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Making Babies

Towards a child-centred view of Assisted Human Reproduction

A response to the Report of the Commission on Assisted Human Reproduction

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Introduction and summary of recommendations

In 2005, the State-appointed Commission on Assisted Human Reproduction (CAHR) published its long awaited report on the regulation of the Assisted Human Reproduction industry in Ireland.

In the time since its publication no significant effort has been made to introduce legislation in this area nor has any meaningful public debate taken place. This paper is an attempt to bring that debate forward. It analyses the CAHR report, critiques it, and offers an alternative regulatory framework for the AHR industry.

The basic critique this paper offers of the CAHR approach is that it is too adult-centred, that is, it is overly concerned with the rights (real and presumed) of the many adults who seek infertility treatment.

To date, it has been overwhelmingly the case that those dominating this debate have been either individuals seeking infertility treatment, or those who offer such treatment.

For its part, the public has seen the happy, healthy babies produced by these treatments and have heard or read the interviews with the proud and happy parents and have concluded that this is a story with a happy ending. Insofar as they are aware of any controversy attending this issue they usually associate that controversy with debates concerning the right to life of the embryo.

But a voice has been lost from this debate, and it is a voice almost entirely absent from the CAHR report, that is the voice of those children conceived through AHR techniques such as In Vitro Fertilisation (IVF) using third party sperm, eggs or embryos.

It is now 31 years since IVF produced its first live baby, Louise Brown. But other forms of AHR have been around longer than that. For example, the first recorded case of donor insemination dates back to the 1890s, and it was readily available in the 1930s.

Therefore, many of the children donor-conceived through one or another AHR technique are now well into adulthood and they number in the tens of thousands. This number is rapidly increasingly, especially in view of rising infertility, which is partly a result of the delay in couples marrying.

These donor-conceived children have set up websites, networks and organisations to help them locate their biological parents and their half-siblings. Their plight is often akin to that of adopted children denied the knowledge of their biological parents and half or full siblings by the practice of closed adoption which is now widely considered as cruel and unenlightened.

The voices of donor-conceived offspring have to be given centre-place in this debate, and

legislators and other policy-makers must listen to them before making crucial decisions on the form of legislation.

AHR regulation and legislation that makes the concerns of donor-conceived offspring central will look very different from regulation and legislation that makes the concerns of either the adults wishing to avail of AHR, or those who provide AHR, central.

Admittedly, the CAHR document does make use of the concept of a child's 'best interests', but in reality the concern expressed for a child's best interest often appears to be subservient to adult needs.

For example, CAHR recommends that an end be brought to donor anonymity but goes no further than this because the philosophical framework out of which it operates is dominated by considerations of adult autonomy and equality.

This leads to CAHR deciding that the form of family in which a child is raised is not central to his or her well-being. Therefore it does not think it is important that children be raised by a married mother and father, or even by a loving mother and father.

It also goes very far down the road of regarding the family as something that is a purely social construct rather than as something that is 'given', that has deep roots in biology, and that these biological origins are not incidental, but are in some sense essential, or at the very least are important to human flourishing.

The importance of the biological family seems to be borne out by the experience of adopted children, donor-conceived offspring grown into adulthood, and by the evidence which shows that children, on average, tend to fare best when raised by their own loving biological parents in a stable marriage.

This paper takes a 'maximalist' approach to child-welfare. In other words, it looks at the issue of AHR from an almost exclusively child-centred point of view. It is hoped that legislators and policy-makers will in the future allow themselves to be more influenced by such an approach than heretofore.

Key Principles to Guide Legislation

- The welfare of the child should be the primary consideration in AHR. (Art 3, Convention on the Rights of the Child.) Values such as equality and adult autonomy, while important, should not be put on a par with children's rights.
- Children have the right, where possible, to be raised by their parents. (Art 7, UN Convention on the Rights of the Child.) Children have a right to their mother and father.
- The roles played by a mother and father are gender specific in important ways, and their complementary but different nature is vital to the optimum development of the child.

Key Principles to Guide Legislation contd.

- AHR should be confined to stable, heterosexual married couples, as abundant research shows that this is the family form with the best outcomes for children.
- The right of clinics to choose to treat only stable married couples should be enshrined in law.
- Removing a child from biological kinship networks deprives her or him of an important and irreplaceable source of identity.
- The welfare of the child demands that extreme care should be taken when proposing to create a family where a biological parent will be replaced by a social parent. Donor conception should be permitted under only the most stringent of conditions as set out below.
- Couples wishing to conceive through the use of donor gametes, should undergo a preparation period similar to that undertaken by prospective adoptive parents.
- Counselling and preparation should be provided by an independent agency with no vested interest in AHR. This should include counselling and information about all the ethical, social, psychological and medical implications of their plans, with particular reference to the need to inform any offspring at an early stage of their origins.
- Information and counselling should be provided to prepare prospective parents to deal with the likely sense of loss of a donor-conceived child, and with any difficulties that it may hold for the prospective parents themselves.
- Funding should be made available to provide ongoing support for anyone affected by donor conception or surrogacy. There are different challenges at different stages of the life cycle.
- Donors should receive counselling, and in particular be made aware that their donation potentially has life-long consequences.
- Donor anonymity should be abolished. All donors must commit to update personal and medical information on a regular basis, and be aware that offspring may some day seek contact.
- Donors should be screened, not just for medical conditions, but for maturity and the ability to cope with the prospect of offspring wishing to make contact.
- Donors should not be paid, and any expenses should not constitute a financial incentive to donate sperm or eggs.
- Donors should commit to disclosing that they have been donors to significant members of their own family, including children, and the donor's own siblings and their children.
- Egg donors should be limited to one donation to minimise the chance of future health difficulties.

Key Principles to Guide Legislation contd.

- Children have a right to be conceived from a natural, unmodified sperm from one identified, living, adult man and a natural, unmodified ovum from one identified, living, adult woman. Artificial gametes should not be used in AHR.
- Stringent record-keeping should be put in place, including funding for an agency to maintain contact, as in open adoption, between donors and offspring.
- Ideally, the same donor should be used in any one family in order to ensure genetic links between siblings. Where the same donor is used by more than one family, no more than ten siblings should be born from the same donor.
- Given that so-called 'reproductive tourism', (where people travel to foreign countries to access gametes or embryos) is legal under EU treaties, a public information campaign should be undertaken to inform prospective parents of the need to ensure that donors are not exploited, and that children have a right to know their biological origins.
- Donor conceived offspring have a right to be informed of other half-siblings outside their own family.
- Insofar as possible, any records of past donor conceptions or surrogacy arrangement records kept by individual clinics or in other places should be centralised and made available to donor conceived people who seek them.
- A DNA tracing service should be instituted for people conceived before legislation, on the lines of the UK Donorlink.
- Birth certification should reflect the truth of people's origins. A long form and short form should be used. The short form should contain only the names of the legal parents, but the long form should contain all details of any donors or surrogates involved in the child's conception.
- The long form of the birth cert should be made available on request to any offspring over the age of 18.
- The spouse of a woman undergoing AI or AHR using donor sperm should be required to formally adopt the child.
- Couples wishing to use embryo donation to conceive should undergo a formal adoption process.
- Embryos should not be 'commissioned' or created for the purposes of embryo donation.
- A regulatory body should be put in place which will prioritise the rights of the child in AHR.
- Surrogacy should be made illegal. It is inherently exploitative.

Making babies

Towards a child-centred view of Assisted Human Reproduction

A response to the Report of the Commission on Assisted Human Reproduction

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, CAHR Report, p.11

Although one of the first recorded cases of donor insemination was in the 1890s, the last forty years have seen an explosion of scientific techniques designed to circumvent infertility. The most celebrated landmark was Louise Brown's birth in 1978.[1] What began as a way to help married couples conceive, rapidly became something else entirely. In 2008, a transgender legal male gave birth to a baby using donor sperm.[2] Should science do everything that science can do? It begins to look like a very important question.

CURRENT SITUATION

There is no Irish legislation governing Assisted Human Reproduction[3] (AHR). In theory, anyone can set up a clinic. The lack of legal clarity resulted in several court cases, notably, the High Court case of MR vs TR (Nov 2006)[4] MR, who is separated, sought custody of three frozen embryos, hoping to have further children. She lost her case, but appealed to the Supreme Court. A judgment is pending. In another case (McD v L and Anor, April 2008)[5] a gay man donated sperm to a lesbian couple, on the understanding that he would be a 'favourite uncle' figure. Later, wanting a fuller role in his child's life, he applied for visitation rights. In an extraordinary judgement, Hedigan J declared that the lesbian couple constituted a stable de facto family, the bloodlink was of no great weight, and that it was not in the child's interests to have contact with his father. Both cases illustrate a lack of understanding of what constitutes a child's best interests.

Non-statutory Irish Medical Council Guidelines provide virtually the only regulation of AHR. They state that IVF should only happen after thorough investigation has failed to find a treatable cause for infertility. Extensive discussion and counselling must take place. Written and informed consent should be obtained. Embryos must not be destroyed or produced for research.[6] Donation of embryos may be considered. Particular care must be taken regarding the biological consequences of donor insemination.[7] There is ample evidence that even these guidelines are flouted by clinics.[8]

The Commission on Assisted Human Reproduction (CAHR) was set up by Minister Micheal Martin in 2000, to address the lack of regulation of AHR and to make recommendations. The lack of diversity of viewpoint among the committee was controversial. For example, only one person, Prof Gerry Whyte, believed that the embryo was entitled to legal protection from conception.

In 2005, CAHR recommended allowing the third party donation of sperm, eggs and embryos and 'non-commercial' surrogate motherhood. 'Services should be available without discrimination on grounds of gender, marital status or sexual orientation, subject to the best interests of the child'. It accepted destructive embryo research under certain conditions and 'voluntary donation of excess healthy embryos to other recipients, voluntary donation for research or allowing them to perish.' Donor-conceived children should be entitled to information about their origins after 18, but it was not mandatory for parents to inform children. Virtually the only areas outlawed were commercialisation or profit making by donors or surrogates, reproduction by human cloning, animal hybrids, generating embryos for research purposes, and research on embryos over fourteen days old.

Human beings have a profound need to reproduce and to cherish the next generation. Although some may accept it relatively easily, for many people infertility[9] is deeply distressing. There is great natural sympathy for infertile people, and headlines like 'Miracle baby' celebrate every technological innovation. Once conceived, a child should be cherished by society regardless of the means of conception. However, in focusing almost exclusively on the needs of infertile people, understandable though it may be, the needs and rights of children can become secondary, in the assumption that a loving family is enough. Voices like Elizabeth's, who is donor-conceived, and now a mother, need to be heard.

> I am passionately opposed to donor conception, because it deprives children of a basic human right: to know, and be brought up by, their mother and father. It is completely different from adoption, because in that case the child already exists and needs to be cared for. Donor conception exists for the convenience of people who want to be parents. Wanting a baby is a natural desire, but is not to be achieved by unethical means. Why can't infertile people adopt a baby? 'Because it wouldn't be *ours*.' Why do they privilege the genetic link on the one hand and deny it on the other?[10]

The Report is almost entirely framed in terms of 'treating' the infertile. However, donor insemination, or egg donation, does not treat infertility, but merely circumvents it through the use of others' gametes. (In fact, only AHR using a couple's own gametes can be properly considered fertility treatment[11] [12]) All the feelings of infertile couples, which are used to strengthen adults' claims to AHR, such as disbelief, pain, isolation, exclusion, bitterness, anger, confusion and depression, are also experienced by donor-conceived children. Some children may deal reasonably well with being donor-conceived. However, there is a growing body of first-hand testimony from offspring, that they feel betrayed, adrift, and have a profound sense of loss.[13] They speak of feeling 'lopsided', of being 'genetic orphans', and denied their genetic heritage.[14]

It is now acknowledged that adoption can lead to a child feeling loss and grief, no matter how loving the adoptive family. Yet people are unwilling to acknowledge the loss and grief of a child whose legal parents deliberately decided to erase the presence of a biological mother or father, or both. If children's welfare is paramount, we should aim to maximise the chances of a child, where possible, being raised by both of her biological parents, where there is the greatest potential for stable, long-term commitment. A single parent cannot provide this, nor can same-sex couples, and cohabitation carries with it has a far higher breakdown rate than marriage. Therefore, we should require the 'gold standard'[15] for every child, that is, to be raised in a loving stable marriage. Critics might say that many naturally conceived children's families would not

meet these stringent standards. However, AHR is, or should be, regulated by the state, and involves many parties, including medical personnel. It is not discriminatory to apply higher standards as a result.[16]

COUNSELLING AND CONSENT

CAHR RECOMMENDATIONS

- Counselling should be provided before, during and after treatment to those considering AHR treatment so that they are adequately informed of the risks involved, the potential benefits that may be obtained, and the possibility of success in their particular situation. Suitably qualified professionals should adequately convey the complex medical and scientific ramifications of different treatment approaches in verbal and written form.

- It should be obligatory for all recognised providers of AHR services in Ireland to obtain written informed consent for all the services they provide. Each stage of the AHR process should be covered by comprehensive consent procedures. A set of guidelines should be drawn up setting out the specific types of consent that need to be obtained and it should be obligatory for all service providers to observe the terms of these guidelines.

Suitably qualified professionals should provide appropriate counselling in advance to all donors of gametes and embryos. Such counselling should be a pre-condition for informed consent by donors. There is no mention here of complex ethical, psychological and child-centred ramifications. Also, counselling should not be provided by clinics, but by qualified, independent counsellors with no vested interest.

The British Association of Adoption and Fostering (BAAF) urges that lessons should be learnt from adoption about parenting a child who is partially, or not at all, genetically related. BAAF advocate that like adoption, legislation should require obligatory counselling for couples, and preparation and information sessions, prior to receiving donated gametes.[17] In contrast to the demanding process that prospective adoptive parents undergo, the approach to using donor gametes is positively casual.

Ongoing support for families and donors is essential. Adoption agencies might be funded to provide this support, including facilitating contact between offspring and their donor parents.

Since children have a right to be properly informed about their origins and to access medical and social information, donors must be aware of the consequences of non-anonymous donation, including the complex emotional world their offspring will have to navigate. (Even where anonymity is preserved, tenacious offspring have tracked down donors through the internet.[18]) Donors' partners may not be impressed by the existence of numerous half-siblings of their own children. One 'biodad', donor father of five, as well as three marital daughters, has a website alerting others to the pitfalls of donating sperm as he now thinks his actions were wrong.[19]

The welfare of the child demands that extreme care should be taken when choosing to replace a biological parent by a social parent. Donor conception should be permitted only under the most stringent of conditions.

Consent

Informed consent is a cornerstone of medical ethics. However, people wishing to conceive are extraordinarily vulnerable, and perhaps not open to hearing the negative aspects of AHR.[20] Different issues of consent arise for all involved. For example, ovum donation is relatively recent, and although significant health risks are already known,[21] the long-term implications are not, and may include premature menopause.[22]

The 'offspring of AHR' cannot give their consent. As Joanna Rose, who is donor-conceived has said, adoptees know that the adoptive parents wanting a child was not the reason he or she was separated from his or her biological family, but donor-conceived children have to deal with the fact that their parents planned it that way.[23]

OUR RECOMMENDATIONS

The welfare of the child demands that extreme care should be taken when choosing to replace a biological parent by a social parent. Donor conception should be permitted only under the most stringent of conditions as outlined below.

- Couples wishing to conceive through the use of donor gametes should undergo a preparation period similar to that undertaken by prospective adoptive parents.

- Counselling and preparation should be provided by an independent agency with no vested interest in AHR. This should include counselling and information about all the ethical, social, psychological and medical implications, and the need to inform any offspring at an early stage of their origins.

- Information and counselling should be provided to prepare prospective parents to deal with the likely sense of loss of a donor-conceived child, and with any difficulties that it may hold for the prospective parents themselves.

- Funding should be made available to provide ongoing support for anyone affected by donor conception or surrogacy. There are different challenges at different stages of the life cycle.

- Donor anonymity should be abolished. All donors must commit to update personal and medical information on a regular basis, and be aware that offspring may some day seek contact.

- Donors should receive counselling, and in particular be made aware that their donation potentially has life-long consequences.

- Stringent record-keeping should be put in place, including funding for an agency to maintain contact, as in open adoption, between donors and offspring.

- Donors should be screened, not just for medical conditions, but for maturity and the ability to cope with the prospect of offspring wishing to make contact.

- Egg donors should be limited to one donation to minimise the chance of future health difficulties.

REDEFINING FAMILY AND CHILD WELFARE

The Welfare of the child and the ethics of donor conception

CAHR RECOMMENDATIONS

- Services should be available without discrimination on the grounds of gender, marital status or sexual orientation subject to consideration of the best interests of any children that may be born. Any relevant legislation on the provision of AHR services should reflect the general principles of the Equal Status Acts 2000-4 subject to the qualifications set out in section 4.8.

- Where there is objective evidence of a risk of harm to any child that may be conceived through AHR, there should be a presumption against treatment.

There are a number of puzzling, and even inaccurate statements in the appendix on the welfare of the child. For example, it states that there are no reliable criteria for adequate parenting, and thus, no criteria which can be used to guarantee the best interests of the child.[24] Yet a few pages on, relying heavily on Golombok (1998), a study of donor conceived children where the average child's age was six and only one of 132 parents had told their children about their origins, it declares that what matters is warmth, responsiveness, and sensitivity to the child's needs rather than biological relatedness.[25] This ignores that in general, biological relatedness increases parental responsiveness.[26]

Children have a right to be conceived from a natural, unmodified sperm from one identified, living, adult man and a natural, unmodified ovum from one identified, living, adult woman. Artificial gametes should not be used in Assisted Human Reproduction.

Other research shows similar weaknesses. Some children may conceal a desire to know their fathers, to protect their social parents, especially in the case of lesbian parents.[27] Children studied often do not know they are donor-conceived, and long-term effects are not measured.[28] Donor-conceived adult, Narelle Krech, finds it 'absolutely absurd' that these studies 'prove' that donor conception is not harmful, since children are often unable to comprehend the implications until they become adults.[29]

Of course donor-conceived children love those who rear them. Donor-conceived Geraldine Hewitt is happy in her family, and particularly close to her non-biological father, yet she is searching for her biological father.[30] There is growing evidence[31] that there is a desperate need for donor-conceived people to 'complete the puzzle', no matter how loving their families.[32] Of 47 donor-conceived people [aged 11-59] surveyed by Hewitt, only 3 had not experienced identity issues as a result of anonymous donor conception.[33] Donor conceived Joanna Rose also asks why it is presumed that it is not possible to be psychologically healthy and yet to still not like the method of one's conception? We recognize that being well-balanced may co-exist with a fundamental sense of loss and grief in adopted children, yet blithely decide that genetic relatedness is not of particular significance to donor-conceived offspring. However, parents go to extraordinary lengths to have a child that is genetically related to at least one parent.[34]

Golombok does acknowledge that little is known about the perspective of donor conceived individuals themselves. She also questions what will happen in adolescence and adulthood, or when children discover an aunt or uncle is actually a genetic parent.[35] These are very good questions.

If the genetic link is so vital, will artificial gametes that allow a same-sex couple to have their own "shared baby" solve the problem?[36] This is surely the perfect way to obliterate the mother-father paradigm, if that is our aim. A donor-conceived child may only have a shadowy figure as a biological father or mother, but at least they exist. Children have a right to be born from the union of one natural, unmodified ovum and one natural, unmodified sperm from living adults.[37]

OUR RECOMMENDATIONS

- Removing a child from biological kinship networks deprives her or him of an important and irreplaceable source of identity.

- Children have a right to be conceived from a natural, unmodified sperm from one identified, living, adult man and a natural, unmodified ovum from one identified, living, adult woman. Artificial gametes should not be used in AHR.

FAMILY FORM

Parents do their best, generally speaking, in every family form. However, the Appendix's declaration that whether children of lone parents do less well than stable married households 'seems to depend on their financial situation and the extent to which their mother has an active network of family and friends to offer support', is simply inaccurate. While acknowledging that it may seem unfair and insensitive to highlight differences, and many individuals will defy statistical likelihood, UNICEF still says that statistically, growing up in single parent families is associated with greater risk.

> … including a greater risk of dropping out of school, of leaving home early, of poorer health and of low pay. Furthermore, such risks appear to persist even when the substantial effect of increased poverty levels in single-parent and stepfamilies have been taken into account.[38]

All family forms deserve support. This is not incompatible with seeking to increase the chances of as many children as possible growing up in a stable, two parent biological family.

SINGLE WOMEN

While many single women make very good mothers, it is still a radical experiment to deliberately exclude fathers.[39] [40] When in *Raising Boys without Men*, Riley, aged 8, complained about having no father, author Peggy Drexler insists that this is not 'father hunger'. The optimistic conclusions reached by Drexler and others that fathers do not matter are eerily comparable to the optimistic studies of children of divorce in the 1970s, citing how wonderfully adaptive children were, and all that mattered was a 'good' divorce. Yet we know now from children of divorce themselves of the enormous downside for children that was never considered in the 'heady, early days of the no-fault divorce revolution.'[41]

COHABITATION

A study of over 15,000 mothers found that cohabiting couples were twice as likely to experience family breakdown during early parenting years as married couples on similar incomes.[42] On average, cohabiting couples are less sexually faithful, lead less settled lives, are more likely to be violent, and are less likely to be happy or committed than married couples.[43] One study indicates that gay couples were 50% more likely to break up than married heterosexual couples. The rate of partnership break-up of lesbian couples was about double that for gay couples.[44] Research clearly demonstrates that the 'family structure that helps children the most is a family headed by two biological parents in a low conflict marriage'.[45]

THE NEED FOR A FATHER AND MOTHER

There is abundant research demonstrating the need for fathers,[46] ironically, even from scholars who nevertheless dismiss the need for opposite-sex parents.[47] Michael Lamb, who dismisses the need for fathers, nevertheless states: "That being so, the evidence concerning longer-term influences on the child's adjustment may seem somewhat surprising. Maternal 'inputs' are not consistently correlated with indices of their children's development once they enter secondary school, whereas paternal 'inputs' are so correlated. Indeed, there is an indication that teenagers' sense of self-worth is predicted by the quality of their play with their fathers some

13 years earlier. There are also more consistent associations between father-teenager relationships and the latter's adjustment to adult life than exist between adjustment and mother-teenager relationships (Grossmann et al., 2002). The most detailed of the relevant findings have come from analyses of longitudinal data in the UK National Child Development Study. Eirini Flouri (2005; Flouri and Buchanan,2002a, 2002b) has demonstrated links between parental reports of father's involvement at the age of seven and lower levels of later police contact as reported by the mothers and teachers (Flouri and Buchanan, 2002a). Similarly, father and adolescent reports of their closeness at age 16 have been correlated with measures of the children's depression and marital satisfaction at age 33 (Flouri and Buchanan, 2002b)."

Studies of lesbian mothers that show them to be 'just as child-oriented… and just as nurturing and confident as heterosexual mothers'[48] somewhat miss the point. Children still miss something irreplaceable. Experts agree that the parenting style of fathers is important in its own right for optimum child rearing.[49]

What of the need for mothers? Gay men may make excellent fathers, but they cannot mother. As the first chapter title of Dr. Kyle Pruett's *Fatherneed: Why Father Care is as Essential as Mother Care for Your Child* book says 'Fathers do not mother'.[50] (Strangely, Pruett still manages to convince himself that the gender of parents does not matter.) To be a 'motherless child' has always been seen as a tragedy.[51] There is an unavoidable and intrinsic problem with same gender parents. Children are being told that either a father or a mother is dispensable.

There are some studies purporting to show that children do equally well in same-sex marriages, but in a recent case in the High Court,[52] evidence highlighted fundamental flaws in these studies. An exhaustive analysis of hundreds of studies by Stephen Nock showed "a virtual lack of nationally representative samples used: limited outcome measures: a virtual lack of long-term studies: and frequent reliance on a mother's report of her parenting abilities and skills rather than objective measures of a child's well-being." [53]

Deciding that the gender of parents is irrelevant has far-reaching consequences. For example, it may become akin to 'hate speech' to say that a child needs a mother and father. Equality is an important value, particularly for groups like lesbian, bisexual, gay, and transgender people who historically have suffered discrimination, but there are important human rights protections for children[54], including the right to be raised where possible by a mother and father,[55] that cannot be denied in the name of equality.

OUR RECOMMENDATIONS

- The roles played by a mother and father are gender specific in important ways, and their complementary but different nature is vital to the optimum development of the child.
- AHR should be confined to stable, heterosexual married couples, as abundant research shows that this is the family form with the best outcomes for children.
- The right of clinics to choose to treat only stable married couples should be enshrined in law.

GUIDELINES FOR DONATION

CAHR RECOMMENDATIONS

- Donation of sperm, ova and embryos should be permitted and should be subject to regulation by the regulatory body.
- Appropriate guidelines should be put in place to govern the selection of donors; to screen for genetic disorders and infectious disease; to set age limits for donors and to set an appropriate limit on the number of children to be born by the use of sperm or ova from a single donor.
- Donors should not be paid nor should recipients be charged for donations per se. This does not preclude payment of reasonable expenses and payment for AHR services.
- In general, donors should not be permitted to attach conditions to donation, except in situations of intra-familial donation or the use of donated gametes/embryos for research.

It is preferable to have embryos donated than to allow them to perish or suffer experimentation, but it should be subject to the same rigorous process as adoption. As for donor selection, the UK government is promoting donation through 'Give a toss.com', featuring an attractive blonde declaring, 'We want your sperm'. An online game mimics the action of masturbation and climax. The site asks only, 'Are you between 18-35? Are you healthy? Do you want to help others start a family? Have you got the time?'[56] This crass, shallow approach trivialises donation and its consequences. For example, one sperm donor found that his sister-in-law was furious, because her daughter might one day inadvertently date or marry her unknown cousin.[57]

Currently, the British HFE limits children born from one sperm donor to ten. Joanna Rose advocates[58] using the same donor within a family to create full genetic siblings. The Irish Sims Fertility Clinic limits egg donation to one family.[59] Given that Ms. Rose herself may have anything between 100 to 300 half-siblings, these measures make sense.[60]

While gamete or embryo donation should be on a non-commercial basis, the AHR industry is intrinsically commercial. Fertility doctors are among the highest paid specialists.[61] Fertility drugs are big business. Irish women are going abroad to source egg donors to Spain, the Czech Republic and Crete. An egg can cost €1,000, although the donor may only receive €200 to €300.[62] A European Parliament resolution condemning the trade in human eggs followed several young Eastern European women being severely harmed by egg donation.[63]

It is preferable to have embryos donated than to allow them to perish or suffer experimentation, but it should be subject to the same rigorous process as adoption.

OUR RECOMMENDATIONS

- Donors should not be paid, and any expenses should not constitute a financial incentive to donate sperm or eggs.
- Ideally, the same donor should be used in any one family in order to ensure genetic links between siblings. Where the same donor is used by more than one family, no more than ten siblings should be born from the same donor.
- Given that so-called 'reproductive tourism', (where people travel to foreign countries to access gametes or embryos) is legal under EU treaties, a public information campaign should be undertaken to inform prospective parents of the need to ensure that donors are not exploited, and that children have a right to know their biological origins.
- Donors should commit to disclosing that they have been donors to significant members of their own family, including children, and the donor's own siblings and their children.

IDENTITY

CAHR RECOMMENDATIONS

- Any child born through use of donated gametes or embryos should, on maturity, be able to identify the donor(s) involved in his/her conception.
- Donors should not be able to access the identity of children born through use of their gametes or embryos.
- Donors should, if they wish, be told if a child is born through use of their gametes.
- The child born through surrogacy, on reaching maturity, should be entitled to access the identity of the surrogate mother and, where relevant, the genetic parents.

It is now universally recognised that keeping secrets does not benefit children.[64] In one devastating case, a child heard her mother telling her father during an argument that the children were not his, anyway.[65] The earlier a child knows, the better the outcomes appear to be.[66] Although not every donor conceived adult wishes to know about their origin, very many do. Olivia Pratten said, "I suppose at one point when I'm 40, 50, or 60 I'll know that he isn't around anymore and maybe then I'll stop looking for his face - I don't know." [67] Lynne Spencer says that she longs to fill in the missing part of her family history and the other half of her ethnic background." [68] Christine Whipp's blames donor conception for alienating her from both her biological and legal family.[69]

Thanks to a case taken by Joanna Rose[70], since April 2005 UK sperm, egg or embryo donors must agree to identity disclosure when the child reaches 18. A voluntary register, Donorlink, helps people conceived before records were kept.[71] It also offers a DNA tracing service.

CAHR recommends that children should be told, but decides against making it mandatory for parents to tell as it might constitute an unacceptable intrusion on parents. You cannot vindicate a right to information if you don't know how you were conceived. Some studies state that only 10%-20% of parents tell their children that they were donor-concieved.[72] The issue is not whether children have a right to know, but whether the government has a right to conceal.[73] Appropriate use of birth certificates would ensure parental disclosure.[74] The genetic parents and the legal parents should be listed on the 'long form' of birth cert, and only the legal parents on the short form. Given that virtually every adult will need the 'long form' at some stage, it will be a major incentive for parents to disclose.[75]

The desire to know half-siblings is also very strong. When Wendy Kramer realised she had been wrong to opt for anonymous donation, she and her son set up the US Donor Sibling Registry to help parents and offspring to search.[76] A New York Times story says that donor-conceived siblings, 'who sometimes describe themselves as "lopsided" or "half-adopted," can provide clues to make each other feel more whole.' A mother describes how her son introduces his half-siblings. "This is my sister from another mother, and this is my brother from another mother, this is my other sister from another mother' and so on." [77] Parental disclosure, accurate records, and a sibling register are vital to prevent half-siblings unknowingly entering incestuous relationships.[78]

Thanks to a case taken by Joanna Rose, since April 2005 UK sperm, egg or embryo donors must agree to identity disclosure when the child reaches 18.

Ending donor anonymity does not solve all problems. Take, for example, Dakota, who knows he was donor-conceived. His father lived nearby, but his mother's lesbian partner discouraged contact. Dakota's grandparents and his two other half-sisters do not know. Dakota is angry at his loss. 'We live parallel lives... I'm never going to get it back.'[79]

As in adoption, donors could approach an intermediary agency for limited information, and the agency will inform the offspring. The child should be the one to decide to allow contact or not.

OUR RECOMMENDATIONS

- Donor conceived offspring have a right to be informed of other half-siblings outside their own family.
- Insofar as possible, any records of past donor conceptions or surrogacy arrangement records kept by individual clinics or in other places should be centralised and made available to donor conceived people who seek them.
- A DNA tracing service should be instituted for people conceived before legislation, on the lines of the UK Donor-Link.
- Birth certification should reflect the truth of people's origins. A long form and short

form should be used. The short form should contain only the names of the social parents, but the long form should contain all details of any donors or surrogates involved in the child's conception.

- The long form of the birth cert should be made available on request to any offspring over the age of 18.

LEGAL PARENTAGE

CAHR RECOMMENDATIONS

- In donor programmes, the intent of all parties involved - that the donor will not have any legal relationship with the child and that the woman who gives birth to the child will be the child's mother - should be used as the basis for the assignment of legal parentage.
- In cases involving sperm donation, there should be a requirement that the partner, if any, of the sperm recipient also give a legal commitment to be recognised as the child's parent.
- In the case of a child born through ovum donation and in the case of a child resulting from an embryo donation, the gestational mother should be recognised as the legal mother of the child and her partner, if any, should be recognised as the child's second legal parent.
- The child born through surrogacy should be presumed to be that of the commissioning couple.

If the 'intent' of couples is to be sufficient in order to assign parentage,[80] it will alter parentage beyond recognition, which is now primarily based on ties of blood, or adoption.[81] Bizarrely, CAHR suggests that gestation is sufficient to declare legal parentage of a child born through ovum or embryo donation. Yet in surrogacy, gestation would carry no rights at all. Currently, a man marrying a woman who already has a child has to undergo a rigorous process before being entitled to declare himself the father of her child. The spouse of a woman undergoing AI or AHR using donor sperm should be required to formally adopt the child.

Same sex legal parents will mean that a right to a mother and father is no longer recognised in Irish law. To introduce a situation where a child has no second legal parent, not even an

unknown one, is to deny biology completely. CAHR's proposals reflect a 'revolution in parenthood'[82]. Traditionally, marriage has been a child-centred bond, designed to maximize the possibility that a child will be raised by the two people responsible for bringing him or her into the world.[83] However, in Canada, the law that legalised same sex-marriage also removed 'natural parent' in federal laws, replacing it with 'legal parent', thus changing the understanding of parenthood for every Canadian child.[84] In one court case, the relationship between a lesbian couple and a gay man who were 'co-parenting' broke down. Instead of recognizing the right of the child to a father and mother the court declared that the child had three parents.[85] In theory, a child could have five 'parents', the egg provider, the sperm provider, the surrogate mother, and the 'commissioning' adults.[86] Could a 'suitcase kid' end up shuttling between four or five different homes, each containing people with a claim to being a parent?[87]

OUR RECOMMENDATIONS

- Couples wishing to use embryo donation to conceive should undergo a formal adoption process.
- Embryos should not be 'commissioned' or created for the purposes of embryo donation.
- A regulatory body should be put in place which will prioritise the rights of the child in AHR.

SURROGACY

CAHR RECOMMENDATIONS

- *Surrogacy should be permitted and should be subject to regulation by the regulatory body. (* denotes that there was a dissenting opinion.)
- Women who decide to participate as surrogate mothers should be entitled to receive reimbursement of expenses directly related to such participation.

In Christine O'Rourke's dissenting opinion against surrogacy, she wonders what would happen if a surrogate mother changed her mind?[88] Would 'reasonable force' be used? In Britain, apparently yes. The courts found against a surrogate, a biological and gestational mother, in

favour of the biological father, even though she had had exclusive care of the child for seventeen months. The boy's natural father was escorted by court officials to remove the child.[89]

The offensive term, 'rent-a-womb', illustrates how surrogates are regarded. The manager of an agency that facilitates gay men in finding surrogates and egg donors argues that egg donors should be selected on looks, brains, youth, health and psychological soundness, whereas surrogates should be selected on how well they gestate babies, and how well they work with others.[90] One doctor states that most egg donors are smart college girls, while surrogate mothers typically are stay home mothers of a lower-socio economic class.[91]

CAHR acknowledges that Irish law would more than likely grant parentage to the surrogate mother, rendering adoption necessary, but still say surrogate mothers should receive reasonable expenses even though any hint of a commercial aspect would disqualify from adoption.

OUR RECOMMENDATIONS

- Surrogacy should be made illegal. It is inherently exploitative and unfair to the child.

CONCLUSION

Had the Commission been more representative in the first place, it might have come to conclusions that acknowledge the deep need of children and adults to know who they are, to be cared for and protected by the people who are their natural parents, or at least by a mother and father, and to have a secure sense of identity. In short, science should not be allowed to do all that science can do.

Footnotes

1 After at least eighty painful failed attempts involving other women and innumerable embryos, and a somewhat cavalier approach to consent, Doctor Edwards and Doctor Steptoe announced the first IVF birth. See Deech, R and Smajdor, A, *From IVF to Immortality – Controversy in the era of Reproductive Technology*, Oxford University Press, London, 2003, p 40.

2 Mundy, L. *Everything Conceivable: How Assisted Reproduction is Changing Men, Women and the World,* London, Allen Lane, 2007, p.51

3 CAHR defined Assisted Human Reproduction as any procedure that involved the handling of gametes and embryos. Two main types of intervention were understood by this definition: assisted insemination (AI) and in vitro fertilization (IVF). The latter refers to when conception takes place outside the body, literally, 'in glass', and may be undertaken using the potential parents' gametes, or may involve the use of donor gametes and surrogacy.

4http://www.courts.ie/judgments.nsf/bce24a8184816f1580256ef30048ca50/e5617d292b7b6b2680257248003299 92?OpenDocument

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6 *Guide to Ethical Conduct and Behaviour*, Medical Council, Article 24:1, 2004,p.35

7 ibid Article 24:4, p.35

8 Dr Aonghus Nolan, a member of CAHR, gave evidence to the High Court in 2006 to the effect that 'the guidelines are impractical, unworkable, don't reflect the reality of IVF treatment and are not adhered to by most IVF clinics here.' http://www.irishtimes.com/newspaper/ireland/2006/0728/1153813832134_pf.html Carolan, Irish Times, July 28, 2008

9 The definition of infertility used by CAHR is the World Health Organisation's (1993) that is, 'failure to conceive after a year of unprotected intercourse.' Given that it was decided that AHR should be extended to single people and same-sex couples, this definition raises as many questions as it answers. CAHR Report p.x

10 http://frabjousdays.blogspot.com/2007/01/brown-eyed-girl.html

11 'People don't realise how demanding the treatment is, that it's hi-tech medical intervention. It requires a woman to take a heady concoction of drugs which set her hormones whirling madly. This cocktail overrides a woman's menstrual cycle and puts her into a fake menopause, then another barrage of hormones turbo-charge her ovaries into overdrive. Instead of producing one egg a month as normal, she grows numerous eggs.' Devlin, M, 'The silent sorrow of unfulfilled longing,' *The Irish Times*, Nov 4th, 2005. http://www.irishtimes.com/newspaper/features/2005/1104/1130406928338.html

12 Techniques such as NaPro Technology have perhaps the greater claim to the description of fertility treatment. NaPro works with a woman's biological markers and aims to normalise her hormonal profile. Unlike IVF, it presents no health risks to the woman and is relatively inexpensive. Conception occurs *in vivo*, that is, in the body.http://www.fertilitycare.ie/FertilityCare.html

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