CONFIDENTIALITY IN GAMETE DONATION

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ABSTRACT

During recent decades, the third person intervention in human artificial insemination has created new hopes for infertile couples. However these new progresses have propounded new ethical and legal concerns for families. One of them is confidentiality regarding gamete donor's identity, and its disclosure to the future child and others. Of course, negligence to this ethical issue would produce a big barrier for efficient health care services.

For compiling this article we searched different websites including Pubmed, Ovid, Elsevier, Google and etc and the resulting articles were investigated carefully.

In this article, the history of gamete donation in different countries is reviewed initially and the mentioned reasons for anonymity with that of disclosure are compared.

Because of the different cultures and values of various societies, it is not justifiable to propose a unique method regarding this issue; however, there have to be clear rules in this regard, in each country. In order to facilitate this process, pretreatment counseling courses should be established to explain different aspects of this issue for the recipients.

Key words: Gamete donation, Confidentiality, Ethics.

INTRODUCTION

The recent advances in the Assisted Reproductive Technology (ART) have created new hopes for infertile couples. One of these methods -that has been accepted widely- is gamete donation. Gametes are divided into two types: sperms and oocytes. Oocyte donation has provided an opportunity of pregnancy and parenthood for women with some problems including primary or premature ovarian failure, surgically removed ovaries, risk of transmitting genetic abnormalities, recurrent failure of IVF treatment, inheritable disease, poor responders to ovarian stimulation, abnormal oocytes, ovarian dysfunction because of chemotraphy or radiotherapy, advanced age with diminished ovarian reserve and women who are menopauses.

Oocyte donation is an invasive procedure. Most centers stimulate the development of several follicles in the donor, with synchronizing the cycles to allow embryo transfer during the recipient's implantation window. Treatment with gonadotropin releasing hormone analogues increases the number of oocytes. The oocytes may then be fertilized and the embryos be transferred through the cervix or fallopian tubes or via intrafallopian gamete transfer (1- 7).

The oocyte donation is an invasive procedure and doesn't have any medical benefit for donors; so, it has created a large amount of ethical and legal dilemmas (1). Many children are born each year in the world by the use of donated gametes (8). However, there are many questions about these children, such as: should the parents disclose this fact to their child? Should the recipients or their child be informed regarding the donor's identity or characteristics? How much information should be presented to them? On the other hand if the child has the right to know, what about the parents right in not to telling them?

Donor insemination was first used in clinical practice in the late 1930s and was generally practiced in secret. In 1945 Mary Barton, a gynecologist, published an article in British Medical Journal about the Artificial Donor Insemination (AID) program (9). The response to the article was one of the outrage and wholesale condemnations of the practice. In 1948 a commission discussed the issue of AID and concluded that it should be a criminal offence; their reasons were a mixture of religious concerns, fears of the possible eugenic implications and the association with its use in agriculture. (9)

The demand for AID continued to grow and in 1968 it became available in the National Health System (NHS) if recommended on medical grounds. Subsequently the 1973 peel committee a committee of the British Medical Association set up to consider human artificial insemination – reiterated this view.

Between 1940 and 1980 there were 480 births in

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Jackson Clinic using this method. Donors were anonymous, assured of confidentiality. Recipients were encouraged to keep AID as a secret and not tell to the child. (8)

At the time of the Wanock committee in 1982, arranged by the British government to examine the ethical implications of reproductive technologies, gamete donation was a practice that although not unlawful, carried out without central rewarding or regulation. The donor offspring was illegitimate at law and the husband of the woman receiving the treatment had no legal responsibilities or duties towards the child; the donor was considered the legal father.

This involved the couple committing an offence by entering false information on the birth certificate, although one unlikely to be found out. Thus the problems with legal issues contributed to the desire to keep the practice secret. In this context, donor anonymity could be seen as a necessary practice for protecting the donor from parental responsibility and allowing the husband parental rights (9).

Internationally, the vast majority of countries endorse anonymous gamete donation. For example, in many western European countries, such as Denmark, France and Spain oocyte donation is permitted by law only in the anonymous procedure. Although there is no legislation in the United States that either prohibits or enforces anonymous gamete donation, the matter is regulated by non-legally binding professional guidelines, which recommend the anonymity of gamete donors. In the United Kingdom Interim Licensing Authority prefers donors to be anonymous. It will agree with known donors if there is no alternative and if the donor, the recipient, and their parents all receive independent counseling (7).

In Belgium, most fertility centers respect full anonymity, and all couples and donors are informed that in an anonymous procedure no information will be given to the parents, the donor or to the future offspring. (1) There is an international trend towards however giving more information. The first country that removed the anonymity of gamete donors was Sweden in 1984. Sweden law allowed the child when sufficiently mature (18 years) to find out the identity of his or her biological parents (9).

As mentioned, the subject of Gamete donation has created a large amount of ethical issues regarding to confidentiality for health care professionals and other involved people.

The aim of this paper is to present evidences which would lead to a change of focus from a concentration on the unhappiness of the infertile couple to a consideration of the long term outcome and consequences of these procedures for the children that are created and the adults that they become.

We tried to introduce the appropriate approach regarding benefits and harms of anonymous or known donation and disclosure or nondisclosure to the child and others.

MATERIALS AND METHODS

For compiling this article we searched different websites including pubmed, Ovid, Elsevier, Google and etc, using keywords of ethics, disclosure, confidentiality, gamete, anonymity, donation and etc. In this study we reviewed different resources and published researches on mental and physical status of children who are conceived via gamete donation by anonymous or known (directed) donation and on necessity of disclosure to the child and others. We considered articles that have been published in the recent ten years.

RESULTS

Reasons of anonymous donation

One of its benefits is the wish to mark explicit boundaries between the two involved families and to minimize the invasion of the third party into the family (1, 9). On the other hand anonymity alleviates the debt of the recipient couple to the donor and enables them to construct their own parental status (11).Anonymity would give legal protection to the donor from parental responsibilities (9).

A further reason is that parents should have the right of privacy and they may wish to keep such information confidential (9). Furthermore, anonymity protects the child from a potentially harmful multiple parents' situation. On the other hand openness may also create confusion in the development of child's identity and leads to an incomplete sense of identity.

Another practical argument against non anonymous gamete donation is that introducing a system of known donors will seriously reduces the number of potential donors and jeopardize the whole program. In Sweden there was a drop in both the number of donors and the demand for AID after the 1984 legislation that removed donor anonymity (9).

Western Australia's select committee (1999) heard submissions from clinicians who said that recording identifying information had reduced the number of both male and female donors prepared to donate, by 90% amongst men and slightly lower in women (9). The recipient couples generally want to have natural-looking families, and anonymity is a way to ensure them that the child grows with strong bond with those parents and to maintain the appearance of a normal family (9, 12). The other reason is that, it is not in the best interests of the

child to know (11).

Reasons for known donation

The option of treatment with known oocytes was motivated mainly by reasons related to fear of anonymity of which the most important one is fear of genetic material of unknown origin (1). Likewise, the genetic link between the recipient woman and the donor is an important motivation in choosing treatment with oocyte of known origin. Researches show that recipients who had asked for a donor with similar blood group acknowledged that the genetic link was an important factor in their choices for known donation (13, 14).

Also having information about genetic background of the child for the ability to answer the child's questions is another important reason (1).Of course there are some practical motivations that have essential role in choosing this method. One of them is the assumption of couples that their donor had a proven fertility because she had children of her own or because she was very young (1).

Another practical motivation is that organizing the exchange in the anonymous procedure takes more time than does the direct oocyte donation, where only cycles of two women have to be synchronized. Older couples often prefer known donation because they feel that there may be not enough time left to become real parents (1).

Having access to information about the donor is also useful if children are to be told about their conception and the use of external genetic material (15). However, even in a non-anonymous donation program the donor does not have the right of having access to the child; they would only be available if the child wants to have contacts with them (9). Also, secrecy about a matter of such importance to the child will always burden the parents for a long period of time and might therefore be indirectly harmful for the child

As the last point,trust in the personality of the donor and physical resemblance between donor and the recipient woman are essential factors that encourage some recipients to opt known donation(1).

Reasons for disclosure of the fact to the child

Many of recipients are willing to tell the truth to their child because they see no reason for not doing so. The future parents wish to have no secrets in the family. They believe that having a child in this way would confirm to the child how much he or she was desired; even the conception has taken place with genetic material from donors (1). Also, secrets may arguably be damaging or at least dangerous in a family and there are some situations in which disclosure to the child would be inevitable. These situations include family disagreement or divorce, severe inherited illness of the social father (telling the child for relieving the anxiety that he or she might inherit under the same condition), death of social father, and existence of a visible ethnic or appearance difference (1, 8).

No matter how they found out about their donation insemination (DI) origins, the reported reactions were anger, resentment at the lies and deceit and loss of a sense of self identity, and all children wished they had been told much earlier. They wanted to have information about their donors, what they looked like, what they were like as persons, their education and interests and especially details about their health and family health record (8).

One of the rights that seems as being of fundamental importance is the right to know one's parents and one's genetic origins, because it is deemed essential to human well being and that people have the right to know the truth about their origins. As John Triseliotis said "Trust is always better than deception, No one has the right to erase part of yourself, even if it is only a minor part" (9, 17).

This means that the wound must remain forever open, in the form of a permanent, difficult interrogation: would my child sill accept me totally as her parent if she knew I was not? The anxieties that result can also affect the couple's relations with sexual troubles and emotional difficulties (12).

One of the recipient women who decided to tell her child said that: "my child has a right to know about his health history, and I would hope that he will know the differences between biological parenting and motherhood. This information is part of my child's history and belongs to him. Not to disclose would be dishonest."(9, 17) But at the present, as the law stands, donor offspring are the only group in Britain specifically denied the right to know the identity of their biological parents (9).

As the social environment is probably informed about the infertility problem and the gamete donation procedure, the parents are forever caught in a web of lifetime anxiety of disclosure of this fact to their child by others (17, 12).

For those who choose to be open about gamete donation there are several approaches and one of them is a story book which has been written as a model of how to explain the situation to young children (19).

Reasons for non disclosure

To force potential parent's to tell their child of his/her genetic origin as a requirement for admission into infertility program is both wrong and discriminatory (20).

Many women who do not plan to disclose to the

child express concerns that such information would only serve to confuse the child. In addition they believe that telling the fact to the children may disturb the child's normal mental and emotional development, and identity issues might haunt a child who knows that she is a product of egg donation (1, 4, and 17).

Another reason for being afraid of disclosure to the child is fear of disturbing the parent – child relationship (1). Of other reasons for non disclosure is the lack of paternity sensation in sperm donation. As the oocyte recipient has the gestational role of mother and her double biological input gives her a biological filiations advantage, the social father does not have any gestational role and if the child disclose about the sperm donation, the relationship between social father and the child would be destroyed (21).

The other fact that should be mentioned is that the couples who use the donor sperm may not agree with such disclosure; because the husband may not agree with disclosure of his infertility (14).

Protection of the donor and her family was also a reason to keep treatment as secrets and to prevent a further scenario where the donor might be confronted with questions from the child born with her genetic material. Where the donor had children of her own, it might be necessary to tell these children too. Perhaps donors also wish to avoid confusion about family relationship (1).

In other cases, recipient couples wished to avoid the child accidentally telling someone who they feared would react negatively towards the donor (1). Likewise religious or cultural reasons motivated some of the recipient couples to keep the treatment secret from the child. They feared that the knowledge of his or her origins would marginalize the child with regards to religion or culture (1). Another reason is that some recipients wished to forget about the treatment:" the child was to be our child "(1). One of these mothers said: "I'm the one who conceived him and matured him with my body until he was born, he has always been a part of me more than any other one except his father" (17).In fact they believe that they are the real mother of their children; therefore there is no reason for disclosure. As one of them said: "I never think of my child as not being mine biologically, He is the joy of my life – that's all he needs to know." The rest is too confusing. Another woman said: "This information seems too disturbing to reveal. My child is my child in every sense of the world".

A few women who do not plan to tell their children said that they would only disclose in the case of medical necessity. One of them said: "I believe that the only benefit to disclosure is the event of an urgent medical necessity" (26).

Disclosure to others or nondisclosure, which is better?

Another issue that has created different views is that whether disclosure of gamete donation for others is necessary or not? Some recipients confirm disclosure for several reasons: The first is that there is no reason to keep the treatment secret and there is nothing to be ashamed about it (1).

In addition recipients can derive a benefit of support from other people. As one woman said: "I relied heavily on my support system. This process is very difficult and I could not have done it without my family and friends" (17).

Another reason for telling others is to help them going through the process: "I feel it is good to be open about it, it helps me to feel that the procedure is normal, and it helps other women struggling with the same issue." The last reason is that the openness may be the best for the children. As one of the women that prefers this method said: "It doesn't seem like a big deal to me. It was a miracle that came true for me to carry my son and to give birth to him, it makes me to feel that I am completely his mother. There is no reason to hide it, I discuss it with my children and they are aware of everything" (17). On the contrary there are some reasons that confirm opposite idea: The first one is that non disclosure to others is the best interest of the children, since this information is part of the child's history and recipients fear from inadvertent disclosure to their child. One of them said: "I want to be the one to tell her. I don't want her to hear from anyone but me" (17).

In addition, the recipient couples don't want their children to be stigmatized by the process. As one woman said: "I don't want my family and friends to view my son as any thing other than my son. I don't want my children defined by this issue. disclosure to others would affect my children adversely in the future. My child needs to have good self – esteem and not a mark against him in the future" (17).

Other reasons that have been considered are: fear of lack of understanding from social environment, fertility problem is a private matter, avoiding confusion as to the identity of the mother, and that openness would place the marginal position for religious or cultural reasons (1).

Several studies in some countries have investigated different views in gamete donation including known or unknown donation and the recipient's trend to disclose this fact for their child and the others. In a study by American society for reproductive medicine in 1993 among 31 recipient couples 17 had used a known donor and 14 had used an anonymous donor; 42% of anonymous donor recipients intended to tell and 88% of known recipients planned to tell the child (23).

One American qualitative study of oocyte donation in which parents used only anonymous donors in 2002 found that among 58 recipients ,56% planned to disclose, 18% did not, and 24% were undecided. In another study in United States of America (1998) it was found that 52% of anonymous donor recipients and 88% of known donor recipients planned to tell the child (5).

In a study that was done in the United States (2004) seventy women had used an anonymous donor, 20 women had used a known donor. Fourteen out of 20 (70%) known donor recipients had an ongoing relationship with the donor (7: sister, 6: friend, 1: other). The remaining 6 (30%) recipients met their donors through the donation process. There were no significant differences in the age, religion, and ethnicity, number of work hours outside the home/week and household income of the recipients between known and unknown donors. Differences in marital duration and education were found in comparisons between two recipient groups on the demographic variables. Women using an anonymous donor had shorter marital duration and a high percentage of them had graduate degrees. In this study regarding disclosure to the child, the anonymous and known recipients were virtually identical. Among anonymous donor recipients 10% have told, 49% plan to tell, 31% are not telling and 10% were not sure. For known donor recipients 10% have told, 50% plan to tell, 30% are not telling, and 10% were not sure. In this study there were no significant differences in disclosure to the child based on known or anonymous donor status (17).

In another study in Finland, Soderstrom Antilla et al. reviewed health and development of children born after oocyte donation. Forty three of 51 donors were donated anonymously and 8 donors were known to the recipient. Thirty – eight percent of the recipients intended to tell the child about the nature of its conception (19).

In another study in the center for reproductive medicine of the private university of Brussels in 2000 it was demonstrated that there was no significant relationship between the choice of known or anonymous donation and the decision taken to inform the child about his / her conception. Neither there was a significant relation between the intention of recipient couples to tell the child and the status of the donor, and whether the recipient couples were in frequent contact with the donor. In this study it was also founded that recipient women who had already given birth to a child tended to be significantly more secretive towards the social environment and the child, avoiding in the way that the children would be treated differently by family and friends (1).

In a study in Australia in 1987 no differences were found in social characteristics and attitudes toward donating oocytes between donors who donated anonymously and donors who donated to known recipients, except that the known donor group felt a significantly greater connection to the potential child (25). In another study in 1994 it was indicated that 58% of the donors regarded the oocyte as another body cell and denied a connection to the potential child, but others had more ambivalent feelings. On the other hand, all the donors and the recipient couples agreed that the woman who is pregnant and gives birth to the child should be regarded as real mother (26).

A survey has been done by Soderstrom – Antilla to determine experiences of oocyte donors concerning treatment and attitudes to donation. A questionnaire was sent to the first 30 finish volunteer oocyte donors at 12 to18 months after donation and all the donations were carried out anonymously and without payment. A total of 67% of the respondents would have liked to have known if pregnancy had been achieved in the recipient. Some 42% of the respondents preferred to receive no information concerning either the child or recipient couple of the respondents, 59% thought the offspring should be told about its origin and 33% thought the child should be given identifying information (27).

Klock et al carried out a study to assess post – donation psychological status of a large sample of professionally recruited, paid anonymous donors. Eighty – eight percent of donors had told other people about being a donor. Eighty – eight percent were not told about the outcome of their donation, but 75% of donors had decided to know the outcome.

All but one donor reported that her privacy was adequately maintained throughout the process.

Sixty – tree percent of donors stated that they would still donate even if the recipient was told her name; 44% reported that they would like to meet the recipient, and 63% reported that they would not object to meet the donor child (2).

Another important matter that has been mentioned in many articles is the parents' knowledge about the donor and the amount of information that they want to know about the donor. In a study by Klock and Greenfield, the amount of information that recipient had about their donors and their disclosure plans were reviewed. Ninety percent of both men and women knew their donor's age, ethnicity, hair color, eye color, height, weight and medical history. Significantly more women than men told others about using a donor to conceive, but two – thirds of women and men would not tell others if they had to do it over again. The finding that a majority of couples regretted telling others indicates that couples are uncomfortable with the

loss of control over the information.

Seventy-one percent of recipients used an anonymous donor, 19% had a known donor and 10% had a donor that they had met once in the donation process. There were no significant differences in the knowledge of various donor characteristics between woman and men. When they asked in an open ended question, what else would you have liked to have known about your donor, 32% of women and 39% of men stated "nothing"; 25% of women and 35% of men not responded; 11% of women and 6% of men would have liked to see a photograph, and 8% of women and 6% of men wished to know more medical history details.

When they were asked to list the three most important donor characteristics, both men and women stated appearance, health and intelligence and when they were asked about their concerns about the donor, both men and women concerned about the genetic and medical background of the donors. Concern about the physical resemblance of the donor was significantly higher for women than men (3).

Soderstrom Antilla et al, surveyed parents' attitudes regarding issues of secrecy in oocyte donation. Only three of the 42 recipients who received oocytes, from an anonymous donor would have wanted to meet the donor personally and 20(48%) did not want to receive any information regarding the donor. The rest were interested in the donor's age, profession, physical appearance, hobbies and the place of residency. The known donors in all cases visited the child regularly. Nobody reported any difficulties in the relationship between the donors and the recipients. They found that all the children born from donated oocytes over a 5 year period were healthy at the time of the investigation (19).

Donor's motivations:

Another issue that should be discussed is the motivations of donors.

The potential benefits gained by the gamete donors do not include direct therapeutic ones, but in exchange for undertaking potential risk (especially in oocyte donation), the donor may gain both direct and indirect non therapeutic benefits. The direct non therapeutic benefit is monetary compensation and the indirect is altruism (28).

In a study in Belgium it was found that the majority of the donors (66.7%) were motivated mainly by the personal relationship that they had with the recipients. They wished to help the couples personally, and in concrete way. Some 22.9% of the donors had more generally altruistic motivations. For instance, they wished to help recipient couples but, if asked, they would also consider undergoing treatment for other couples. Some 36.8% considered infertility a very traumatic experience for anyone who has to deal with it. Often the personal bond with the recipient couple, if any, for the donor was an important reason, but not the only reason for helping them (1, 26).

As might be expected, there was a significant relationship between the way that donors were related to the recipient couples, and their motivations in donation. When donors were close relatives of the recipient couples, their motivations was based on the personal bond. Donors who were relatively unknown to the recipient couples prior to the treatment were significantly more motivated by more generally altruistic reasons (1).

Patrick et al. were asked whether donor's motivation for donation had been altruistic, monetary or others. Both altruism and monetary compensation were reasons given by donors, but no other motivations were stated. Seventeen of 21 respondents cited monetary compensation as a major motivation over altruism. Donors were asked whether they felt that monetary reparation is required for oocyte donation. Sixteen of the donors felt that payment was necessary to compensate for the hardship of donation process. Fifteen stated that they would not donate if monetary compensation had not been provided (29).

It should be mentioned that most reports form North America and Europe state that the most frequent motivation for donation of oocytes is altruism because there is no monetary compensation in Europe, but in the United States, financial remuneration may become a major factor for those who agree to donate.

Consultation with donors:

Another issue that has been propounded is the personal characteristics of donor. The American society for reproductive medicine (ASRM) guidelines which is arranged for screening oocyte donation candidates, has adequate informed consent, thorough medical evaluation, testing for sexually transmitted infections, genetic screening, and a comprehensive psychological assessments (30, 31).

The latter is to ensure that the donor is adequately informed of all relevant aspects of the process, and that she had been able to think through the possible future implications of the donation decisions. As part of the informed consent process potential donor candidates should be aware of all aspects of oocyte disposition and embryo management (30-34).

However extensive and careful psychological screening of potential donors is proposed in all cases (32-35). According to one investigation, donors need to be screened for psychology and

their ability to cope with the psychological unknowns and stresses in a donor cycle. Furthermore, donors need to understand the boundaries of their role and need to be fully capable and free from any kind of coercion in giving informed consent (38).

Lack of attention to these points can create some serious problems for the potential child and his / her family. According to a study that was done in 2000 in Brussels (Belgium) it was reported that some 58.3% of all donors mentioned spontaneously that they made a distinction between the oocyte donated and the child born afterwards. They almost always referred in this respect to the monthly loss of oocytes. In their views, the woman who carries and gives birth to the child must be considered the mother. There was no wish to interfere with the education of the child or to take any responsibility towards the child at all. In 39.6% of the cases, no clear – cut distinction was made between the oocyte and the child. For this reason 12.5% of the donors preferred anonymous donation, so to avoid contact with the child. For 6.9% of the donors, anonymous donation was even a condition of continuing the treatment, in order to protect themselves. Some 27.1% of the donors had ambivalent feelings towards the child born after oocyte donation. They felt responsibility towards the child and wished to be sure that the child was well taken care of by parents, to such an extent that 9.7% of the donors' preferred known donation for this reason (1).

Prudie et al have already pointed out that there is a problem in counseling the donors about the choices that they have to make. An informed choice should at least take into account the possible or likely consequences of the different options. Donors want to know whether they will be contacted by their progeny, what the implications will be for their families, the chance that there will be problems etc. for example the donors should be informed that with the known donation, the donor child would either intrude on the donor's family or invade the donor's personal life by seeking contact (31).

Consultation with recipients:

In counseling sessions with recipient, a different question is asked, including how they will select the donor? Which characters of the donor is important for them? Whether they told the other about the gamete donation? Would they disclose the donation for their child? should a donor registry to be developed?

A psychological consultation is necessary for all recipient couples. The aim of the counseling is not to enforce certain decisions but to guide the decision making process regarding the kind of donation that is used. Attention is also paid to possible psychological consequences of this decision.

Through the counseling, the opinions of recipients will be evident and if the partners have dissimilar views about disclosure decisions, they should come to preliminary agreement about how to handle it before entering to the donation procedure. Couples may benefit discussing the disclosure decision from the separate perspectives of telling others and teling the child, with emphasis on the meaning of the information over time. The importance of allowance to couple to process the decision by themselves is highlighted by one recipient's comments. "I would never disclose because I think it introduces a major complication in the child's life, and I think that it is all right to keep a secret like that, but my husband felt strongly that it was better to tell, so I agreed, but I still don't think that it is better for the child… I think if the therapist had been neutral, my husband would have thought harder about what would be good for the child, not what prevailing societal views which of course are always changing"(3).

Potential parents are also counseled about the way in which they should tell their child in order to minimize possible negative consequences, in the presence of both parents at an early point in life for instance when the child asks about conception in general, and according to the developmental level of the child. The necessary openness should be created that the child may ask questions at any point in his or her development when new questions arise regarding the consequences of the use of donor material. The donor should be presented as a person who gave the gift of life, but who is not the mother.

In one study, it was indicated that after donation, the majority of couples regretted telling others about donation, because of the loss of control over the information, thus this should be discussed with the recipients prior to the treatment(3).

Ahuja et al reported that egg donors and recipients overwhelmingly indicated that counseling was an important part of the egg donation. 85% of the experienced patients felt they had been given enough time to think about and talk through the issue of egg donation at the clinic, clearly, time to talk about relevant issues with the counselor and ask questions of consultants, without being rushed through treatment is important to all recipients (37).

CONCLUSION AND RECOMMENDATION

In this study we reviewed different resources and researches on mental and physical status of children who are conceived via gamete donation by anonymous or known donation and on necessity of disclosure to the child and the others.

Studies showed that there are benefits and harms for both procedures. The important question which should be addressed is "who should decide?" rather than "what should be done?"

On the other hand according to the results of several studies, it appears that regardless the recipients use a known or an anonymous donor, they are thoughtful and satisfied about their decisions. They know what they want in a donor and why they want a particular donor. It is obvious that much of their decisions should be made with concern for well being of the children. It appears that parents, whether they used a known or an anonymous donor and whether they planned to disclose or not disclose to their children were quite clear that they are the parents of their children. They believe that their decisions vis – a – vis telling or not – telling, are in the best interests of their children.

Of course, it is possible that both groups were right. Families with different concerns and values may differ on whether and when they disclose this information to others and to their children. Only subsequent studies over the next several decades will reveal whether one course is really better for the children involved.

For the present, as the studies shows, that there is little evidence to justify clinicians advocating a particular course for parents regarding the donation procedures. We recommend that pretreatment counseling is a valuable resource for couples to clarify their opinions and to come to a consensus about their plans.

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