National Consultative Ethics Committee for Health and Life Sciences

Opinion N° 113

"Request for medically-assisted reproductive technology after the death of the male partner"

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GENERAL CONTEXT.

Before the laws on bioethics, as they were referred to, were voted on 29th July 1994, CCNE's opinion was requested on several occasions on the subject of women requesting insemination with the frozen sperm of their dead spouse or the *post mortem* transfer of cryopreserved embryos. The courts were also asked to rule on such cases and their findings were sometimes contradictory[1].

The 1994 law put an end to such hesitation since it stated that assisted reproductive technology (ART) is intended to respond to parental requests from couples comprising a man and a woman who "*must be living*"[2]. Lawmakers intended to favour a traditional family environment, excluded women on their own from access to ART, either at the time of the initial request or in the course of the procedure if the couple no longer prevailed, in particular following the man's death. The possibility for a woman, whose spouse or partner was no longer with her, to pursue alone a parental project which they had originally planned together, by seeking insemination or embryo transfer *post mortem*, was therefore denied. In this, lawmakers were not following CCNE's position on the subject which, as set out in its **Opinion N° 40, dated December 17 1993**[3], considered that, in the event a woman asks for the transfer of embryos *post mortem*, "*There is no convincing reason for refusing the woman herself this choice à priori" and that "when in vitro fertilization has been performed during the man's lifetime and when the embryos have been frozen… the man's decease indeed does not deprive the woman of the rights that she may consider she possesses to these embryos, jointly created by herself and her deceased partner... The man having deceased, one cannot see who or what authority could, in the last instance, claim rights to these embryos equal to or stronger than those of the woman, or object to her explicitly stated project, about which she has been duly informed, to assume a pregnancy after the transfer of the frozen embryos."*

Subsequently, CCNE confirmed this position on two separate occasions in Opinions formulated on the occasion of the previous revision of the 1994[4] law. In **Opinion N° 60, dated June 25, 1998**, reiterating the arguments set out in Opinion N° 40, it stated : *"An embryo frozen in the context of medically assisted reproduction already launched by the couple, may be transferred after decease of her spouse at the request of the woman, providing circumstances permit her taking a decision which is fully independent of psychological or social*

[1] Decision of the Tribunal de grande instance (District Court), Créteil, on 01/08/1984 ordering the restitution of frozen semen straws to the widow (Parpalaix case); contrary decision of the District Court in Toulouse on 26/3/1991 in similar circumstances. Recognition, by the Angers District Court on 10/11/1992 of the paternal filiation of a child born by embryo transfer two years after the father's decease; contrary decision by the Toulouse District Court on 11/05/1993 refusing the transfer, confirmed by the Toulouse Court of Appeal on 18/04/1994, which ordered the destruction of the frozen embryos. The Supreme Court of Appeal (Cour de Cassation) reversed the decision on 09/01/1996 cancelling the order that the embryos should be destroyed, but rejecting other claims by the woman concerned (Pires case).

[2] Article L. 2141-2 of the *Code de la Santé Publique*

[3] Opinion N° 40, December 17, 1993 on The transfer of embryos after the decease of a husband or partner.

[4] Opinion N°60, June 25,1998 on the Re-examination of the laws on bioethics and Opinion N° 67, January 27, 2000 on the preliminary draft revision of the laws on bioethics.

pressures." CCNE further detailed its position in **Opinion N° 67 dated January 27, 2000,** in which it proposed a new wording for Article L.2141-2, para. 3 of the *Code de la Santé Publique*, i.e.: *" If the couple separates, this is an obstacle to insemination or embryo transfer. However, stored embryos may be transferred if the separation is the result of the man's decease and he has expressly consented during his lifetime to a continuation of the medically assisted reproduction procedure after his death. In this latter case, embryo transfer cannot be performed until at least three months have elapsed and no later than one year after his death. The woman must be provided with psychological counselling."*

As CCNE had recommended in the Opinions quoted above, the various reports submitted for parliamentary discussion at the time of the first revision of the 1994 law excluded the possibility of *in vitro* fertilization (IVF) or insemination using the deceased husband's frozen semen, but recognised the woman's right to pursue the couple's parental project through the transfer *in utero* of cryopreserved embryos[5]. The draft bioethics law, which was voted at first reading by the French Parliament on January 22nd, 2002, adopted the same principle[6]. But this possibility was written out in the law as it was finally adopted on August 6, 2004. To avoid any ambiguity, the law even reinforced the prohibition when it added an explicit paragraph to Article L.2141-2 of the Code de la Santé Publique, to the effect that "the death of one of the members of the couple, the filing of divorce or legal separation proceedings and the end of co-habitation were obstacles to insemination or embryo transfer...".

When the law was revised on August 6, 2004, the various preparatory reports published so far[7] referred to this prohibition. While none of them actually recommended that the prohibition to inseminate or fertilise in vitro *post mortem* be lifted, they all considered — except the report by the Conseil d'Etat — that embryo transfer *post mortem* could be authorised in certain well-defined circumstances. All of the reports drew attention to the ethical dilemma arising out of the opposition between deliberately putting into the world a fatherless orphan and the distress of a woman who wishes to pursue the couple's parental project but whose sole options are destroying the embryos or donating them to another couple. The ban on *post*

[5] Conseil d'Etat : "Bioethics laws, five years later", January 1999, La Documentation française ; Office Parlementaire d'Evaluation des Choix Scientifiques et Technologiques (Parliamentary Bureau for the evaluation of scientific and technological decisions), Report on the application of law N° 94-654 of July 29, 1994; Report N° 3528 of 01/01/2002 for the National Assembly's special Commission on the draft bioethics law; Report N° 3525 of 09/01/2002 for the Assemblée Nationale's Delegation on Women's Rights.

[6] The draft modified as follows Article L. 2141-2 of the Code de la Santé Publique: *"Medically-assisted reproductive technology is intended to respond to the parental wishes of a couple... The man and woman forming the couple must be living, of childbearing age, married or in a common-law relationship, and must give prior consent to embryo transfer or insemination.* ***However, the transfer of cryopreserved embryos can be performed after the man's death as long as he had given written consent to the continuation of the medically-assisted reproductive procedure in the event of his death. This possibility is offered to him when he enters into the process; his consent may be obtained or withdrawn at any time by the Centre where he is registered. Embryo transfer is allowed after a minimum of six months and a maximum of eighteen months following his death. The birth of one or several children following one single transfer puts an end to the possibility of proceeding with another transfer. The woman must be provided with individual counselling. She may, at any time, inform the Centre where she is registered that she wishes to put an end to the transfer procedure. If she marries or re-marries, the embryo transfer is no longer permitted"***.

[7] Assemblée Nationale: Report n°2832 of 25/01/2006 by the Parliamentary mission on family matters and the rights of children; Office parlementaire d'évaluation des choix scientifiques et techniques (OPECST) (Parliamentary Bureau for the evaluation and scientific and technical decisions: Report on the revision of the bioethics law, December 2008; Conseil d'Etat: Report on the revision of the bioethics law, May 2009; Assemblée Nationale: Information Report by the Parliamentary mission on revision of the bioethics law, January 2010.

mortem transfer was even described as "*abusive*" by citizens participating in the Estates General on Bioethics for whom "*authorising a woman to pursue with pregnancy seems self-evident*"[8]. The conclusions in the reports favourable to lifting the ban on *post mortem* embryo transfer subordinate this possibility to express consent given by the man concerned to be included as part of the assisted reproductive technology procedure. They recommend that the practice be confined to specific time periods in order to give the woman time to reflect but also avoid having a pregnancy and a child born too long after the father's death.

The above is the context underlying CCNE's decision to review once more the ethical considerations involved in *post mortem* medically-assisted reproductive technology procedures.

I. THE VARIOUS SITUATIONS

1) *Post mortem* use of cryopreserved sperm

Requests for reproduction using the cryopreserved sperm of a deceased man may be submitted by his partner, spouse or partner, in two circumstances: either the sperm was preventively frozen before treatment that could induce infertility or as part of an assisted reproductive technology (ART) procedure. In either case, the ART procedures concerned are intra-conjugal.

a) Preventive auto-preservation of sperm

Since their creation in 1973, CECOS Centres (*Centre d'Etudes et de Conservation des Oeufs et du Sperm – Egg and sperm study and preservation centres*) have preserved semen for men who are about to undergo medical treatment with a potential for reducing fertility. The procedure is specifically included in various regulatory documents, in particular the rules of good practice governing assisted reproductive technology. It was confirmed by the bioethics law of 2004[9]. As of December 31, 2006, the CECOS Centres were storing the sperm of 34,827 patients[10]. The rules of good practice for assisted reproductive technology specify, in the chapter on the conservation of gametes and germinal tissue for autologous purposes, that "*Anyone about to undergo potentially fertility-reducing treatment must be given access to information on the possibility of gamete or germinal tissue conservation. When such conservation is undertaken in the context of a life-threatening disorder, the patient must be given specific and targeted information."* The text also specifies that consent must be given in writing and that, **subsequently, sperm straws can only be returned to the patient personally.** Patients are asked every subsequent year whether they wish to have conservation continued or discontinued and they alone are permitted to express their wishes in this respect. "***In the event of death, conservation is discontinued"***.[11]
Such preventive auto-preservation before therapies or procedures which could result in

[8]Final Report of the Estates General on Bioethics, July 2009, annex, p. 14.
[9]Art. L. 2141-11 of the Code de la Santé Publique: "For the purpose of subsequent assisted reproductive technology procedures, persons undergoing potentially fertility-reducing treatment or whose fertility may be prematurely impaired may make use of gamete or germinal tissue sampling and conservation procedures, with his/her own consent or, should the case arise, with the consent of one of the holders of parental authority, or of the guardian if the person concerned is a minor or under guardianship."
[10]Agence de la biomédecine: *Bilan d'application de la loi de bioéthique*, (Report on the implementation of the bioethics law), Oct. 2008.
[11]Decree dated August 3, 2010 regarding the rules of good clinical and biological practice of medically assisted reproductive technological procedures, Ministry of Health, official publication on September 11, 2010.

infertility, such as chemotherapy, radiotherapy or surgery, may be requested even if there is no specific or immediate plan to procreate. A considerable amount of time could elapse between preservation of the sperm — which in some cases could take place when the patient is still under age — and the moment when he decides to use the sperm to father a child. However, sperm auto-preservation may also be related to a couple's specific plan, which they have already decided upon, to have a child.

A woman requesting *post mortem* insemination or *in vitro* fertilisation with her deceased spouse or partner's preserved sperm may therefore be carrying out a plan which the man concerned would have participated in and consented to, more or less directly and explicitly depending on circumstances.

b) Sperm cryopreserved in the context of medically assisted reproduction

Sperm may be cryopreserved to respond to a couple's parental wishes. Depending on the medical indications to remedy the couple's infertility, it will be used either for artificial insemination or for in vitro fertilisation, determined by the quality of the sperm.

In the case of intrauterine artificial insemination, sperm is usually collected and prepared in a laboratory on the same day as the insemination. However, there are cases when the man cannot be present on the day chosen for insemination, so that his sperm is frozen to overcome this problem.

In the case of in vitro fertilisation, there will be a need for ovarian stimulation, oocyte retrieval and fertilisation by putting the gametes in contact by conventional methods or using the ICSI (*intracytoplasmic sperm injection*) technique, which consists in injecting a single spermatozoon directly into the egg, through the plasma membrane. When IVF is planned, it may also be necessary to freeze the sperm if it cannot be collected on the same day as the oocytes are retrieved, or if there are fears that already deficient sperm justifying the use of ICSI may further deteriorate, or again because the intended father fears that he will not be able to donate sperm on the date set for retrieval.

The male partner may die unexpectedly before the artificial insemination or IVF procedures are under way. In that case, the reality of the parental project is undeniable since the medically assisted reproduction procedure has already begun.

2) Embryo transfer *post mortem*:

Assisted reproductive technology may require *in vitro* fertilisation, either because of the nature of the couple's subfertility or to avoid passing on a particularly serious disease to the child, in which case preimplantation genetic diagnosis (PGD) on the embryo in vitro is the chosen technique, or again, if there is a need for gamete donation to be used. IVF implies setting up a fairly weighty and trying procedure for the woman concerned, since she must undergo ovarian hyperstimulation and surgery under anaesthesia for oocyte retrieval. In order to avoid having to repeat this procedure if the first attempt at impregnation fails, or if they want to have another child later, the couple may decide to give written consent for a greater number of oocytes to be fertilised so as to have 'spare' embryos, which can be cryopreserved

for a future transfer[12], if their quality is satisfactory. The two partners are consulted every year as to whether they still wish to keep these embryos[13].

The death of the male partner can occur at various points in the ART and IVF process. It may take place before any transfer *in utero* has given rise to the birth of a child. Or it could happen after one or several children have been born to the couple. In either case, if the woman wishes, despite her husband's or partner's death, to continue with the birth of the child the couple had planned together, using the cryopreserved embryos for a transfer *in utero*, she will be thwarted by the prohibition contained in the law stipulating that the death of one of the members of the couple puts an end to the parental project.

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Generally speaking, the various cases of post mortem reproduction under consideration have one feature in common: they are all exceptional. The potential number of requests for *post mortem* embryo transfer never seems to total more than one or two cases per annum in France. The number of requests to use sperm *post mortem* could be greater in so far as they can also be formulated following sperm auto-preservation before treatment for a life-threatening disease.

Another situation must also be mentioned: the woman dying while she is pursuing an ART procedure but before embryo implantation has led to the birth of a child. If her husband wished to pursue the couple's parental project, he could only do so by calling on another woman who would be prepared to carry the embryo. As CCNE has already stated that it disapproves such a procedure, whatever the circumstances[14], the case is not dealt with in this Opinion. Nor do we intend to consider the case of frozen embryos after the couple has separated as this is a different issue.

II. ETHICAL ISSUES

1) Ethical objections to *post mortem* assisted reproductive technology

Freedom to procreate is an integral part of the protection of the private life of individuals and a fundamental right[15]. Can we consider, however, that there are ethical reasons for limiting this freedom, particularly when it involves assisted reproductive technology? In the event that

[12]Only about 20 to 25% of couples will have embryos that can be frozen, depending on their morphology and their cleavage kinetics.

[13]As of 31/12/2006, 176,500 frozen embryos were stored in ART centres in France, which does not signify that they are necessarily 'spare'. At that time, 53% of couples had confirmed their project in writing, 27% had not replied to the annual letter of enquiry or were in disagreement and 20% had decided not to pursue their parental project. Agence de la biomédecine, *Bilan d'application de la loi bioéthique*, Oct. 2008 (Report on the implementation of the bioethics law), Oct. 2008.

[14]Opinion n°110 Ethical issues raised by gestational surrogacy, May 6, 2010

[15]Article 16 of The Universal Declaration of Human Rights: "...the right to marry and to found a family"; Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms: "Right to respect for private and family life"; articles 7 and 9 of the Charter of Fundamental Rights of the European Union: "right to Respect for private and family life" and "the right to marry and right to found a family".

frozen sperm is to be used or a cryopreserved embryo is to be transferred after the death of the male partner, objections could in fact be made in the name of the child's best interest, or the mother's or of the interests of the community.

a) The child's interest

A child born in these circumstance would be fatherless, which signifies that he or she would be deprived of one of children's elementary birthrights. This deliberately programmed situation is different from those which must be faced *a posteriori* in the event of a father's death, departure, or absence. It gives food for thought on the meaning and the position of fatherhood in today's society and on the risk of the father's role being attenuated. But we must also take into consideration that the child will know who is the father, even though he is dead, that filiation on both sides of the family will be a matter of record and that such a child will be filling his or her own genealogical space in the paternal line.

Another reason for disquiet is that a birth in these sorrowful circumstances could burden children with an indelible connection to a time of mourning[16] and that this could be a destabilising factor or cause psychological trauma. Conversely, other opinions might be held to the effect that such children represent birth despite bereavement and life's victory over death. In either case, however, it would be damaging for the child to be *a priori* placed in a predetermined position, and be given a real or supposed role as a substitute for a dead man. Children should, on the contrary, be welcome in their own right and be comforted by the thought that they were wanted by both their parents and that they did have a father, even if he is no longer with them.

The difficulties such children might encounter must not, however, be underestimated. Statements from the parents of children deprived of the presence of a father or mother following an untimely death do refer to the consequences of this absence[17.] In their experience, even though the orphans know that they were conceived in an act of love, they always feel a sense of loss and of being different and apart from other children. When the mother is pregnant at the time of the father's death, they find it difficult to accept that he was not there when they were born and therefore was never able to know them. If that is so, how will it be possible to explain to them and get them to accept the fact that their father was already dead when they were conceived? Fear of death in general and above all, fear that the remaining parent could die is always very strong in children and could well be aggravated in the particular circumstances of such births. Other vulnerability-inducing factors, particularly during adolescence, could be a tendency on the part of their mothers to overprotect them or to idealise the image of the deceased father. Finally, again according to this testimony, it seems that it is not unusual to find that the parents of the deceased refuse to see their grandchildren because they are seen as the grief-laden reminder of the loss of their own child.

b) The mother's interest

[16]This point is referred to in most of the theories arguing against *post mortem* ART, in particular by the *Conseil d'Etat* in its May 2009 report quoted above.

[17]Hearing of two members of FAVEC (Fédération des associations de conjoints survivants - Federation of Associations of surviving spouses) on November 18th, 2010. FAVEC has not taken a stand specifically on the issue of *post mortem* reproduction.

The situation of a woman who deliberately decides to become pregnant when she has just lost her husband or companion is different from that of a woman who is obliged to bring up her child single-handed after the child's father has died or left her. But is this decision to pursue a parental project, which was interrupted by the death of her partner, always entirely free and informed when it is being taken by a bereaved woman? In particular, if disease was the cause of death, it is likely that the period of time before the end was fraught with considerable anguish and intense physical fatigue, the consequences of which she may still be suffering. Her vulnerable state at this time may, in particular, make her overly sensitive to pressure from family, friends or even society. She may not be fully aware of the possible difficulties she will encounter as a single mother, particularly if she cannot count on support, either financial or emotional. She will have looked forward to experiencing pregnancy with a companion and she will be on her own, without being able to share the burden of any of the decisions that will have to be taken[18].

c) The community's point of view

A woman seeking assisted reproductive technology *post mortem* will have to ask for help from the community since she will be needing medical attention and will be receiving social benefits. The question may then arise of whether the community should contribute to the deliberate decision to bring about the birth of a fatherless child and whether it should take on the financial burden to the same extent as would be the case if such circumstances came about unintended. But this argument could be partly countered if the woman concerned was asking to have returned to her embryos or preserved sperm straws so that she could undertake, at her own expense, medically-assisted reproduction in a country authorising this procedure after the death of a spouse.

Apart from the financial considerations, society cannot be unconcerned about favouring the birth of children in a context which may be unfavourable to them, since they will be deprived of a father and single parenthood is often a destabilising factor, or even the cause of a family's precarious situation[19]. However, a situation which is the result of a positive decision, in an exceptional context, cannot be systematically equated to situations which, more often than not, are forced upon the person concerned and which represent a social phenomenon due to multiple causes in diverse socio-economic conditions.

Another objection, raised in particular by the *Conseil d'État*, is whether it is advisable to modify existing law substantially in order to cope with extremely rare situations. It is a fact that filiation and inheritance law would have to be adapted to take account of the particular position of a child whose date of birth did not fall within the presumed period of time of conception. However, the legal complications that were mentioned would not be insurmountable as evidenced by various modifications to existing laws already proposed[20].

[18]Like any other single mother, she may, later on, have to face problems such as ill health or job loss and have to cope on her own if friends and family are unable to help. The members of FAVEC who were heard by the Committee emphasised the community's lack of recognition for the status of orphan or of widowed parent, so that material or moral support is unavailable, particularly when the couple were not legally wedded.

[19]Supporting this view: the *Observatoire National de la Pauvreté et de l'Exclusion Sociale's* 2009-2010 Report (National Observatory of poverty and social exclusion) and *"Les familles monoparentales : des difficultés à travailler et à se loger*" (Single parent families: difficulties in finding work and housing), INSEE 2008 – Demographic studies and surveys.

[20]According to article 311 of the *Code Civil*: "*The law presumes that a child was conceived during the period of*

The questions that need to be asked regarding assisted reproductive technology after the death of the male partner remain, therefore, **essentially ethical in nature, not legal.**

2) The difference between using cryopreserved sperm *post mortem* and embryo transfer *post mortem*.

Are ethical issues different depending on whether the request for ART concerns the *post mortem* use of cryopreserved sperm or *post mortem* embryo transfer? Does the fact that oocyte fertilisation takes place before or after the man's death modify the nature of the request and its consequences? Is the assurance that the man gave free and informed consent to the possibility of posthumous procreation of equal strength in both of these cases?

In Europe, countries authorising *post mortem* assisted reproduction technology considered there was no reason to distinguish between the use of cryopreserved sperm and embryo transfer. This is the situation in Belgium, Spain, the Netherlands and the United Kingdom. Denmark, Italy and Switzerland explicitly forbid both of these practices. Under German law *post mortem* insemination is proscribed and in principle, embryo cryopreservation is disallowed[21].

a) Conflict between the couple's decision to continue with the parental project after the male partner's death and the responsibility incurred by bringing about the birth of a fatherless child.

Is procreation after the father's death still contained in the initial parental project or does it become the project of the woman alone? Some people consider that death marks the end of the couple's plans. Others feel that conjugality may continue after death. A joint project can be pursued after one of the partners dies in the same way as, for instance, plans decided by the couple regarding their children's upbringing. But in the case of a parental project, the two partners are not only committed to each other; their joint responsibility is also to a third party, the future child. A continuation of the parental project *post mortem* can therefore only be acceptable if it is the expression of the will of both members of the couple who gave explicit consent[22]. This would imply a procedure for securing consent before the man dies. In practical terms, consent — revocable at any time — to *post mortem* procreation could be

time which extends from the three-hundredth to the on-hundred-and-eightieth day, inclusively, before the date of birth". This rule, when the couple is married, is associated with the legal presumption of the husband's paternity, set out in article 312 of the *Code Civil*: *"The father of a child conceived or born during a marriage is the husband"*. In the case of *post mortem* reproduction, presumption of paternity would be excluded since the child would be born more than 300 days after the husband's death.

When the couple is not married, paternal filiation can be established, according to article 316 of the *Code Civil*, *"by recognition of paternity... before or after the birth of the child"*. If the child is born *post mortem*, the deceased father will not be able to proceed with recognition, which is a voluntary and personal expression of his wishes. Nor can prenatal recognition apply, as provided by law, because it could only concern a particular child and therefore implies an on-going gestation.

The *Conseil d'État*, in its 1999 report on "*Les lois bioéthiques : cinq ans après",* (The bioethics laws: five years later) had proposed several modifications to the *Code Civil* to override these impediments, as regards both the establishment of paternal filiation and inheritance law. These modifications were included in the draft law on bioethics voted on first reading by the French Parliament in 2002.

[21]Senate's working document: *L'accès à l'assistance médicale à la procréation*, (Access to assisted reproductive technology) série Législation comparée, n°LC 193, January 2009.

[22]The decree quoted above setting out the rules of good practice for assisted reproductive technology specifies that written consent prior to ART procedures must be renewed before each attempt at IVF, intra-conjugal artificial insemination and embryo transfer.

obtained at the time sperm or embryos are frozen and could be renewed annually at the same time as patients are questioned regarding their wish to continue, or not, with cryopreservation. In the case of embryo transfer, consent to the creation of embryos and to freezing spare embryos was already given at the time of *in vitro* fertilisation. The parental project is already under way and the embryo exists while both potential parents are still alive. In case of death, consent would only concern the embryo's future and the clinical action of *post mortem* transfer. In the case of insemination or IVF *post mortem,* consent to fertilisation cannot have been given while the man was alive even though commitment to a parental project may have already been expressed clearly and unambiguously by both members of the couple. Consent secured prior to death would therefore concern *post mortem* conception of an embryo and not the future of an existing embryo.

If it is thought that what matters is the couple's determination to continue with the parental project after death — regardless of how far the project had been implemented — there is no reason to distinguish between the use of cryopreserved sperm and *post mortem* embryo transfer, since that which determines the existence of an embryo, instead of cryopreserved sperm straws, is not the state of progress of the parental project, but the medical indication which necessitated *in vitro* fertilisation. But if one considers that consent to *post mortem* reproduction can only be valid if the parental project has already been materialised by the fertilisation of an oocyte, then only *post mortem* embryo transfer is allowable. This position is founded on the possibility of projects varying over time, all the greater if the project is less structured and further away from completion. Clinicians have observed considerable variability linked to psychological changes due to disease, becoming particularly noticeable as the end of life draws near. However, doubting the validity of consent given by a man as to the use of his gametes for impregnation after his death may be viewed as particularly intrusive. It could be interpreted as a lack of understanding of the psychological distress endured by couples desperately wanting a child and, in particular, as a denial of a man's wish to consent to the posthumous use of his gametes so as to alleviate his wife's wretchedness at not achieving motherhood.

In either case, the couple's wishes are confronted in the same way with the child's interest. Be it following *post mortem* use of sperm or *post mortem* embryo transfer, the child will be born fatherless. The fact that in the case of embryo transfer, the decision was to have a fatherless child see the light of day, whereas in the case of *post mortem* insemination, the decision was to conceive a fatherless child, will not bring about any change in the child's situation. Furthermore, the risk of possible 'instrumentalisation' of the child to fill the gap left by the loss of the deceased is identical in both circumstances.

b) Pushing back life's boundaries.

The entire history of medical science shows that, in the main, progress and technical breakthroughs aim at postponing death (advances in resuscitation and vital organ transplantation are cases in point). *Post mortem* reproduction which became possible once sperm could be frozen, followed by embryos *in vitro*, can be seen as simply one step further in this evolutionary process. But in this respect, the two possibilities — embryo transfer or *post mortem* insemination — do not have the same effects. In the case of *post mortem* insemination or IVF, the future child was conceived at a time when his or her father had

already been dead for some while, long or short, which symbolically is tantamount to allowing a dead man to procreate. In the case of the transfer of an embryo conceived when the father was still alive, the future child already has a form of existence bestowed by both members of the parental couple; the fact that a deceased person is procreating is not so palpable and therefore less disturbing.

However the boundary between life and death is not always so clearly defined as is evidenced by requests for *ante mortem* assisted reproductive technology which are in fact more frequent than *post mortem* requests. The possibility of sperm auto-preservation when medical treatment could impair the fertility of the patient is often a decision taken in the context of serious and life-threatening disease. The couple may then be tempted to make an emergency request for insemination when the patient's condition deteriorates[23].
Furthermore, the 2004 law on bioethics subscribed to the possibility of calling on ART when it aims to "*avoid the transmission of a particularly serious disease to a child or to one of the partners of a couple"*[24]. In two Opinions[25] previous to the 2004 law, CCNE had considered the ethical problems arising out of such couples' wish to have children and had put forward recommendations in favour of their being able to call on ART despite the fact that, at the time, prognosis for their condition could only be described as uncertain[26].

In certain cases, when the request for ART is formulated by a couple with both partners alive, the possibility of giving birth to a fatherless child therefore still exists. There is here a certain degree of legal inconsistency in so far as the law, on the one hand, permits and organises practices allowing couples to bear children in a context where the risk of a child being orphaned is theoretically possible and, on the other hand, forbids *post mortem* medically assisted reproductive technology, precisely to avoid the birth of an orphan child. The programmed birth of a fatherless child is therefore an argument which is not sufficient, in itself, to justify the ban on *post mortem* procreation.

More generally, so-called *ante mortem* procreation raises the issue of the legitimacy of interfering in the decision of a couple to bear a child when one of the two partners is suffering from a pathology which is potentially lethal at some point in the future. It highlights the extent to which intervention of this nature is unsound when it is based solely on an estimate of the life-expectancy of the person concerned, since whatever limits might be decided could

[23]The chairman of the French Federation CECOS, J.-L. Bresson, said that if transfer was authorised but not insemination, he feared that couples would ask for IVF *ante mortem*, which would have as a consequence an increase in the number of cryopreserved embryos: *Mission parlementaire d'information sur la révision des lois bioéthiques*, (Information Report by the Parliamentary mission on the revision of the bioethics law, 2010, T.2, p. 338).

There would be a risk that *in vitro* fertilisation could become a kind of insurance policy, not just against sterility, but also against fate putting an end to a parental project in the event of death. IVF would thus become a symbol of the crossing of two boundaries: that of the impossibility of having a child because of sterility and that of the impossibility of having a child after death.

[24]This article of the law mainly concerns HIV serodiscordant couples with the objective of reducing the risk of contamination of the other member of the couple or of the unborn child.

[25]**Opinion N° 56 dated February 10, 1998** on ethical issues raised when a couple, in which the man is HIV-positive and the woman is HIV-negative, wish to bear a child and **Opinion n° 69 dated November 8, 2001** on medically assisted reproduction for couples presenting a risk of viral transmission – Reflections on responsibilities.

[26]Today's context is different. ART practices for a couple in which one of the partners is HIV-contaminated, include recommendations concerning the viro-immunological data of the contaminated person before proceeding with ART so that, if antiretroviral treatment is provided, the patient's life expectancy is, in the long term, close to that of people who are not contaminated.

only be arbitrary.

But the fundamental distinguishing feature of *ante mortem* reproduction is that, in this case, the sequence of events is not completely reversed as it can be by the abolition of the threshold between life and death which is characteristic of *post mortem* reproduction. This is an essential element and sufficient in itself to differentiate the *ante mortem* borderline cases from *post mortem* reproductive situations.

3) Authorisation of *post mortem* embryo transfer.

Although ethical objections to requests for the transfer of embryos *post mortem* must be taken into consideration, there are also compelling ethical reasons to accept them.

The issue is not so much connected to the "rights" of a couple or of a woman over the cryopreserved embryos, as to "power of decision" over their future. The embryo's fate does in fact depend only on the couple who conceived them and the law recognises this. The couple concerned will be able to decide whether they want the embryo to be implanted *in utero*, or destroyed, or hosted by another couple or donated for research.

If the man dies, the woman alone will be left with the entire responsibility of deciding the embryo's future, except, paradoxically, that of carrying it and persevering with pregnancy as she would be able to do if the embryo was already inside her body. The existence of embryos outside their mothers' bodies thus creates an entirely new situation with the effect of redistributing the power of decision regarding the fate of the embryos between the protagonists who participated in their conception *in vitro*. As the sociologist Simone Bateman-Novaes points out, conception *in vitro*, since it takes places "*in a relationship which spans across at least two major institutional domains: family and medicine, will be subjected to at least two sets of standards and values, which may on occasion be the source of tension between protagonists in so far as each set refers to relationships and practices with different objectives*"[27]. These are precisely the conflicts the courts were required to adjudicate on before the bioethics law in 1994 banned *post mortem* medically-assisted reproductive technology[28].
But situations where a woman who wishes to continue with a parental project, which she and her deceased partner had planned, is not allowed to do so in application of the law, are all the more distressing for her because she will be faced with an impossible choice. The law leaves her with no alternative but to ask for the embryos to be destroyed, to give them over for research or donate them to another couple. The law goes so far as to prescribe that she be expressly asked if she consents to donating to another couple this same embryo she is not allowed to carry herself[29]. This would be a particularly harrowing situation if the *post mortem*

[27]Simone Bateman-Novaes: "*Parents et médecins face à l'embryon : relation de pouvoir et décision", L'embryon humain*, éd. Economica, 1996, p. 185-192,

[28]A survey carried out by the *Revue du Praticien* in 1998 revealed a difference of opinion between the medical profession and parents: 74% of physicians were in favour of legal prohibition while 69% of parents were in favour of *post mortem* embryo transfer. Reference quoted in the 18th February 1999 report of the *Office Parlementaire d'Évaluation des Choix Scientifiques et Techniques sur l'application de la loi n°94-654 du 29 juillet 1994* (Parliamentary Bureau for the evaluation of scientific and technical decisions on the implementation of law n° 94-654 of 29th July 1994).

[29]Article L. 2141-5 para. 3 of the *Code de la santé publique*: "In the event that one of the members of the couple dies, the surviving partner is consulted in writing as to whether he or she is willing to allow the stored embryos

embryo transfer was her last chance to become a mother, was might be the case, in particular because of her age or if her subfertility or sterility was the reason for initiating the *in vitro* fertilisation procedure. As for the child born of such a donation, it would seem appropriate to reflect on what might be the psychological consequences of being born in a family "by default" because the law forbade birth in the family of the couple who conceived and wanted that child.

Is the community entitled to interfere and deny in this way in a woman's wish to become a mother, although the freedom to procreate is a private matter? It is true that a woman who decides to become pregnant thanks to assisted reproductive technology will need to ask the community to help her in this undertaking. It may therefore seem legitimate that society — while refraining from taking upon itself any discretionary powers of decision — should organise the conditions in which the project can be implemented and, in particular, consider the best interests of the unborn child.

In the case of *post mortem* embryo transfer, being deprived of a father must be weighed against the respect for the couple's wish to pursue their parental project. Certainly, the project was based at the outset on shared responsibility between the two members of the couple, which could be justification for the project to become void if one of them were to die. But nor can it be claimed that a couple's existence necessarily ceases if one of them dies. The couple may specifically wish to extend its existence by the implementation of a project which was planned and initiated together, particularly when the project is a family. For these reasons, pursuance of a parental project by a woman on her own could be contemplated if, before he died, the male partner had given formal consent to this possibility.

Planning the birth of a fatherless child must also be weighed against the actual reality of an existing embryo and the respect owed to that embryo. Philosophical, theological and scientific concepts abound on the nature of the embryo. CCNE, in previous Opinions designates the embryo as a "potential human being"[30]. Some people recognise the embryo as the unique result of the union between two gametes and two wills, the beginning of a destiny, a singular being about which a decision will be taken. For others, the biological difference between sperm straws and a fertilised oocyte does not imply that they be given a different status since their futures are similar and in both cases, depend solely on the existence or non existence of a parental project.

The couple's joint decision and the certainty that a child was wanted by the father as much as by the mother cannot compensate the handicap of being born fatherless. However, a child's condition cannot be reduced to this distinctive feature, however unfortunate it may be. The child will also have a mother and there is no *a priori* reason to believe that she will be unable to bring her child up alone as many other single mothers manage to do. There may also be next of kin on the father's side of the family ready to assist. Such children will know who their father was, can be made aware of family history and will be able to situate themselves as the son or daughter of a father, who may be dead, but whose symbolic presence will persist[31].

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to be hosted by another couple, in compliance with provisions in article L. 2141-5."

[30]See CCNE's **Opinion n° 112** "Ethical reflection concerning research on human embryonic cells and on human embryos *in vitro"*.

[31]The difference in status between a dead father and one who is unknown or absent should be borne in mind. The physical absence of a dead father does not exclude a very vivid symbolic presence, via memories, accounts, portrayals. Conversely, the presence of a living father does not exclude that he may be, or felt to be, emotionally absent. As for an unknown father, his only presence must be in the imagination.

Nor is it out of the question that someone in the mother's environment may be able to take on the vacant paternal role.

The child's interest will be all the better protected because the woman's decision to proceed on a *post mortem* embryo transfer was conscious, informed and deliberate. A waiting period after the man's death should be provided in order to avoid a decision being taken while a woman is still in the throes of bereavement. Women should also be informed of the high rate of failure of frozen embryo transfers[32], so that the disappointment of a failed transfer does not compound the pain of bereavement.

The motivations behind a couple's decision to give life to a child whose father knows that he will not be able to participate in his child's upbringing may be a subject that would benefit from clarification, but all decisions to procreate, whatever the circumstances, respond to a person's innermost feelings which CCNE has no cause to pass moral judgement on. As the Committee emphasised in its Opinion n° 40, "*There are many possible motives for one or other of these decisions,* [continuing or abandoning the parental project] *determined by the wife's overall reaction to her husband's death, and by the way in which she overcomes this bereavement during the period of mourning that follows...but it is not possible to formulate any general judgement on the nature and value of these motives".* However, it does seem advisable to provide moral support to a woman at a time when she is particularly vulnerable and she will be taking a decision which will have consequences on the rest of her own life and on the life of the child she may be giving birth to. Counselling should be offered so that all the psychological, social, legal and medical considerations can be discussed with her and she can take a decision which is truly free and informed.

4) Authorisation for *post mortem* use of cryopreserved sperm

Can the ethical reasons which have been put forward above for authorising *post mortem* embryo transfer be also seen as reason to lift the ban on the *post mortem* use of cryopreserved sperm? All opinions expressed so far in favour of embryo transfer excluded the possibility of an extension to *post mortem* insemination.

One would have thought that requests for assisted reproduction with the cryopreserved sperm of a deceased spouse would possibly be more frequent than requests for embryo transfer. The courts have recently had to settle a case involving a request by a widow for the sperm straws of her deceased husband so that she could proceed with insemination in another country, which CECOS, who were storing the straws, were refusing to do. The Rennes Court of Appeal, on June 22, 2010, did not allow her access to the cryopreserved sperm, in accordance with rules of good practice for ART which stipulate that restitution is only allowed in the presence of the patient and with his consent[33]. As we have seen, this prohibition may seem somewhat paradoxical in view of the fact that the law organises, for the purpose of future reproduction, the harvesting and storage of sperm straws belonging to men suffering from a serious life-threatening medical condition.

[32]The birth rate following frozen embryo transfer is 13% (Agence de la biomédecine: data for 2010)

[33]The applicant was claiming the right, in her capacity as wife and heir, to restitution of the sperm considered as one of the assets of her late husband's estate. But article 16-11 of the Code Civil stipulates that "*the human body, its components and products cannot be the subject of patrimonial law*."

Should sperm straws be destroyed after the donor dies or should they be considered as having been intended, just like an embryo *in vitro*, for the purpose of procreation requested by a couple pursuing a parental project? As we have pointed out above, the presence of cryopreserved sperm rather than of an embryo does not depend on the degree of commitment of the couple to their project, but to the medical indication. Death may take place during the ART process, before any IVF procedure is attempted or after several insemination attempts have failed.

So perhaps the first step should be for the request to be based on the established existence of a project of which both members of the couple are the authors and on express consent by the male partner to his frozen sperm to be used if he should die. But the impossibility of securing the man's consent at the time his gametes are used for fertilisation, could allow for a measure of doubt as to whether he would have consented to the procedure which may be taking place several months, or possibly years, after his sperm was collected. Men are in fact questioned every year on whether they wish to continue with the cryopreservation of their sperm straws, but a positive reply to the question is not necessarily connected to a specific parental project.

The particular situation of the child will be identical to that which prevailed in the case of *post mortem* embryo transfer. In either case, the community will have helped the mother in her deliberate undertaking of giving birth to a fatherless child. However, in the case where the request bears on the transfer *in utero* of an embryo, and irrespective of the various philosophies concerning the nature of the embryo and its ontological difference from gametes, the woman whose request is denied is compelled to take an agonising decision regarding the future of an already existing embryo, a decision which furthermore, will always be an unwilling one. In the case of post mortem insemination or IVF, she will not be made to deal with this dilemma since she does not need to take an explicit decision about frozen sperm straws. What she will be asking the community to help her with, is to conceive, *ex nihilo*, a child with the gametes of a deceased man. But death is not a pathological barrier to conception to which a medical remedy must be found.

Furthermore, in the case of *post mortem* insemination or IVF, for the child, the symbolic burden of having been conceived with the gametes of a man deceased could compound the negative feelings brought about by being born without a father.

CONCLUSION

For some members of CCNE, *post mortem* procreation, be it via embryo transfer or by the use

of frozen sperm, should continue to be prohibited by reason of a child's unalterable right to have both parents living at the time of conception. Deliberately contributing to bring about the birth of a fatherless child, simply because that child is the fruit of a 'parental project' would be equivalent to dignify this concept as an imperative overriding the interests of the child, that is the right to not be deprived of his or her father's affection and upbringing. It would give the mother's distress precedence over the distress of the child to be conceived. This resolve on the part of the couple to procreate beyond the barrier of death could be dictated by an illusory desire to survive vicariously through a child's existence. The widow would in effect be locked into her past and her bereavement.

Other CCNE members consider that the difference which is made between *post mortem* embryo transfer and the *post mortem* use of frozen sperm, is not always clearly justified in ethical terms. For that reason, they would have preferred to have a certain amount of flexibility added to the implementation of procedures so that all requests for the *post mortem* use of frozen semen are not systematically rejected.

Nonetheless, as regards the *post mortem* use of cryopreserved sperm, the majority of CCNE members do not consider it advisable to reverse the prohibition of this practice, for the reasons set out above, in particular the greater difficulty in verifying the father's consent at the actual time of procreation and also the non presence of any embryo produced by both partners and thereby materialising the parental project.

Post mortem embryo transfer is a different case altogether. Couples already engaged in a medically-assisted reproductive technology procedure which gave rise to the cryopreservation of so-called 'spare' embryos are in sole possession of the power of decision over the fate of these embryos. If the man dies, then it is the woman who is in charge of any decision regarding the future of the cryopreserved embryo, except, paradoxically the power to request the embryo's transfer *in utero* in the hope of carrying a child to term. The law forbids her to continue with the parental project she had started jointly with her deceased spouse. Furthermore, not only is her request rejected, but she will also be put into a position which is aggravated by the fact that she must make an impossible choice. The law leaves her no other alternative than asking for the embryo's destruction, or donate it for research or else consent to another couple acting as host. This may appear as particularly harsh if the embryo transfer represented her last chance to become a mother, in particular because of her age or infertility.

Freedom to procreate is a private matter and, as CCNE emphasised in its Opinion n° 40 on "The transfer of embryos after the decease of a husband or partner", there may be a large number possible motives for the woman's desire to pursue or not the parental project, on the nature and value of which *"it is not possible for formulate any general judgement"*. Nonetheless, a woman who decides to become pregnant with the aid of medically-assisted reproductive technology will be asking for the community's support. Society therefore has a degree of responsibility in the matter and would seem justified in laying down the conditions in which the procedure should be performed, in particular to protect the best interests of the fatherless child it will have knowingly contributed to put into the world.

For the above reasons, the majority of CCNE's members consider that the transfer *in utero* of an embryo after the death of the male partner should be authorised if the woman's request complies strictly with the following conditions:

1. The man must have expressed his wishes before he died by giving express consent to

the transfer, after his death, of a cryopreserved embryo. By so doing, he will be fully committed by a decision which could lead to the birth of a child he will not be able bring up himself.

2. A minimum waiting time must be set after death, so that the woman's decision is not taken at a time when she is particularly vulnerable. During this period of time, counselling should be offered so that all the psychological, legal, social and medical consequences of her decision, for herself and for the child yet to be born, can be explored. However, the waiting time should not exceed a maximum period so that the possible birth of a child should not be excessively remote from the father's death.

3. Modifications will need to be made to French law so that the child's paternal filiation can be ensured.

Paris, February 10, 2011