**General Scheme of the 2017/18 Assisted Human Reproduction Bill**

**Comments and recommendations concerning donor-conceived children**

**By the Iona Institute and Dr Joanna Rose**

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*‘Science has given us something new: families that are designed, from the start, to have only a single parent; to have quite a few parents; to have two parents, only one of whom is biologically related to the child, the other of whom is not biologically related, with a third party out there who is biologically related, but often, unknown…parental roles are being divided up and divvied out, outsourced and re-shuffled and even deleted.’*

Lisa Mundy, ‘Everything Conceivable: How Assisted Reproduction is changing men, women and the world’, p.96

*‘Should science do everything that science can do?’*

Prof Dervilla Donnelly, Chair of the Commission on Assisted Human Reproduction, Commission on Assisted Human Reproduction Report, p.11

**Introduction**

THIS submission on the General Scheme of the AHR Bill has been written with the help of Dr Joanna Rose. Dr Rose is herself donor-conceived and has campaigned in the UK for the rights of donor-conceived people such as herself to have their rights to genetic kinship and identity properly protected under law. She won a landmark case in the British courts that brought an end to anonymous egg and sperm donation.

As the quote from Lisa Mundy above indicates, when Assisted Human Reproduction (AHR) uses donor eggs, sperm and embryos in order to help individuals wishing to have children, we are embarking on what amounts to a massive experiment with the lives of children.

The General Scheme overall is incredibly complex and far-reaching. We could comment on the use of embryos for research, on surrogacy, on posthumous conception, on the creation of ‘saviour siblings’ for the express and totally instrumental purpose of harvesting stem cells and bone marrow from them for the purpose of helping an ill sibling.

For the purposes of this submission, however, we will restrict ourselves solely to the issue of donor gametes and the ethical implications of donor-conception, especially for the children thus conceived.

**Donor-conception and the devaluing of the natural ties**

Donor-conception, by its very nature, devalues the importance of the natural ties and the General Scheme very much goes along with this, paying only scant regard to them.

It allows that only one ‘intending parent’ should have a biological link to the child. They can do so by gestating the child in their own womb, or by providing a gamete. As an example, a single man availing of AHR would have to provide his own sperm. He would have to then find a woman willing to provide him with an egg and another willing to carry his baby (the surrogate mother).

This resultant child would be raised by his or her natural father, but the tie to the other biological parents, namely the genetic mother (the egg donor), and the birth mother (the surrogate) can be cut with the full blessing of the law.

The proposed Bill does abolish anonymous gamete donation, but by the time the child is 18, what is the likelihood that the child, now an adult, will ever have a proper relationship with his or her sperm donor father or egg donor mother? This will be especially the case if the donor is from overseas, which is quite likely. Sperm used in Irish clinics tends to be imported from Denmark. (See “Ireland’s IVF children: an identity crisis?”, Irish Times, July 22, 2017).

This willingness on the part of the proposed law (and the Children and Family Relationships Act before that), to see the natural ties cut is quite remarkable given what we now know about the lengths adopted children – no matter how well loved they were by their adoptive parents – often go to find their natural parents, especially their mothers.

But adoption differs from donor conception (or ‘Donor-Assisted Human Reproduction’ (DAHR) as it is also called) in one very crucial respect. In the case of adoption, the natural tie has been broken by circumstance in most cases. With DAHR it is broken by deliberate design.

The proposed Bill seems to have learnt almost nothing from the experience of many adopted people in their search for their genetic kin. For the reasons already given, the prohibition on anonymity will amount in many cases to little more than a nod to the natural ties.

In addition, we are now in a position to learn from the experience of donor-conceived people themselves, many of whom are now adults. As with adopted people, many never go looking for their genetic kin, but many do, and their experiences must be seriously considered. Some donor-conceived people are against all donor-conception.

Given how little importance the General Scheme gives to the natural ties, can it really be said that the General Scheme has the ‘best interests’ of children at heart?

**Adult autonomy view underlies the Scheme**

Indeed, far from having the ‘best interests’ of children at heart, it would seem that what is really to the fore in the Scheme is the wishes and desires of ‘intending parents.’

The use of the term ‘intending parents’ is very telling in this regard. Throughout the Scheme, the ‘intending parent’ is given far greater standing than the biological parents (the gamete and embryo donors). It is the person who wishes to be a parent who counts, not the natural parents.

This is extremely adult-centred. The natural parents are not considered by the proposed law to be the parents unless they intend to be. The child may have an entirely different view, of course, which is the case with many donor-conceived children. They might well regard their natural parents as their parents, whatever those parents, or the law, intended. The natural parents of a child *are* its parents, no matter what the law says, or what the intention of the adult(s) is.

We can also see how adult-centred the Scheme is by the way it treats the issue of family structure, that is the form of family the child will be raised in. Will the child be headed by a married opposite-sex couple, a married same-sex couple, a cohabiting couple (opposite-sex or same-sex), a single man, or a single woman?

The underlying philosophy of the Scheme is that the number of parents, the sex of the parents, and whether they are married or not, is entirely irrelevant to the welfare of the child. This is quite aside from the issue of deliberately cutting the natural tie to at least one parent, which donor-conception also inevitably involves and the identity issues this can create.

**Our overarching recommendation; minimise the damage to children caused by deliberate disruption of genetic kinship ties**

We take the view that family structure matters (we can provide supporting material for this claim if called on). We also take the view that the natural ties matter far more than the General Scheme allows.

However, we realise that in these two respects, the die appears to be cast. Therefore, the recommendations that follow seek to minimise the possibility that donor-conceived children will suffer in the future from having their genetic kinship ties deliberately disrupted and kept hidden from view until at least the age of 18.

We hope the Health Committee will look seriously at our recommendations, which put the interests of donor-conceived people, not intending parents, to the fore.

The recommendations that follow are not exhaustive, but if implemented, they would have the effect of at least lessening the damage that will be caused to some children by having their genetic kinship ties deliberately disrupted, something that is facilitated and permitted by the proposed AHR law and by the Children and Family Relationships Act.

**Recommendations**

1. **Counselling**

Those wishing to avail of donor-conception, and those who wish to donate gametes should be required to receive counselling. The counselling should be independent of, and if need be paid for, by the AHR clinics. There is too much of a conflict of interest if the clinics both pay for and provide the counselling.

The counselling should discuss not only infertility issues, but the identity issues many donor-conceived children will in the future face. Prospective donors should be informed about the possibility that in the future their donor offspring may seek to make contact with them and wish to form a relationship.

1. **Tracing genetic kin**

It must be made as easy as possible for donor-conceived children to find their genetic kin, both their genetic donor-parents and genetic half-siblings. It must be borne in mind that one sperm donor can have many children, both in Ireland and overseas. Donor-conceived children should be enabled to trace their genetic kin both in Ireland and overseas. This should be the responsibility of the Assisted Human Reproduction Regulatory Authority (AHRRA).

1. **Assisting existing donor-conceived people**

While the proposed Bill will end donor anonymity, it does not do so retrospectively. The AHRRA should help donor-conceived people to trace their genetic kin (which is to say, their natural families), and also provide counselling where necessary. Although adoption in the past was closed, great efforts are made to help parents and children find each other.

1. **Use the term “donor parent”, instead of “donor”**

The term ‘donor’ on its own does not properly capture the genetic relationship of the donor to the child created via the donated gamete. It would be better to use the term ‘donor parent’, or even better, ‘donor mother’ or ‘donor father’.

1. **Use the term “gestational mother” or “birth mother” instead of "surrogate"**

Similarly, the term ‘surrogate’ doesn’t properly capture the vital role of the surrogate in the child’s life. It would be better and more accurate to speak of ‘’gestational mother’ or even ‘birth mother’.

1. **Use the term ‘intervention’ instead of ‘treatment’**

To speak of fertility ‘treatment’ implies that the infertile person will be cured. Sometimes those presenting to AHR clinics for donor-conception will not be infertile at all. A single man or woman, for example, wishing to have a child via DAHR is likely not infertile as such. They can provide an egg and/or a womb, or sperm. But they need someone else’s womb or gamete to have a child. ‘Treatment’ here is a misnomer. A better word might be ‘intervention’.

1. **Minimum age of the donor parent should be 25**

Donating a gamete that may result in a child is a profound act that must be properly understood in all its implications. For this reason, a donor must be mature enough to grasp these implications and therefore we recommend a minimum age for a donor parent of 25.

1. **Limit on number of families created by a single donor parent should be four worldwide**

The Scheme says the number of families created via one donor parent should be four. This limit must apply to families created in other countries as well, so the number is four in total. The genetic kinship networks of a donor-conceived child should not be overly complex and members of that network too difficult to trace. Ensuring this limit is adhered to should be the responsibility of the AHRRA, working with the clinics.

1. **Prohibition on gamete donation from close family members is too narrow**

‘Close family members’ in the Scheme refers to those very closely related by blood. It does not exclude other blood relations, for example first cousins, or relations by marriage, for example, brothers and sisters-in-law. If the sperm of a brother-in-law was used, the “uncle” of the child would, in fact, be the biological father.

Is it fair on the child that the one person is both the ‘uncle’ and the biological father of the same child? It is unprecedented in human history to deliberately blur the roles of the different members of a family in this way and therefore the definition of ‘close family members’ needs to be broadened to include members by marriage as well.

1. **It must be ensured that gametes obtained from overseas have been not commercially purchased**

The Scheme proposes to prohibit paying gamete-donors commercial fees, paying them only ‘reasonable expenses’ instead. It will have to be ensured that ‘intending parents’ or clinics have not paid commercial rates for eggs or sperm obtained from overseas. This should be the responsibility of both the clinics and the AHRRA.

1. **Intending parents, like donors, should undergo a health check**

Donor parents are required to receive a health check. So should intending parents to ensure they are healthy enough to raise a child. They should also undergo a psycho-social assessment in the same way as would-be adoptive parents.

ENDS