow the uncontrolled introduction of this medical procedure. They are, however, particularly moved by the human tragedy for certain couples of being able to obtain embryos with their own gametes although the "intended" mother is unable to bring the pregnancy to term, for the lack of a uterus.

In these circumstance, with GS, the embryo developing in the womb of the woman who has donated her gestating capability is the outcome of the union of the two gametes of the "intended parents" who have clearly expressed their wish to bring up a child to whom they are closely related by genetic ties. Our purpose is certainly not to grant excessive pride of place to such ties (the absence of which, so often, is no hindrance to the harmonious development of children for whom no such ties exist) but we feel that there are legitimate grounds for leaving the door open to this procedure, one among other multiple facets of medically assisted reproduction.

We feel furthermore, that retaining the existing prohibition with its consequences as regards legal filiation is contrary to the higher interests of all the children who will continue to be born with the help of GS practiced in countries where it is not illegal and where French couples who can afford to, will continue to go.

We express the wish that GS, strictly controlled in order to preserve the dignity and safety of all those involved, should be provided for, by way of derogation, when the law is revised. We would also consider that such a derogation should be necessarily accompanied by a prospective study for the purpose of evaluating its consequences.

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