

Embryo Donation: Adoption in Disguise?

Locating Embryo Donation within the Adoption and
Assisted Reproductive Technology
Frameworks

Catherine Helm

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FREQUENTLY USED TERMS

ACART	=	Advisory Committee on Assisted Reproductive Technology
ART	=	assisted reproductive technology
ECART	=	Ethics Committee on Assisted Reproductive Technology
HART Act	=	Human Assisted Reproductive Technology Act 2004
HFEA	=	Human Fertilisation and Embryology Authority (UK)
RTAC Code	=	Code of Practice for Assisted Reproductive Technology Units – Drafted by the Reproductive Technology Advisory Committee
The Code	=	The Code of Health and Disability Services Consumers’ Rights Regulation 1996
The guidelines	=	Proposed Guidelines on Embryo Donation for Reproductive Purposes
TWG	=	Treatment Working Group
UNCROC	=	United Nations Convention on the Rights of the Child

INTRODUCTION

The birth of IVF technology brought both the gift of life and the inevitable destruction of its potential.¹ During IVF treatment a woman's eggs are collected and fertilised outside the womb. One or two embryos are placed in the woman's womb and any remaining embryos can be frozen. If the IVF treatment is unsuccessful or if the couple want to add to their family, these frozen embryos can be thawed and transferred to the woman at a later stage.² After completing their family, patients may still have frozen embryos in storage. Until recently, *in vitro* embryos surplus to a patient's needs could only be destroyed, donated to research or placed in storage, all of which result in the embryos destruction.

Embryo donation has been hailed as offering a morally preferable alternative to destruction.³ Patients with embryos remaining after IVF treatment can donate these to other infertile couples or individuals. The recipient woman then carries the pregnancy to term and is deemed to be the mother of any offspring she bears.⁴ If she undergoes the procedure with her partner's consent, her partner is also deemed to be a parent.⁵ From the moment the embryo is implanted in the recipient's womb, donors relinquish all legal rights to the embryo and resulting offspring.⁶

To date embryo donations have been relatively rare.⁷ Many couples are uncomfortable with the idea of another family raising their child and opt to discard rather than donate

¹ The status of the embryo is highly contested. Some view embryos as a ball of cells or as property. Others take a gradualist approach, which recognises embryos are morally significant but does not afford them the full rights of a human being. Still others hold that life begins from the moment an egg is fertilised and thus any disposal of embryos destroys life (*Evangelium Vitae*, 60-61). This is the position most commonly associated with Catholicism. For the purposes of this dissertation I will adopt the Warnock Committee's gradualist approach, as this generally has been the foundation of legislation.

² An individual may also undergo IVF treatment. However I will refer only to couples in this dissertation as embryos can only be *donated* if they were created using the donors' own gametes. An individual undergoing IVF requires donor sperm.

³ The Nathaniel Centre's submission to ACART on the public discussion document: "Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues", July 2007.

⁴ Status of Children Act 1969, s17

⁵ Status of Children Act 1969, s18

⁶ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(viii)

⁷ Since the first application for embryo donation in March 2007, ECART has considered a further 10 applications – ECART Meeting Minutes March 2007 – September 2008.

their embryos.⁸ Embryos offered for donation are usually the donors' "second best" embryos; the healthiest embryos having been used in the donors' IVF treatment.⁹ As the quality of frozen embryos degrades with time, there is an increased risk that donated embryos will not result in a pregnancy or live birth.¹⁰ Although embryo donation offers a practical solution to a difficult situation, in reality it is only likely to provide a viable future for a small percentage of stored embryos.¹¹

However as the practice increases it will be vital that clear guidance is in place to protect the interests of donors, recipients and offspring. The HART Act is the principal legislative response to emerging assisted reproductive technologies and practices.¹² Section 19 gives ECART responsibility for approving or declining applications for embryo donation; applications may not be approved unless they are consistent with ACART's embryo donation guidelines. As the current guidelines are under review, this dissertation will principally evaluate ACART's Proposed Guidelines on Embryo Donation for Reproductive Purposes.¹³

Ultimately, the dissertation attempts to locate embryo donation within the existing adoption and ART frameworks. Like gamete donation, recipients share a biological link with offspring through gestation. However, as neither recipient shares a genetic relationship with the resulting child, embryo donation also resembles adoption. Consequently, embryo donation does not fall neatly into either the adoption or the gamete donation frameworks. This becomes particularly evident in Part Two when I try to fit embryo donors within the Code of Health and Disability Services Consumers' Rights Regulation. Although the Code covers the consent of gamete donors to donation, it does not appear to cover the consent of embryo donors.

⁸ A survey undertaken in 2003 by the American Society of Reproductive Medicine found that only 2% of all embryos in storage are being donated to other infertile women: Michelle L. Anderson "Are you my mommy? A call for regulation of embryo donation" (2006) 35 Cap. U. L. Rev. 589

⁹ V Soderstrom-Anttila, T Foudila, U Ripatti and R Sieberg "Embryo donation: outcomes and attitudes among embryo donors and recipients" (2001) 16 Human Reproduction 1126

¹⁰ Ibid., 1126

¹¹ The Nathaniel Centre "Embryo Adoption" 2008 <<http://www.nathaniel.org.nz/?sid=29>> accessed 19/03/08

¹² Alison Douglass "Report on the Regulatory Framework Governing Assisted Reproductive Technologies in New Zealand August 2006 – Prepared for the Ministry of Health" (2006) <<http://www.acart.health.govt.nz/moh.nsf/indexcm/acart-resources-publications-regulatoryframeworkreportaug06>> accessed 10/03/08

¹³ For simplicity I will refer to the proposed guidelines as "the guidelines" throughout this dissertation.

Establishing where embryo donation lies in relation to the adoption and gamete donation models is nonetheless important, as it will influence our evaluation of ACART's guidelines. If embryo donation is an extension of gamete donation we could expect the guidelines to focus on the treatment of infertility. If embryo donation is more akin to adoption we would expect a much greater concern for the welfare of resulting offspring.

The dissertation is divided into three Parts, which consider issues arising prior to embryo donation, during the donation and post-donation respectively:

Part One addresses the limitations on which embryos can be donated and the criteria, or lack thereof, for selecting suitable recipients.

Part Two illustrates the concerning lack of protection for donors consenting to the donation of embryos. It suggests that donors would be better protected by specific consent regulations than the ill-fitting Code of Health and Disability Services Consumers' Right Regulation 1996.

Part Three considers post-donation issues, which relate to the offspring's need to know his or her genetic origins. Like adoptees, offspring may struggle to understand their identity.¹⁴ Encouraging openness and enabling offspring to access information about their donors will enable offspring to develop into a cohesive self.

Underlying each Part is the conviction that embryo donation presents much stronger welfare concerns than gamete donation. Although not all aspects of the adoption model are relevant to embryo donation, the welfare focus is one feature that embryo donation can adopt.

¹⁴ Keith Griffith *New Zealand Adoption: History and Practice, social and legal, 1840-1996* (K.C. Griffith, 1997) 101.

PART I: PRE-DONATION

Clause 2(a)(i) lists three criteria for determining whether an embryo can be donated. The following chapter examines each of these in turn, paying particular attention to the issues they raise regarding the creation of embryos for donation and the on-donation of recipients' surplus embryos. Although the clause is not well written, the restrictions it imposes are sound.

CHAPTER ONE WHICH EMBRYOS CAN BE DONATED?

1.1 Existing embryos created as part of the donors' own IVF treatment

ECART must determine that the embryos being donated are existing embryos created as part of the donors' own IVF treatment – clause 2(a)(i) of the Proposed Guidelines

The corollary of this is that embryos cannot be created for the purpose of donation. While it is unlikely that couples would put themselves through IVF treatment simply to give away their embryos, this does not mean that they should be prohibited from doing so. The rationale for the restriction has not been articulated.

One possible reason for the limitation is that the guidelines are “moving to see embryo donation as much more akin to adoption than gamete donation”.¹⁵ Couples are essentially donating potential full siblings of their own children, which raises more complex ethical issues than the donation of gametes.¹⁶ Following the adoption model, embryo donation should be more concerned with finding families for potential offspring than creating embryos for infertile couples. But even the Adoption Act 1955 does not prohibit people from having a baby for the purpose of adoption. So the

¹⁵ Carol Nader “Plan to introduce ‘adoption’ of IVF embryos” (21 August 2007) *The Age* <<http://www.theage.com.au/news/national/plan-to-introduce-adoption-of-ivf-embryos/2007/08/20/1187462178139.html>> accessed 07/04/08

¹⁶ *Ibid.*

similarities between embryo donation and adoption do not explain the purpose of clause 2(a)(i).¹⁷

There may be ethical or moral reasons for restricting donation to existing embryos. Catholicism condones the creation of embryos outside the womb as this “dissociate[s] the sexual act from the procreative act”.¹⁸ While condoning IVF, some theologians hail embryo donation as an “act of rescue” which rectifies an injustice that has already occurred.¹⁹ On this view, creating an embryo for the purpose of donation is no longer saving a life that began at conception but creating life through IVF. Whatever our views on the morality of IVF treatment; a clear distinction can be made between donating existing embryos and creating embryos. In response to ACART’s public discussion document entitled “Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues”, the Nathaniel Centre highlighted this difference saying: there are some occasions when, for the good of the child, the decision is made to place them with a family that is not genetically their own.²⁰ Even then, the difficulties experienced by adoptees and their parents are significant. The submission continues:

To reluctantly accept that there are circumstances when we need to separate a child from their genetic family of origin is one thing. To set out to deliberately deprive children of this link *for the sake of the needs of the adults involved* is quite another. It is inconsistent with respect for the family and for the child.

This is a similar stance to that seen in Article 9 of the United Nations Convention of the Rights of the Child (UNCROC). Although the article applies to children not embryos, it expresses a strong reluctance to separate children from their parents unless it is necessary for the best interests of *the child*.

A Treatment Working Group is currently drafting guidelines for the creation of embryos using donated egg and donated sperm. This suggests that clause 2(a)(i) was

¹⁷ Clause 2(a)(i) has three components. In this chapter, reference to clause 2(a)(i) relates to the requirement that donated embryos must be “existing embryos created as part of the donors’ own IVF treatment”.

¹⁸ Catechism of the Catholic Church, para. 2377

¹⁹ The Nathaniel Centre, above n 12

²⁰ Henceforth I will refer to this public consultation as “ACART’s recent consultation”.

not motivated by the moral considerations offered above, although I find these arguments very powerful.

Another possible explanation for clause 2(a)(i) is that it would prevent an embryo sharing scheme similar to the egg sharing arrangements permitted in the United Kingdom.²¹ Egg sharing is where a woman undergoing IVF is offered free or reduced cost treatment in exchange for sharing a pre-agreed proportion of the eggs obtained.²² Because only one egg retrieval procedure is performed, only one fee is charged which is shared between the donor and recipient.²³ Egg sharing ameliorates donor egg shortages and makes fertility treatment more accessible to those on low incomes.²⁴ Although egg sharing is legal in the United Kingdom, Belgium and the People's Republic of China it remains a controversial procedure.²⁵ A particular concern is its "quasi-commercial status", which some fear circumvents the prohibitions on paid donation.²⁶ In New Zealand this may not be such a problem. While the HART Act prohibits direct payment for the supply of human gametes and embryos, it does not necessarily prohibit the sharing of treatment costs. Section 13(1) of the HART Act provides: "[n]o person may give or receive valuable consideration for the supply of a human embryo or gamete". Whether or not the section prevents egg sharing will turn on the meaning of "valuable consideration."

Irrespective, egg sharing does not appear to be practiced in New Zealand. It is nevertheless conceivable that a similar scheme could be employed for embryo donation. Infertile couples could divide the costs of IVF treatment and share the resulting embryos. If section 13(1) prohibits egg sharing then it would also prohibit the sharing of embryos. If section 13(1) does not prohibit egg sharing, clause 2(a)(i) would, as donated embryos must have been created for the donors' own use. Where recipients contribute to the donors' treatment costs, the embryos would be created for

²¹ HFEA Code of Practice, para. G.15

²² E. Blyth "Subsidized IVF: the development of 'egg sharing' in the UK" (2002) 17 Human Reproduction 3254.

²³ K.K. Ahuja "Egg-sharing in assisted conception: ethical and practical considerations" (1996) 11 Human Reproduction 1127.

²⁴ E. Blyth, above n 23

²⁵ Boon Chin Heng "Egg sharing in return for subsidized fertility treatment – ethical challenges and pitfalls" (2008) 25 Journal of Assisted Reproduction and Genetics 159.

²⁶ Eric Blyth, Marilyn Crawshaw and Ken Daniels "Policy formation in gamete donation and egg sharing in the UK – a critical approach" (2004) 59 Social Science and Medicine 2617-2626; Martin H. Johnson "The medical ethics of paid egg sharing in the UK" (1999) 14 Human Reproduction 1913.

the use of both donors and recipients.²⁷ This may explain the purpose of clause 2(a)(i). Preventing embryo sharing would avoid the heartache that has resulted from egg sharing in the United Kingdom: if the donors' embryos do not result in a live birth, they must live with the knowledge that the recipients may be raising their child.²⁸

Retaining the restriction in clause 2(a)(i) may have interesting implications for the proposed guidelines on the use of donated eggs in conjunction with donated sperm. Currently a Treatment Working Group (TWG) is considering whether a couple can use donated sperm and donated egg to create an embryo for their own use. In effect, there is little difference between creating embryos for the purpose of donation and donating gametes for the purpose of creating an embryo. In both situations the nurturing parents have no genetic relationship with the offspring. However in the former situation, the offspring's genetic parents were presumably in a relationship; this will not usually be the case where donated eggs are combined with donated sperm.²⁹

The following section considers those occasions where the gametes being combined *were* donated by a couple. If the TWG's guidelines are approved, recipients could create embryos from a couple's gametes but couples would be unable to create embryos for recipients. Is this distinction justified? Or does it follow from clause 2(a)(i) that individuals in a relationship should be prevented from donating gametes to the same recipient?

Whilst the TWG recommended that embryos should not be created from the gametes of donors who would be in a prohibited relationship under Schedule 2 of the Marriage Act 1955 or Schedule 2 of the Civil Union Act 2004; it did not consider whether embryos can be created from the gametes of donors in a legal relationship.

Nonetheless, I do not think it follows from clause 2(a)(i) that couples should be prevented from donating gametes to the same recipient. My opinion is based on the

²⁷ The proportion of embryos the recipient will receive is agreed on before the treatment is paid for.

²⁸ E. Blyth, Marilyn Crawshaw and Ken Daniels, above n 27

²⁹ IVF treatment for a couple's own use may involve a donated gamete; in this situation the offspring's parents would not be in a relationship. However clause 2(a)(i) goes on to say that only embryos created from a couple's own gametes may be donated. If the donors' own gametes are required and the embryo must be intended for the donors' own use, we can presume the offspring's genetic parents were in a relationship.

purpose of clause 2(a)(i) and the interpretation of section 13(1) of the HART Act. I suggested earlier that section 13(1) may not cover embryo sharing arrangements, in which donors have their IVF treatment subsidised by recipients. Based on this interpretation I submitted that the purpose of clause 2(a)(i) may be to prevent embryo sharing. If this is the correct purpose of the clause, it follows that couples do not need to be prevented from donating gametes to the same recipient. Unlike embryo sharing, section 13(1) unambiguously prohibits the supply of gametes for valuable consideration. On this analysis, retaining clause 2(a)(i) does not produce any inconsistency with the proposed guidelines for the use of donated eggs in conjunction with donated sperm.

I have struggled to find the purpose of the first requirement in clause 2(a)(i). Even if its purpose is to prevent embryo sharing, the clause does not need to be retained. Clause 2(a)(i) states both that donated embryos must be “[e]xisting embryos created as part of the donors’ own IVF treatment” and that they must be “[s]urplus to the donors’ own reproductive needs”. This second requirement also suggests that embryos cannot be created for the purpose of donation and it too would prevent the practice of embryo sharing. Embryo sharing pre-apportions the number of embryos each party will receive (ES-B). At the time the embryos are distributed, donors will not know how many they require and how many will be surplus. Since the requirement that embryos must be surplus also serves to ensure donors’ have completed their families before donation; this clause could be retained and the former removed.

1.2 Created from the donors’ own gametes

ECART must determine that the embryos being donated are created from the donors’ own gametes – clause 2(a)(i) of the Proposed Guidelines

This provision prevents the on-donation of embryos. Hence, embryo *recipients* cannot donate their surplus embryos to another family. Likewise, where IVF patients use donated gametes to create embryos any surplus embryos must be destroyed or donated

to research. The following chapter examines the purpose of clause 2(a)(i) and concludes that it is an important provision which should be retained.³⁰

Clause 2(a)(i) facilitates the preservation and promotion of “the human health, safety, and dignity of present and future generations” by protecting the connection between donors and offspring.³¹ Through counselling and education, the guidelines encourage parties to create and maintain links with each other and the resulting offspring. Joint counselling enables the parties to meet and discuss ongoing contact and information sharing. Although contact agreements cannot be enforced, the hope for this requirement is “that children will grow up knowing their genetic origins and probably both sets of parents and their siblings.”³²

Removing clause 2(a)(i) would make it difficult to preserve these family connections. The danger of on-donation is that creates “too long a chain” between genetic parents and offspring.³³ Since offspring would have to trace their genetic parents across unrelated families, providers would need to keep detailed records of all on-donations.³⁴ Multiple donations increase the opportunities for incorrect information to be recorded.

More significantly, on-donation means that donors cannot choose who will bring up their potential child. Instead the decision would be made by recipients who have no relationship to the embryo. This would undermine the guidelines’ joint counselling requirement, which brings together genetic and nurturing parents in the hope that family connections will be maintained. Joint counselling would be senseless where neither donors (i.e. the couple on-donating the embryo) nor recipients have any genetic relationship to the potential offspring. Although it may enable links between siblings to be formed; it would not facilitate relationships between the offspring, genetic parents and the extended family or whanau.

³⁰ Clause 2(a)(i) has three components. In this chapter, reference to clause 2(a)(i) relates to the requirement that embryos being donated are created from the donors’ own gametes.

³¹ HART Act, s 4(b)

³² Margaret Somerville “Dispossessed and forgotten: the new class of genetic orphans” (18 September 2007) *MercatorNet* <http://www.mercatornet.com/articles/dispossessed_and_forgotten_the_new_class_of_genetic_orphans/> accessed 25/06/08

³³ Monica Konrad *Nameless Relations: Anonymity, Melanesia and reproductive gift exchange between British Ova donors and recipients* (Berghahn Books, 2005) 200.

³⁴ *Ibid.*, 213.

Furthermore on-donation carries the risk of commodifying embryos. A recent ACART Paper emphasizes that:

[T]he donation of embryos is not the same as passing ownership. Instead, embryo donation is in the nature of a gift.³⁵

This has been a key theme in developing the guidelines and allowing the on-donation of embryos may compromise this position.

The restriction in clause 2(a)(i) facilitates the guidelines efforts to preserve and promote the links between offspring and their genetic families. Although on-donation might give more infertile couples the chance to become parents, this should not be the guidelines' only consideration. Embryo donation “not only enable[s] a woman to become pregnant, but also creates a family with a past, present and future.”³⁶ Clause 2(a)(i) respects this reality and should be retained.

1.3 Surplus to the donors' own reproductive needs

ECART must determine that the embryos being donated are surplus to the donors' own reproductive needs – clause 2(a)(i) of the Proposed Guidelines

To ensure donors freely consent to the donation, it is necessary to determine that they no longer need their *in vitro* embryos. Establishing this fact also minimises the likelihood of donors withdrawing consent. This is important as recipients will already have experienced many failed attempts to conceive. It would be devastating for recipients to be given embryos only to have their dreams crushed again by the donors' withdrawal of consent.

Interestingly clause 2(b)(i) of the guidelines require ECART to take into account “whether the donors have completed their family”. As this appears to serve no

³⁵ ACART Secretariat Paper “Embryo donation draft guidelines – further issues for consideration” (9 May 2008)

³⁶ Bianka Atlas “Assisted reproductive technology: proposals for reform from a child welfare perspective” (2005) 5 NZFLJ 3.

additional function to clause 2(a)(i), I suggest it could be removed. This would be preferable to removing clause 2(a)(i), which provides donors with greater protection. Under clause 2(a)(i) ECART “must determine” that embryos are surplus to the donors needs; clause 2(a)(i) simply requires ECART to “take into account” whether the donors have completed their family.

CHAPTER TWO

TO WHOM CAN EMBRYOS BE DONATED?

Whereas Chapter 1 found that the restrictions in clause 2(a)(i) are appropriate, the restrictions on who can receive embryos are less apposite. Unpersuasive arguments support the limitation that donors can only give embryos to one recipient family. Although the guidelines demand police vetting information, the process for selecting recipients is arguably not restrictive enough. Unlike adoption, where prospective adoptive parents undergo an extensive screening process, embryo recipients are not assessed for their suitability to raise genetically unrelated offspring.

2.1 Full genetic siblings in no more than two families

Embryo donation is limited to producing full genetic siblings in no more than two families – clause 2(a)(ii) of the Proposed Guidelines

ACART’s rationale for this restriction is that donation to more than one family “increases the number of children and families genetically related.”³⁷ Given New Zealand’s small population, this in turn increases the risk of consanguineous relationships developing between siblings and “might result in medical, legal, social or emotional difficulties for the families involved.”³⁸

However in ACART’s recent public consultation many submitters disagreed with this reasoning. A common criticism was that there is no similar restriction in the Adoption Act 1955; if birth parents wish to place more than one child for adoption, they can choose different adoptive families for each child.³⁹ The Bioethics Council noted that most donor couples will only have a limited number of surplus embryos; accordingly the risk of consanguineous relationships between siblings is remote. Any risks can be further minimised if offspring receive accurate information about their conception

³⁷ ACART “Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues” (July 2007); ACART “Consultation with the Minister of Health in respect of Guidelines on Embryo Donation” (March 2008).

³⁸ Ibid.; Ibid.

³⁹ Susan Fraser, New Zealand Law Society, Keith Griffith: submissions to ACART on the public consultation titled “Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues” (July 2007).

and birth.⁴⁰ In addition, the quality of donated embryos is usually poor as donors use the healthiest embryos in their own IVF treatment. The embryos' quality is further diminished by the freezing process; frozen-thawed embryos have been associated with slightly lower implantation and clinical pregnancy rates than fresh embryos.⁴¹ Given the quantity and quality of donated embryos, it is unlikely that embryo donation will result in many live births. The submissions suggest that the risks cited by ACART are inadequate.

Ken Daniels gives a more compelling explanation of the restriction saying: “[it] recognises the intensity of the engagement process between the two families both in the lead up to donation and post donation.”⁴² The guidelines require donors and recipients to undergo joint counselling and discuss the implications of the donation for themselves and the resulting child.⁴³ An open and ongoing relationship between the parties is encouraged. Nonetheless, I think it should be up to donors to decide whether the process of engagement is so intense that it can only be undertaken once. Daniels himself has commented that the whole basis of the guidelines is “trying to get the professionals out of a brokering role and letting the people make their own decisions. It’s empowering the people.”⁴⁴

Allowing embryo donation to more than one family would not mean embryos can be on-donated; clause 2(a)(i) clearly prohibits this. However I can see no reason why *donors* could not donate embryos to more than one recipient. Links between offspring and their genetic parents could still be maintained if donors chose the recipient families and were engaged in the counselling processes. The advantage of allowing donation to more than one family is that embryos surplus to the recipients needs would not necessarily need to be destroyed.⁴⁵ If donors have a large quantity of spare embryos these could be distributed among several recipients at the outset.

⁴⁰ Submission made by the Bioethics Council.

⁴¹ Julinda Lee and Christine Yap “Embryo donation: a review” (2003) 82 *Acta Obstetrica et Gynecologica Scandinavica* 992.

⁴² Ken Daniels “Guidelines for Embryo Donation for Reproductive Purposes in New Zealand: A Child/Family Approach” in Jennifer Gunning and Søren Holm (eds) *Ethics, Law and Society Volume III* (Ashgate Publishing Ltd., 2006) 102.

⁴³ Proposed Guidelines on Embryo Donation for Reproductive Purposes 2(b)(vii)

⁴⁴ Above n 16

⁴⁵ While this is also a benefit of on-donation, it does not raise problems about the preservation of genetic links.

Alternatively, if recipients possess unused embryos, donors have the option of giving these to someone else. While some donors may wish to donate their embryos and never give them a second thought, others may have a strong and ongoing interest in the fate of their potential children.

The New Zealand and Australian Code of Practice for Assisted Reproductive Technology Units states that in the absence of specific legislation or the wishes of a donor, fertility clinics must have a documented policy that limits the number of children born from any one donor.⁴⁶ The limit must be based on “an appropriate risk assessment of the potential for accidental consanguinity” and must not exceed 10 families per donor.⁴⁷ The Otago Fertility Service restricts each donor to four families, to allow each family to have two or three related children and to minimise the risk of consanguinity.⁴⁸ Despite its greater population, the United Kingdom specifies that a donors’ gametes or embryos can be given to a maximum of 10 families.⁴⁹

If the purpose of clause 2(a)(ii) is to minimise the risk of consanguinity then the requirement is excessively restrictive given that gametes can potentially be donated to 10 families. If the purpose is to recognise the intensity of the engagement process between donors and recipients, this would be a decision better left to donors who will know what they can cope with. Likewise if the aim of the clause is to preserve links between donors and offspring, this can still be achieved by enabling donors, but not recipients, to donate to more than one family.

2.2 Screening of potential recipients

The health and wellbeing of children born as a result of the performance of an assisted reproductive procedure or an established procedure should be an important consideration in all decisions about that procedure – section 4(a) HART Act

While the wellbeing of children is an important consideration, it is not paramount. This can be contrasted with adoption, where the adoptee’s best interests lie at the

⁴⁶ Para 9.14

⁴⁷ Ibid.

⁴⁸ Hamish McNeilly “Sperm and egg donors needed” (6 October 2008) *Otago Daily Times*, 6.

⁴⁹ HFEA Code of Practice, para 6.4.6.1

heart of all decision making.⁵⁰ This difference is perhaps necessary due to the ambivalent legal status of the embryo. Unlike adoptees, embryos are not afforded the full protection of the law. Their significance as potential children cannot be ignored, however this must be balanced against the interests of donors and recipients who already command the laws privileges.

Nevertheless adoption provides a useful comparison when evaluating whether the guidelines make the health and wellbeing of future offspring an important consideration. Like adoptees, embryo donor offspring share no genetic relationship with either of their nurturing parents. In adoption, the transfer of a child to non-genetic parents is preceded by a careful screening of the prospective parents. This is not the case with embryo donation. The following section considers whether a similar screening process should be established in the context of embryo donation.

2.2.1 Screening of prospective adoptive parents

Prospective adoptive parents submit an application to Child, Youth and Family which contains an application form, a medical form, a police consent form and two references.⁵¹ Having expressed their interest in adoption, applicants are visited and assessed by a Child, Youth and Family (CYF) social worker. The assessment is based on the applicant's ability to meet the needs of an adopted child in the following areas:

- Identity⁵²
- Attachment⁵³

⁵⁰ While the Adoption Act 1955 does not explicitly make the welfare of the child a paramount consideration, this is now accepted to be the central focus of all decisions regarding the child: *The Director General of Social Welfare and L* [1989] 2 NZLR 314

⁵¹ *Current Adoption Practice in New Zealand* – information given to prospective adoptive parents by Adoption Services.

⁵² Adoption Services' *Assessment Framework*. The Framework explains the identity requirement, saying: children parented in an informed environment will have a healthy sense of self. Thus adoptive applicants need to be committed, have respect for the child's identity, know and accept the lifelong and intergenerational nature of adoption, recognise the impact of separation and be aware of the developmental stages of children.

⁵³ Adoption Services' *Assessment Framework*. The Framework explains the attachment requirement saying: securely attached children will feel loved and achieve trust and autonomy. Thus adoptive parents must recognise and value the role of attachment in the development of the brain, be able to articulate their own attachment experience, be emotionally secure, have appropriate expectations about their own and others' behaviour, be mutually committed to the adoption decision and have realistic expectations about the adopted child joining their family.

- Integrity⁵⁴
- Resilience⁵⁵
- Safety⁵⁶
- Support⁵⁷

If the assessment is positive, the applicants create a profile about themselves, their family, their interests and values. Birth parents then choose who they wish to parent their child from a range of relevant profiles.⁵⁸

Legal responsibility for the child is transferred by an adoption order. An order cannot be granted until all the required consents have been obtained and the Social Worker has provided the Court with a report on the applicants.⁵⁹ Before furnishing this report, the Social Worker is required to ask Police if they know anything about the character of the applicants and the results of this inquiry are also presented to the Court.⁶⁰ Most importantly, an adoption order cannot be made until the Court is satisfied of the requirements in section 11 of the Adoption Act.

Section 11(a) is concerned with the characteristics of applicants and whether these qualities make them “fit and proper” persons to parent a child. This assessment may be undertaken before the child is born or even conceived.⁶¹ Indeed, birth parents

⁵⁴ Adoption Services’ *Assessment Framework*. The Framework explains integrity as follows: children growing up with role models will learn values and behaviours that will enable them to develop healthily and contribute positively to society. Thus adoptive parents must be law-abiding, engage in self-development, be able to resolve conflict, be respectful of others, model an acceptance of diversity.

⁵⁵ Adoption Services’ *Assessment Framework*. The Framework explains resilience as follows: adopted children will feel affirmed and able to express their inherited nature in a flexible family. Thus adoptive parents must be resourceful and have problem solving skills, be resilient, be flexible, be autonomous.

⁵⁶ Adoption Services’ *Assessment Framework*. The Framework explains safety as follows: children need to be brought up in a safe and secure environment to have their fundamental right to education, health, warmth, care and security provided for. Thus adoptive parents must have the physical, mental, emotional and intellectual capabilities to undertake active parenthood, be able to provide the essentials of life, be able to access community resources, provide a stable environment.

⁵⁷ Adoption Services’ *Assessment Framework*. The Framework explains support as follows: in being part of a family that is supported by a group of family, friends and community, children get a sense of belonging in society. Thus adoptive applicants should have a family, have honest and open communication within their family, be able to call on practical support to assist with child rearing, be socially integrated and have their needs met by social supports and friends.

⁵⁸ *Current Adoption Practice in New Zealand*, above n 52

⁵⁹ Adoption Act 1955, s10; Adoption Regulations 1959, reg.7

⁶⁰ Adoption Regulations 1959, reg 7

⁶¹ After submitting their profile it may be months before an applicant is selected by a birth parent.

cannot be shown an applicants profile until a Social Worker has assessed them and determined that they are capable of raising a child.⁶²

Section 11(b) is concerned with the characteristics of the child and whether placement with the applicants will best meet that child's needs and wishes. Hence a court may refuse to grant an adoption order even though a Social Worker regards the applicants as suitable prospective parents.

2.2.2 Screening of prospective embryo recipients?

Section 11 illustrates that the assessment of prospective parents is a two stage process. A distinction is drawn between screening applicants for their suitability to adopt *a child* and establishing whether the adoption will serve the welfare and best interests of *the particular child*. If embryo recipients were also screened, this latter consideration may be inappropriate as embryos do not have unique interests and wishes to be taken into account.

Nonetheless, a requirement that recipients be "fit and proper" persons to raise a child might be warranted. Currently the guidelines allow donors to select recipients from a range of profiles.⁶³ However, unlike adoption, recipients are not screened for their ability to raise a child before these profiles are given to donors. Given that embryo donor offspring are also genetically unrelated to their social parents, does gestation justify this distinction?

I do not think it can, as it is not pregnancy which determines whether someone will be a good parent. A recent study conducted in the United Kingdom found no evidence to suggest that the gestational link in embryo donation families resulted in more positive parenting than it did in adoptive families: "[t]his suggests that prenatal attachment is not an essential prerequisite for parent-child bonding."⁶⁴ And although there is no screening process for recipients of sperm or eggs, this is justified not on the basis of

⁶² *Current Adoption Practice in New Zealand*, above n 52

⁶³ This is implicit in clause 2(a)(iv): "The profile/s provided by the recipients for the donors include/s any police vetting information."

⁶⁴ Fiona MacCallum, Susan Golombok and Peter Brinsden "Parenting and Child Development in Families With a Child Conceived Through Embryo Donation" (2007) 21 *Journal of Family Psychology* 2.

gestation but because the offspring will still be related to one of its nurturing parents. With embryo donation, recipients are in truth bringing up another couple's child.

The truth is obscured by statutory presumptions in the Status of Children Act 1969, which define parenthood in terms of gestation rather than genetics. The pretence is particularly striking in section 18. There, a pregnant woman's partner is presumed to be the child's father even though he has no genetic or gestational relationship to the child; he is the legal father by virtue of his consent alone.⁶⁵ If gestation is how we define parenthood then without this fiction children do not have fathers. While the presumptions of the Status of Children Act are convenient, adoption has shown that convenient fictions for parents produce difficult realities for children.⁶⁶ Failure to acknowledge the pretence will cause one fiction to lead to another and will undermine the progress that has been made towards greater transparency in assisted reproduction. Statutory presumptions of parenthood should not justify the absence of screening in embryo donation as these presumptions are based on a fiction that parenthood is gestational rather than genetic. The presumptions simply mean that recipients cannot be screened *after* the birth of the child, because by then the recipients are the child's legal parents.

So the question becomes: should the state intervene to ensure embryos are placed with suitable recipients or will that inappropriately elevate the status of the embryo? Given that applicants for adoption may be screened before the child is born, a screening process similar to section 11(a) of the Adoption Act 1955 would not improperly privilege embryos.

The lack of recipient screening might be explained by the state's reluctance to interfere with individual autonomy. In the past assisted reproductive procedures were a private matter between doctors and patients; clinicians did not need the approval of outside bodies to treat patients as they saw fit.⁶⁷ Over time assisted reproduction has become more politicized as the state's regulation of procedures has increased. Ethical

⁶⁵ If the mother's partner is a female, she may also be deemed a parent under the section. However for this example I need to refer to a male.

⁶⁶ The identity issues faced by donor offspring will be discussed in Part III.

⁶⁷ Ken Daniels "The Best Interests of the Child in Assisted Human Reproduction: The Interplay between the State, Professionals, and Parents" (2000) 19 *Politics and Life Sciences* 40.

approval is required for certain procedures, which means that those seeking treatment are required “to move the most private and personal aspects of their lives temporarily into the public domain.”⁶⁸ However the state’s intervention remains reluctant:

...the field [of ART] is strewn with ethical, cognitive, and legal land mines. Governments are forced to make judgements that cut across religious and ethical beliefs and for which there is little unequivocal supporting evidence. In summary, the issues are subjective, controversial, time-consuming, and, potentially, vote-losing.⁶⁹

To avoid treading on anyone’s toes, the state has tended to play a facilitative role in the regulation of ART rather than being a protective guardian.⁷⁰

Adoption on the other hand is a highly politicized path to parenthood, which makes the well-being of adoptees its primary consideration. However, this was not always the case. Before the Adult Adoption Information Act 1985 was enacted there were fears that politicising adoption would damage relationships between adoptees and adoptive parents. Instead the Act brought greater transparency and openness to adoption practices, which have seen benefits for all involved.⁷¹

Politicization may likewise lead to greater openness in embryo donation and reduce any stigma surrounding the practice. Placing embryo donation within the public realm would recognise that the practice is more akin to adoption than gamete donation. Although embryo recipients share a biological link with offspring, they have no genetic relationship with the child. Embryo donation therefore raises more complex welfare consideration than gamete donation. Conversely, gamete donation is more concerned with treating infertility than placing potential children. The state’s reluctance to impede individual autonomy cannot justify the lack of recipient

⁶⁸ Ibid., 41.

⁶⁹ Ibid., 42.

⁷⁰ Ibid., 42.

⁷¹ Open adoptions have allowed birth parents to see how their child is growing and to feel that they are being positively portrayed to the child. For adoptive parents, openness teaches them that love is not a limited commodity. Adoptees find it comforting to hear why they were given up for adoption. Knowing their birth parents, also helps adoptees to understand their identity: Keith Griffith, above n 15, 276 – 279.

screening since embryo donation principally raises welfare considerations akin to adoption, rather than privacy issues like gamete donation.

To some extent the police vetting of recipients has already brought embryo donation into the public realm. Vetting involves searching for any convictions held by potential recipients in accordance with the Criminal Records (Clean Slate) Act 2004. In addition, information held by Police is searched to see whether any violent or sexual behaviour has been recorded which may not necessarily have resulted in a conviction. This shows a concern for the “health and wellbeing” of potential offspring and is closely analogous to the Adoption Regulations 1959, which require a Child Welfare Officer to make inquiries of Police about the applicant’s character.⁷² Clearly ACART recognises that embryo donation is closely analogous to adoption, however as vetting alone is insufficient for adoption I still query why it is enough for embryo donation.

I have found no justification for screening adoptive parents but not screening embryo recipients. If embryo donation follows adoption into the public sphere as I suggest it should, there seems to be no reason for treating the selection of recipients differently to the selection of prospective adoptive parents. If there is a reason, this needs to be articulated by ACART.

⁷² Adoption Regulations 1959, reg 7

PART II: DONATION

As donors embark on their own infertility treatment, the possibility of “surplus” embryos may seem like a luxury. When this possibility eventuates, the decision to donate unused embryos becomes one of the most significant decisions in the donors’ life. It is during this decision making process, leading to the giving or refusal of consent, that donors require protection.

Part Two examines whether consent provisions for embryo donation adequately protect donors. These provisions are found in the guidelines, the HART Act and the Code of Health and Disability Services Consumers’ Rights Regulation 1996 (“the Code”). In future the Fertility Services Standard for embryo donation may also provide assistance, however this Standard has yet to be finalised.⁷³

Chapter 3 explores whether the above documents confer a right to give informed consent to embryo donation. With reference to the Code, Chapter 4 then provides a more detailed definition of informed consent and its elements. In trying to apply the Code’s rights to embryo donation, it becomes clear that embryo donation does not fit within the existing framework. Improvements will be suggested to ensure that donors are protected when providing consent.

CHAPTER THREE

THE RIGHT TO GIVE INFORMED CONSENT TO DONATION

3.1 Proposed Guidelines on Embryo Donation for Reproductive Purposes

No assisted reproductive procedure should be performed on an individual... unless the individual has made an informed choice and given informed consent.

– section 4(d) HART Act

⁷³ Personal correspondence with Wayne Gillett from the Otago Fertility Service, 12 September 2008

This principle is incorporated into the embryo donation guidelines. Section 5 of the HART Act defines ‘assisted reproductive procedure’ as a procedure performed for the purpose of assisted human reproduction that involves the creation, storage, manipulation or use of an in vitro human gamete or embryo, and includes the implantation into a human being of human gametes or embryos. Although the definition appears to be wide, it is limited by the references in sections 4 and 5 to the *performance of a procedure*. This qualification draws a distinction between two forms of consent:

- Consent to a procedure being performed on oneself for the purpose of assisted reproduction.
- Consent given by the donors for the recipient’s use of the donors’ gametes or embryos.

The former is concerned with the health and wellbeing of those undergoing medical procedures; the latter is concerned with the wellbeing of the resulting offspring and the decision of donors to give up a potential full sibling of their child(ren). It is this latter form of consent that I am particularly concerned with.

However section 4(d) appears to be concerned with the former; consent to the performance of a medical procedure on oneself. The principle states that “no procedure should be performed on *an* individual [individual A]... unless *the* individual [again individual A] has made an informed choice and given informed consent.” This form of consent is relevant to donors as they undergo IVF treatment and recipients when the embryo is implanted; it is not relevant to donors wanting to consent to the donation of surplus embryos, as no further procedure needs to be performed on the donor. The embryos have previously been created as part of the donors’ IVF treatment and may have been in storage for up to 10 years before the donors decide to donate them.⁷⁴ Apart from section 4(d) of the HART Act, the guidelines contain no other reference to informed consent. Given that the guidelines

⁷⁴ Section 10 of the HART Act allows embryos to be stored for a maximum of 10 years.

do not cover the donors' consent to the donation itself, I will now consider whether the Code affords this right.

3.2 The Code of Health and Disability Services Consumers' Rights Regulation 1996

No body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than with the informed consent of the consumer – Right 7(10)

The Code confers numerous rights on consumers of health and disability services including the right to make an informed choice and give informed consent. ACART has noted that the Code applies to embryo donors and it now appears to be taken for granted that Right 7(10) empowers donors to give free and informed consent to the gifting of their embryos.⁷⁵ While this may be true, I think the right is more contentious than submitters assume. There are several hurdles that need to be overcome in order for Right 7(10) to apply to embryo donors.

Firstly, it is unclear whether an embryo is a “bodily substance”. Neither the Code, nor its parent statute, the Health and Disability Commissioner Act 1994, define this term. The Health and Disability Commissioner has suggested that the term “bodily substance” will embrace sperm and eggs; however the Commissioner has not predicted whether embryos would also fall within the definition.⁷⁶ While I do not wish to debate the status of embryos, differing perceptions of when life begins may influence whether embryos are viewed as merely a substance or something more significant. Those who perceive embryos to be a collection of cells are likely to describe embryos as a substance; those who view embryos as life or potential life may not wish to label embryos in this way.

Secondly, even assuming that embryos are a bodily substance it could be argued that they were not “removed or obtained in the course of a health care procedure”. An *in*

⁷⁵ Minutes of the Fifteenth Meeting of ACART, 14 December 2007.

⁷⁶ The Health and Disability Commissioner: submission to ACART on the public consultation titled “Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues”, July 2007.

vitro embryo is not removed from anyone. During IVF, egg and sperm are cultured together in carefully controlled conditions outside the body before the resulting embryo is placed back in the woman's uterus. It is also questionable whether "obtained" includes the creation of an embryo or simply refers to original substances acquired by means other than removal.

Thirdly, it is debatable whether embryo donors fall within the definition of "consumer" in section 2 of the Health and Disability Commissioner Act 1994. The Act defines consumer widely enough to include any person being provided with counselling⁷⁷ or fertility services.⁷⁸

As the guidelines make counselling mandatory for embryo donors,⁷⁹ it has been suggested that they will be covered by the Code.⁸⁰ While ACART has adopted this position,⁸¹ I think it extends the application of the Code too far. Right 7(1) provides that "[s]ervices may be provided to a consumer only if that consumer makes an informed choice and gives informed consent..." If we define consumer as a person receiving counselling, then presumably the 'services' for which consent is required are counselling services. Likewise Right 7(7) stipulates that "[e]very consumer has the right to refuse services and withdraw consent to services". It is a double standard to use counselling as a means of fitting donors within the Code, and then to relate the donors' consent to the donation of embryos rather than the provision of counselling.

Alternatively donors can be defined as consumers on the basis that they are being provided with fertility services. This is also problematic. Embryo donation can be divided into two stages. In the first phase, the potential donors undergo IVF treatment and are thus consumers of fertility services. In the second phase, the recipient woman is the consumer when she has the donated embryo implanted in her uterus. Arguably donors are no longer consumers in this second phase as they are not being provided with a fertility service. Indeed, it could be argued that they provide a service by donating their surplus embryos to others.

⁷⁷ Health and Disability Commissioner Act 1994, s 2(b)(i)

⁷⁸ Health and Disability Commissioner Act 1994, s 2(b)(iii)

⁷⁹ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(ix)

⁸⁰ Treatment Working Group Discussion Paper to ACART "Informed Consent", 11 July 2008.

⁸¹ *Ibid.*; ACART "Minutes of the Fifteenth Meeting of the Advisory Committee on Assisted Reproductive Technology" (14 December 2007).

It is unclear whether the reference to consumer in Right 7(10) refers to a consumer in this first or second stage of the embryo donation process. If we think of the consumer as the donor, we read clause 10 as saying: no body part or bodily substance removed or obtained in the course of *the donor's* health care procedure may be stored, preserved or used otherwise than with the consent of *the donor*. However if we think of the consumer as the recipient, we read clause 10 as relating to the recipient's right to give informed consent to the performance of a medical procedure. We can interpret the clause as saying: no body part or bodily substance removed or obtained in the course of *the donor's* health care procedure may be stored, preserved, or used otherwise than with the consent of *the recipient*.

Given that Right 7(1) already covers consent to the performance of a medical procedure,⁸² it is likely that “consumer” in Right 7(10) would be interpreted to mean the donor rather than the recipient. On this interpretation, donors have a right to give informed consent to any health procedure such as IVF treatment⁸³ and also to give informed consent to the use of their surplus embryos by the recipients.⁸⁴ Nonetheless the clause would be less ambiguous and donors' rights would be better protected if it read “no body part or bodily substance removed or obtained in the course of *a consumer's* health care procedure may be stored, preserved or used otherwise than with the consent of *that* consumer.” This would make it clear that the consumer is the person undergoing IVF treatment rather than the recipient of the embryos.

However even with these changes, viewing embryo donation as a two stage process is problematic. Although distinguishing between the IVF and implantation phases of embryo donation may enable potential donors to fall within the definition of consumer in Right 7(10), the distinction creates problems when applied elsewhere in the Code. If we accept that donors are consumers of fertility services only when undergoing IVF treatment, then it is questionable whether they have a right to withdraw consent to the donation. Right 7(7) states that “[e]very consumer has the right to refuse services and

⁸² Right 7(1) of the Code provides: “Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise”.

⁸³ The Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 6(1)

⁸⁴ The Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 7(10)

to withdraw consent to services”. Arguably potential donors only have the right to withdraw consent to IVF services, since during the implantation stage they are no longer consumers.

In order to avoid these problems it may be better to regard fertility services as an ongoing process. Because the donation of embryos is a consequence of IVF treatment it could be viewed as part of the same service. Donors could be treated as recipients of fertility services until all embryos created during IVF have been used, disposed of or donated. This reaches the same conclusion as ACART – that the Code applies to embryo donors – but via a different path. ACART has preferred to call embryo donors consumers on the grounds that they are being provided with counselling services; this indicates that they view embryo donation as two distinct phases. However that analysis creates inconsistencies elsewhere in the Code.

Given all the obstacles discussed above, I think that the donors’ right to give informed consent to donation is a stretch. Even accepting that embryo donors are consumers of an ongoing fertility service, it is unclear whether an embryo is a “bodily substance” that is “removed or obtained during a health care procedure.” I will continue this Part assuming that donors do have a right to give informed consent to embryo donation and I will explore the scope of that right. However in Chapter 4 (4.4) I will discuss how the right could be made more secure and the scope of the right better articulated through regulations.

CHAPTER FOUR

THE SCOPE OF THE RIGHT TO GIVE INFORMED CONSENT

Informed consent is defined as consent freely given to any health-care procedure by or on behalf of a health consumer and obtained according to the Code.⁸⁵ Three elements are essential and are represented in Rights 5, 6 and 7 respectively. Right 7 was discussed above: namely, the right to make an informed choice and give informed consent. Rights 5 and 6 represent key steps prior to the exercising of choice and consent set out in Right 7: Right 5 affords consumers the right to effective communication with health providers or professionals and Right 6 gives consumers the right to be fully informed.⁸⁶

This chapter will discuss the scope and application of these three rights in the context of embryo donation. Whereas Right 5 can be applied without difficulty, the scope and application of the right to be fully informed is less certain. When applying Right 7 to embryo donation, the right to withdraw consent becomes a contentious issue.

4.1 Right 5: Right to effective communication

Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter – Right 5(1) of the Code

Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively – Right 5(2) of the Code

There do not appear to be any issues unique to embryo donation, which complicate the application of Right 5(1). However the guidelines' counselling requirements may make the application of Right 5(2) somewhat contentious.

Concerns have been raised about the conflicting interests of fertility clinics involved in embryo donations. Where counselling is not independent from the clinic there is a

⁸⁵ Health and Disability Commissioner Act 1994, s2

⁸⁶ Mark Henaghan *Genes, Society and the Future: Volume I* (Human Genome Research Project, 2007) 263.

fear that professionals may be motivated financially rather than by a concern for the consumer's welfare. Encouraging former patients to donate embryos provides the opportunity for clinics to profit from the recipient's medical fees.⁸⁷ Hence, independent counselling may better ensure that consumers and providers "communicate openly, honestly, and effectively".

On the other hand, if counsellors are part of the clinic's professional team the embryo donation process may be less impersonal: "a counsellor's presence in the team can ensure that the treatment discussions are far-reaching and can soften the impact of technology in this highly personal area".⁸⁸ So for the opposite reasons, communication may be more open, honest and effective where counsellors *are* part of the fertility clinic's professional team.

The guidelines do not indicate whether counsellors should be independent of fertility clinics. Rather they leave counselling to be governed by the RTAC Code, or when it comes into effect the Fertility Services Standard. The RTAC Code states that "[i]t is mandatory for a counsellor with expertise in reproductive issues, recognisable by ANZICA, to be attached to the ART unit. All embryo donors, donors' partners and recipients of donor gametes or embryos must undergo counselling." Thus it seems that independent counselling is not required in New Zealand.

4.2 Right 6: Right to be fully informed

Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances needs to make an informed choice or give informed consent – Right 6(2) of the Code

Right 6(1) stipulates that every consumer has the right to information that a reasonable consumer would expect to receive, including an explanation of his or her condition; an explanation of the options, risks, side effects, benefits, and costs of each option; advice on the estimated time within which services will be provided; and the results of tests and procedures. While this information may have been relevant to

⁸⁷ Boon Chin Heng "Independent Counselling on embryo donation for infertility patients" (2007) 22 Human Reproduction 8.

⁸⁸ Sue Emmy Jennings "Introduction" in Sue Emmy Jennings (ed) *Infertility Counselling* (Blackwell Science Limited, 1995) 6.

donors when they were consenting to IVF treatment, it is not relevant to donors consenting to the use of their embryos.

However Right 6(2) outlined above, could apply in the context of embryo donation. The Code does not canvass what kind of information a reasonable donor could expect to receive. This is not surprising given the Code covers a wide range of health and disability services, of which fertility treatment is one small part. To understand the application of Right 6(2) in the context of embryo donation, it is therefore necessary to look to the HART Act and the guidelines and for detail.

Unfortunately this is not as straightforward as could be envisaged. Rather than confer or explain rights for the benefit of donors and recipients, the guidelines are drafted to assist ECART's consideration of embryo donation applications. Thus the guidelines are divided into two sections; both approached from the viewpoint of ECART. Clause 2(a) begins: "when considering an application for embryo donation ECART must determine that..." Clause 2(b) is headed: "ECART must take into account all relevant factors, including..." This format makes it difficult to identify what is required by donors before they can give informed consent.

4.2.1 Implicit rather than explicit requirements

The format of clause 2(b)(vii) is particularly unclear. It requires ECART to take into account whether, in the professional opinion of the counsellor(s) or medical specialist(s), the parties have considered, discussed and understood a range of factors. While the clause does not require the parties to be provided with information, this is implicit in several of the factors. For example, in order to consider, discuss and understand the information sharing requirements of the HART Act, the parties require information about the statute. Likewise to understand that embryos may not be able to be refrozen after being thawed, the donor must be informed of this fact. The donors' right to be fully informed would be better protected if the information required by donors was made explicit in the guidelines rather than by implication.

4.2.2 Counselling: a requirement of consent?

Adding to the confusion, clause 2(b)(vii) also contains a number of factors more concerned with counselling than the provision of information. Thus the counsellor(s)

or medical specialist(s) must be of the opinion that the parties have considered, discussed and understood such things as:

- Each other's needs, wishes, expectations, and plans regarding ongoing contact and information sharing.
- Each other's attitudes towards openness about the donation, especially with any resulting child.
- Their reasons for wishing to donate and receive embryos.
- Their feelings now, and feelings they may experience in the future, concerning the donation of embryos.

The combination of counselling and informing factors in clause 2(b)(vii), may suggest that counselling is a component of the rights to be fully informed and give informed consent. This interpretation would be similar to the consent provisions found in the United Kingdom's Human Fertilisation and Embryology Act 1990. Under that statute counselling is not obligatory, however donors cannot consent to the donation of embryos unless they have first been given the opportunity to receive implications counselling.⁸⁹ While it is clear in New Zealand that counselling is mandatory,⁹⁰ it is unclear whether this is a prerequisite for giving informed consent or a separate requirement altogether.

Despite the importance of counselling and the benefits of mandatory counselling, this does not mean that counselling should be a *condition* of informed consent. In Canada, the Assisted Human Reproduction Act 2004 makes counselling mandatory under section 14; but it is not a prerequisite of consent under section 8.⁹¹

While counselling may involve the provision of information, I do not think it should be regarded as "information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent".⁹² Counselling is more commonly defined as: "a therapeutic procedure in which a usually trained person adopts a supportive non-judgemental role in enabling a client to

⁸⁹ Human Fertilisation and Embryology Act 1990, Schedule 3, cl. 3(1)(a)

⁹⁰ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(ix)

⁹¹ Health Canada "Regulatory Impact Analysis Statement" (2007) 141 Canada Gazette 13.

⁹² The Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 6(2)

deal more effectively with psychological or emotional problems”.⁹³ Information, by contrast, is understood to be “communication of the knowledge of some fact or occurrence”.⁹⁴ Whether or not counselling is required by Right 6(2), it is compulsory under the guidelines. So while the scope of Right 6(2) is unclear, the outcome is the same on either interpretation.

4.2.3 Legal advice: a requirement of consent?

The guidelines mandate independent legal advice for donors and recipients due to the number of people involved, the rights and responsibilities concerned, and the impact of donation on resulting children.⁹⁵ Again it is unclear whether the provision of legal advice is “information” that a reasonable consumer needs to make an informed choice or give informed consent. Like counselling, advice may include the provision of information. More broadly though, it encompasses “an opinion given or offered as to action”.⁹⁶ I do not consider legal advice to be “information” required by Right 6(2); however as it is mandatory under the guidelines, the effect is the same as if it were.

4.2.4 Section 46 HART Act

Section 46 of the HART Act is an unambiguous facet of the right to be fully informed. The section sets out information that fertility clinics must provide to donors before they consent to embryo donation. Recipients must also be given this information before fertility services are performed. The information includes (s46(3)):

- Which information about donors is obtained and kept by providers
- How long the information is kept
- Why the information is obtained and kept
- Which part of the information is forwarded to, and kept indefinitely by, the Registrar-General
- The rights given by the Act to donor offspring, the guardians of donor offspring, and other people to obtain information about donors

⁹³ *Shorter Oxford English Dictionary* (6th ed, Oxford University Press, 2007) 536.

⁹⁴ *Ibid.*, 1379.

⁹⁵ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(v); ACART Secretariat Paper above n 35

⁹⁶ Above n 93, 34.

- The rights given by the Act to donors and other people to obtain information about donor offspring
- The importance of telling offspring about the nature of their conception
- The availability of counselling

Unlike the guidelines, this section unequivocally outlines specific information required by donors under Right 6 of the Code.

4.3 Right 7: Right to make an informed choice and give informed consent

4.3.1 Right to withdraw consent until implantation

Every consumer has the right to refuse services and to withdraw consent to services – Right 7(7) of the Code

ECART must determine that the parties understand that donors have the right to vary the agreed terms of donation or withdraw from the donation until the embryos have been placed in the uterus of the recipient woman – clause 2(a)(viii) Proposed Guidelines on Embryo Donation for Reproductive Purposes

Clause 2(a)(viii) allows donors to vary or withdraw consent until the embryo is implanted in the recipient woman’s uterus. The United Kingdom takes a similar approach to New Zealand, allowing consent to be withdrawn or varied by notice until the embryo has been used to provide treatment services.⁹⁷ Both these positions can be contrasted with Canada’s Assisted Human Reproduction (Section 8 Consent) Regulations. There, donors can withdraw consent only until the recipients have acknowledged in writing that the embryo has been designated for their reproductive use.⁹⁸ This is clearly a much more restrictive provision than those found in New Zealand and the United Kingdom.

The following two chapters explore whether New Zealand should continue to allow withdrawal of consent until implantation, or whether it would be better to adopt the Canadian stance. The approach we take will impact on how we deal with embryos

⁹⁷ Human Fertilisation and Embryology Act 1990, Schedule 3, cl. 4(2)(a)

⁹⁸ Assisted Human Reproduction (Section 8 Consent) Regulations, reg 14(3)

surplus to the recipients needs. If we are only interested in the disposal of surplus embryos, then the Canadian approach has the advantage of simplicity. If, as I proposed in Chapter 2, we allow donors to move unwanted embryos between a number of recipient families, then the New Zealand approach provides this flexibility.⁹⁹

4.3.2 Withdrawal of consent and the disposal of surplus embryos

The time limit for withdrawing consent determines who is responsible for disposing of the recipient's unused embryos. In Canada Regulation 14(3) of the Assisted Human Reproduction (Section 8 Consent) Regulations makes recipients responsible for disposal as donors relinquish all rights to the embryo once the recipients have acknowledged its designation for their use. Disposing of embryos does not undermine the donors' right to withdraw consent as this right no longer exists.

In New Zealand the relationship between the right to withdraw consent and the disposal of embryos has not been fully worked through. Right 7(9) of the Code provides: “[e]very consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.” Here again we run into problems with the definition of consumer. In Chapter 3 I concluded that the only way to fit donors within the definition was to view the provision of fertility services as an ongoing process. Consequently, both embryo donors and recipients are consumers and it is unclear which consumer has the right of disposal. Having decided that right 7(10) is likely to apply to donors, the similar wording of right 7(9) suggests that the “consumer” referred to is again the donor. Nonetheless a less ambiguous clause would read: “[e]very consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained *from that consumer* in the course of a health care procedure.” Even if this ambiguity were resolved it is still questionable whether a “bodily substance” includes an embryo.

The guidelines do not specify who has responsibility for disposal. Instead it invites the parties to reach agreement among themselves.¹⁰⁰ Embryo donation applications often

⁹⁹ Refer to discussion on clause 2(a)(ii) in Chapter 2.1

¹⁰⁰ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(viii)

record that “in the absence of a guideline or rule, ECART has been encouraging agreement by all parties to the disposal of surplus embryos and assuming that this decision is with the donors”.¹⁰¹ I think this is the correct approach regardless of whether donors have a right of disposal under the Code. Since donors do not completely relinquish rights to the embryo until implantation, recipients should not be able to dispose of embryos if disposal precedes implantation.¹⁰² Granting donors responsibility for disposal is consistent with the finding of ACART’s Executive Group that embryo donation does not pass ownership to recipients; rather it is in the nature of a gift.¹⁰³ Although ECART presumes that donors have the right to make decisions regarding disposal, ACART may be advised to specify this in the guidelines or in regulations.¹⁰⁴ This will be particularly important if Right 7(9) of the Code cannot be applied to embryo donors.

Presuming donors do or should have the right to dispose of the recipient’s leftover embryos, the difficulty is how to give effect to this right. Should recipients be required to return any unused embryos to the donors? Or should donors simply be notified before destruction and given the opportunity to object? The guidelines provide a flexible solution, which allows parties to decide when and how surplus embryos will be disposed. Some donors may want closure after donation and would prefer the recipients to dispose of any surplus embryos. Other donors may wish to stay involved in the process and retain control over the embryos’ fate. The guidelines enable parties to make arrangements specific to their needs.

Nonetheless there remain unresolved issues with this approach. If donors place the responsibility for disposal with recipients, how does this reconcile with the donors’ right to withdraw consent until the embryo is placed in the recipient’s uterus? Disposal by recipients, even with the donors’ prior agreement, unavoidably terminates the donors’ right to withdraw consent until implantation. If this situation is intentional, it may be more accurate for clause 2(a)(viii) to read: “ECART must determine that the parties understand that donors have the right to... withdraw from

¹⁰¹ For instance applications E07/35, E07/26 and E07/25, ACART “Minutes of the Twelfth Meeting of the Advisory Committee on Assisted Reproductive Technology” (20 November 2007).

¹⁰² Recipients have the right to terminate the pregnancy under clause 2(b)(viii) of the Proposed Guidelines on Embryo Donation for Reproductive Purposes.

¹⁰³ ACART Secretariat Paper, above n 35

¹⁰⁴ Chapter 4.4 will expand on this suggestion of consent regulations for embryo donation.

the donation until the embryos have been placed in the uterus of the recipient woman *or until the disposal of the embryos in accordance with the agreement reached under clause 2(a)(vii).*”

Canada’s regulations on withdrawal of consent simplify the issue of how surplus embryos should be disposed of. However this simplicity comes at the expense of the flexibility demonstrated in New Zealand’s guidelines. Although the relationship between the disposal of embryos and the right to withdraw consent has not been fully resolved, I think it would be better to address these issues than to follow the Canadian approach to withdrawal of consent, which restricts donors’ freedom to change their minds. The following section provides additional support for this view.

4.3.3 Withdrawal of consent and clause 2(a)(ii) – one recipient family

Where embryos can only be donated to one family, the choice between the Canadian and New Zealand approach to withdrawal of consent is less critical. Given that ECART must consider whether donors have completed their family before approving an embryo donation application,¹⁰⁵ it is unlikely that donors would use surplus embryos themselves simply to prevent their destruction. However, if as I suggested in Chapter 2.1, donors could select more than one recipient family, the Canadian approach would be inappropriate. The benefit of allowing donation to more than one recipient family is that donors could transfer embryos from a recipient considering destruction to a recipient wanting to expand their family. Given my belief that only donors should select families for the embryos,¹⁰⁶ this reshuffling would not be possible if the Canadian approach was adopted. In Canada, donors lose their right to withdraw consent at the beginning of the recipient’s treatment. If recipients do not use all the embryos, donors would therefore be unable to place these embryos with another recipient family. By allowing withdrawal of consent until implantation, there are potentially greater options for the treatment of recipients’ surplus embryos.

¹⁰⁵ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(b)(i). But note discussion in Chapter 1.3: clause 2(a)(i) has the same effect as clause 2(b)(i).

¹⁰⁶ Refer to discussion in Chapter 2.1

4.4 Written consent

ECART must take into account all relevant factors, including whether there is written consent to the embryo donation – clause 2(b)(ii) of the proposed Guidelines

Assisted reproduction is a complex area involving a number of parties.¹⁰⁷ Written consent provides some evidence that there has been consideration and reflection on these complexities.¹⁰⁸ Accordingly the United Kingdom and Canada insist that donors give written consent to embryo donation.¹⁰⁹

New Zealand has not tended to place the same weight on written consent, as unwritten consent is “a general principle of law”.¹¹⁰ Under the Code¹¹¹ written consent is only required if:

- The consumer is to participate in research.
- The procedure is experimental.
- The consumer will be under general anaesthetic.
- There is a significant risk of adverse effects on the consumer.

Embryo donation does not fall within any of these categories. In ACART’s recent consultation many submitters felt written consent is too restrictive for embryo donation as it ignores eyewitness testimony and imposes a higher standard than that required for medical procedures.¹¹² Under the guidelines ECART does not have to “determine that” consent is in writing; it is simply required to “take into account” whether written consent has been given.¹¹³ This suggests there may be situations where written consent can be dispensed with. Although the guidelines do not describe these occasions, one example might be where a donor dies before giving written consent to embryo donation.

¹⁰⁷ Treatment Working Group Discussion Paper, above n 80

¹⁰⁸ Department of Health “Review of the Human Fertilisation and Embryology Act: A Public Consultation” (2005) para 4.8

¹⁰⁹ Human Fertilisation and Embryology Act 1990, Schedule 3, cl. 1; Assisted Human Reproduction Act, s8

¹¹⁰ ACART, above n37

¹¹¹ The Code of Health and Disability Services Consumers’ Rights Regulation 1996, Right 7(6)

¹¹² ACART “Consultation on Aspects of Assisted Reproductive Technology: Summary of Submissions: Embryo Donation” (March 2008).

¹¹³ The Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a) and cl. 2(b)

4.4.1 Post humorous use of embryos

The recent ACART consultation asked whether gametes from deceased persons should be used where there is no written consent given prior to death. Although the question was slightly ambiguous¹¹⁴ submitters gave some interesting responses, several of which touched on the post humorous use of embryos.

Two organisations strongly opposed the post humorous use of gametes or embryos regardless of whether prior consent was obtained.¹¹⁵ These objections were based on the perceived needs of potential offspring to know their genetic parents¹¹⁶ and the view that post humorous use of gametes is “technologised [sic] parenthood to serve demand”(Voice for Life).¹¹⁷ At the other end of the spectrum it was suggested that a surviving partner could give consent on behalf of the donor.¹¹⁸ The Nathaniel Centre, who advocated this approach, noted that the post-humorous donation of embryos is morally distinct from using the gametes of a deceased person to *create* embryos without prior written consent.¹¹⁹ The New Zealand Law Society’s submission recommended that in the absence of written consent, ECART should consider applications on a case-by-case basis.

The European Society of Human Reproduction and Embryology recently commissioned a Task Force to analyse the ethics of post humorous reproduction. Members of the Task Force unanimously thought that embryos could be used by a deceased’s partner.¹²⁰ Unfortunately there was no consensus on whether post humorous donation to others should be permitted; let alone if consent should be in

¹¹⁴ It is unclear whether the question is asking if gametes should be able to be retrieved from dead persons, or whether it is asking if gametes obtained prior to death but currently in storage should still be able to be used.

¹¹⁵ Auckland Women’s Health Council and Voice for Life: submissions to ACART on the public consultation titled “Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues” (July 2007).

¹¹⁶ Ibid.

¹¹⁷ Voice for Life, above n 115

¹¹⁸ The Bioethics Centre and The Nathaniel Centre: submissions to ACART on the public consultation titled “Advice on Aspects of Assisted Reproductive Technology: A consultation paper on policy issues” (July 2007).

¹¹⁹ Refer to discussion in Chapter 1.1

¹²⁰ The Task Force noted that there are additional concerns when a surrogate is used in the case of maternal death.

writing. This can be contrasted with the unequivocal view of Canada and the United Kingdom, that the deceased's prior written consent is essential.¹²¹

Given the diversity of opinion, further consultation or investigation by a Treatment Working Group would be valuable. In addition, those commencing IVF treatment could be required to describe their wishes for the post humorous use or disposal of any embryos. Standardised consent forms addressing this issue would avoid the need for ECART or the donor's surviving partner to speculate about the donor's intentions.

4.4 Suggested Improvements

The above analysis has proceeded on the presumption that donors have a right to give informed consent to the donation of embryos. However, as illustrated in Chapter 3, it is questionable whether the Code grants embryo donors this right. Even if it does, I am not convinced that it should.

The Code confers rights on consumers of health and disability services and places corresponding obligations on providers of those services. The application of the Code is extremely wide and the rights in the Code are consequently quite general. Among other things, the Code covers health treatment, health examinations, health research, disease prevention, rehabilitative services, diagnostic services, counselling and fertility services.¹²² Fertility services are distinct as they bring a third party into being. Particularly with embryo donation, where the resulting child will have no genetic relationship with either of its social parents, this raises welfare as well as health issues. Unsurprisingly given its wide application, the Code is concerned with the rights of consumers in a health rather than welfare context.

The content of the Code clearly illustrates this. For instance, as noted in Chapter 4.2, the information to be provided to consumers under Right 6 has a distinctly health focus. Consumers have the right to have their condition explained to them as well as the risks, side effects, benefits, and costs of each available option. They should also be

¹²¹ Assisted Human Reproduction Act, s8; Human Fertilisation and Embryology Act 1990, Schedule 3, cl.1; Consent to post humorous use of gametes has been the subject of much literature, particularly since the English Court of Appeal decision *Ex parte Blood* [1996] 3 WLR 1173. The issue could occupy a dissertation in itself. While I do not want to grossly simplify a complex area, for the purposes of this dissertation it is enough to note that written consent to the post humorous use of gametes and embryos is crucial in both the Canada and the United Kingdom.

¹²² Health and Disability Commissioner Act 1994, s2

advised of the estimated time it will take for services to be provided and the results of any tests and procedures. This information is relevant to potential donors consenting to IVF and to recipients consenting to the implantation of an embryo. However it is not relevant when donors are consenting to the use of their embryos, since donation presents them with no further health issues.

Right 7(10) *is* relevant to fertility services, which usually involve the removing or obtaining of bodily substances. However I submit that the provision should be confined to gamete donation. With gamete donation egg or sperm has often been “removed or obtained” for the purpose of donation. The focus is on curing infertility and finding gametes for families.¹²³ Donors consent simply to donation; they do not choose who will receive their gametes. Welfare considerations are less pressing than they are with embryo donation, because offspring will be genetically related to one social parent. Conversely, embryos cannot be created for the purpose of donation. Thus the aim of embryo donation is to find families for existing embryos. This is the same focus as adoption, which is very much a welfare centred process.

The Code, as its name suggests, is focused on health and disability. I do not think it is the appropriate place to be dealing with donors consent to embryo donation, which raises welfare rather than health concerns. Canada has already recognised this problem in its Assisted Human Reproduction (Section 8 Consent) Regulations. These regulations complement section 8 of the Assisted Human Reproduction Act 2004, which allows the use of *in vitro* embryos only where donors have given written consent in accordance with the regulations to its use for that purpose. In a Regulatory Impact Analysis Statement, Health Canada notes:

Section 8 of the Act does not address obtaining consent for a medical procedure. Rather, the section 8 regulations are intended to protect the rights of gamete and *in vitro* embryo donors and the well-being of children conceived with the assistance of AHR technology.¹²⁴

¹²³ Law Reform Commission “Review of the Adoption of Children Act 1965 (NSW)” (1997) R81, para 11.56

¹²⁴ Health Canada, above n 91

A similar approach could be taken in New Zealand. While consent to medical procedures associated with embryo donation is adequately handled by the Code, consent to donation could be more specifically prescribed in regulations.

In fact if the Code is unsuitable for embryo donors, regulations may be *necessary*. Neither the guidelines nor the HART Act grants donors the right to give informed consent. The purpose of the guidelines is not to confer rights on parties but to “issue guidelines and advice to the ethics committee”.¹²⁵ And while section 4(d) of the HART Act could be amended to protect embryo donors,¹²⁶ the Act applies to assisted reproduction generally and is not intended to prescribe informed consent requirements specific to embryo donation.

Regulations could provide both the source of the right and the detail necessary to give effect to that right. It could also grant a right to withdraw consent to embryo donation if Right 7(7) of the Code does not apply to embryo donors. The guidelines appear to provide a right of withdrawal when it says “...donors have the right to vary the agreed terms of donation or withdraw from donation until the embryos have been placed in the uterus of the recipient woman”.¹²⁷ However because the guidelines are designed to assist ECART’s approval process, the ‘right’ referred to above is preceded by the direction that ECART must determine that the parties have understood they have this right. The focus therefore is on making donors aware of their right; it does not *confer* a right on donors. While the guidelines helpfully detail the scope of the right to withdraw consent,¹²⁸ the right itself was presumed to arise under Right 7(7) of the Code.

Regulations could also specify how consent is to be given and withdrawn. This might include such things as whether consent or withdrawal of consent should be in writing. It might also consider whether recipients need to be notified of the donors’

¹²⁵ HART Act, s35(1)

¹²⁶ New Zealand could adopt the principle used in section 2(d) of Canada’s Assisted Human Reproduction Act, which states: “the principle of free and informed consent must be promoted and applied as a fundamental condition of the use of human reproductive technologies”. Unlike section 4(d) of the HART Act, this is broad enough to cover both donors and recipients.

¹²⁷ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(viii)

¹²⁸ Clause 2(a)(viii) states that consent can be varied or withdrawn until “the embryos have been paced in the uterus of the recipient woman”.

withdrawal of consent for it to be effective.¹²⁹ Regulations could clarify that if the donor is a couple consent can be withdrawn by either spouse or common-law partner.¹³⁰ It may also be an appropriate place to outline key information that donors require to be fully informed.¹³¹

While the content of the Canadian regulations differs from some of the New Zealand requirements,¹³² the structure of the regulations may provide a useful guide. In particular I think the clear distinction between conferring rights on donors and ensuring donors are informed of those rights is commendable. Not only must donors give written consent to the use of their embryos,¹³³ they must also sign a document acknowledging they were informed of specific matters before giving consent.¹³⁴ This gives donors the opportunity to see what they should have been told and whether they have in fact been told it.

New Zealand's Legislature has already anticipated that informed consent to assisted reproductive procedures may require specific regulations and section 76(1)(a)(i) of the HART Act makes this possible. Currently a Treatment Working Group is investigating possible gaps in the informed consent framework and how these might be cured. It will be important for the Group to look at the applicability of the Code to embryo donors. If the Code does not apply, regulations would be the best vehicle for granting donors a right to give informed consent and elaborating on that right.

¹²⁹ In Canada the Assisted Human Reproduction (Section 8 Consent) Regulations state that consent must be in writing (reg. 14(1)) and that it is only effective if the recipient is notified in writing (reg. 14(2)) before the recipient acknowledges in writing that the embryo has been designated for their reproductive use (reg 14(3)).

¹³⁰ Regulation 14(3) of the Assisted Human Reproduction (Section 8 Consent) Regulations states: "If the donor is a couple, the consent of the donor may be withdrawn by either spouse or common-law partner".

¹³¹ Section 5 of the Code of Practice for Assisted Reproductive Technology Units gives a list of information which donors must be given. This includes: the legal, financial, psychosocial and medical implications of ART; details of their condition and treatment; chances of success; availability of counselling; drugs used and possible side effects; current success rates of the ART Unit; the ART Unit's private policy. Again, this information is relevant more to medical procedures than the donation of embryos.

¹³² For example, in Canada consent cannot be withdrawn once the recipients have acknowledged in writing that the embryo is designated for their use: Assisted Human Reproduction (Section 8 Consent) Regulations, reg.14(3). In New Zealand consent can be withdrawn until the embryo has been implanted in the recipient's uterus: Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(viii)

¹³³ Assisted Human Reproduction (Section 8 Consent) Regulations, reg. 13

¹³⁴ Assisted Human Reproduction (Section 8 Consent) Regulations, reg. 12

PART III: POST-DONATION

Through years of secrecy in adoption we have learnt the importance of knowing our genetic ancestry. It is this knowledge that helps us to form our identity, to feel a sense of continuity with the past and to develop a complete biography.

The principles of the HART Act, which are incorporated into the guidelines, implement the lessons from adoption and encourage openness between all involved in assisted reproductive procedures. In particular, the HART Act establishes a comprehensive information sharing-regime for donors and offspring. In spite of the progress towards openness, there remains room for improvement. Under section 50(3) of the HART Act, offspring cannot access identifying information about their donors until they are 18; and even then, only if they know there is information to be accessed. Unless they are told, offspring have no way of knowing they are donor conceived.

CHAPTER FIVE

ACCESS TO INFORMATION

Donor offspring should be... able to access information about [their] origins
– section 4(e) HART Act

The Act has the following [purpose]: ... To establish a comprehensive information-keeping regime to ensure that people born from donated embryos or donated cells can find out about their genetic origins – Section 3(f) HART Act

Through mandatory counselling,¹³⁵ the guidelines endeavour to educate parties about the rights and needs of offspring to access information about their genetic origins.¹³⁶ The offspring's rights arise under Part 3 of the HART Act, which establishes an information-sharing regime for donors and donor offspring.

¹³⁵ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(a)(ix)

¹³⁶ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(b)(vii)

5.1 Information-sharing under the HART Act

Under this regime providers of fertility services are obliged to gather prescribed information about the donors whenever an embryo is donated.¹³⁷ This information includes the donor's name, gender, address, date of birth, place of birth, height, eye colour, hair colour, ethnicity and cultural affiliation. In the case of a Maori donor, providers must also gather information about the donor's whanau, hapu and iwi to the extent that the donor is aware of those affiliations. Significant aspects of the donor's medical history must be recorded, as well as any relevant medical information about the donor's parents, grandparents, children and siblings. Donors may update or correct this information at any time.

The provider must promptly notify the Registrar-General of any donor offspring births.¹³⁸ When the provider ceases to provide services or when 50 years have elapsed since the offspring's birth, the provider must give the Registrar-General any of the information it holds on the donor.¹³⁹ The Registrar-General keeps this information indefinitely.

Neither the provider nor the Registrar-General can disclose information about a donor unless disclosure is authorised or required by the Act.¹⁴⁰ Information requested by a medical practitioner may be divulged if it is required for the provision of medical treatment or advice.¹⁴¹

Where donor offspring aged 18 years or older requests information about a donor, the relevant agency must disclose that information.¹⁴² If the offspring is under 18 years of age the agency may only disclose non-identifying information about the donor.¹⁴³ Nevertheless offspring aged 16 or 17 can apply to the Family Court for an order allowing them access to their donor's identifying information.¹⁴⁴ If an order is not

¹³⁷ HART Act, s47

¹³⁸ HART Act, s53

¹³⁹ HART Act S48; The Registrar-General is the person appointed under section 79(1) of the Births, Deaths and Marriages Registration Act 1995.

¹⁴⁰ HART Act, s51(a)

¹⁴¹ HART Act, s51(c)

¹⁴² HART Act, s50(1)

¹⁴³ HART Act, s50(3)

¹⁴⁴ HART Act, s65

granted, offspring may still be able to obtain identifying information about donors with the help of their guardian(s). Upon request, guardians of offspring under 18 years of age must also be provided with identifying information about the donor.¹⁴⁵ The relevant agency may withhold information about a donor if they reasonably believe that disclosure will endanger any person.¹⁴⁶

5.2 Age restrictions on access to identifying information

Despite a wealth of academic discussion, it remains unclear why under 18 year olds are prevented from accessing identifying information about donors.¹⁴⁷ Under the Adult Adoption Information Act 1985, adoptees cannot access identifying information about birth parents until they are 20 years of age.¹⁴⁸ In its consideration of adoption law reform, the Law Commission could see no reason for fixing a chronological age at which children can receive information about their birth parents.¹⁴⁹ The age limitation has been criticised as a form of age discrimination and the different age restrictions expressed in the Adult Adoption Information Act 1985 (20 years) and the HART Act (18 years, but 16 or 17 with a court order) illustrate the arbitrariness of this requirement.¹⁵⁰

Critics of the age restriction assert that people should not have to struggle and claw for what is a simple birthright: to tell oneself and others who you are.¹⁵¹ This birthright is said to arise under Articles 7 and 13 of the United Nations Convention on the Rights of the Child (UNCRC).¹⁵² Article 7 provides:

The child shall... have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

¹⁴⁵ HART Act, s50(2)

¹⁴⁶ HART Act, s50(4)

¹⁴⁷ Law Commission “New Issues in Legal Parenthood” (2005) NZLC R88; Bianca Atlas, above n 36; Andrew Bainham “Birthrights? The Rights and Obligations Associated with the Birth of a Child” in JR Spencer and Antje Du Bois-Pedain (eds) *Freedom and Responsibility in Reproductive Choice* (Hart Publishing, 2006) 92-99; Department of Health, above n 108.

¹⁴⁸ Section 2 defines an adult as “a person who has attained the age of 20 years”. Section 9(1) states that “any adult adopted person may make a written application... for identifying information relating to either or both of that person’s birth parents”.

¹⁴⁹ Law Commission, above n 147, 153.

¹⁵⁰ *Ibid.*, 123; Andrew Bainham, above n 147, 168.

¹⁵¹ Bianca Atlas, above n 36

¹⁵² *Ibid.*; Andrew Bainham, above n 147, 158-159; Law Commission, above n 147, 110.

In the contexts of assisted reproduction and adoption the words “from birth” tend to be emphasized. Hence, the child’s right arises “not tomorrow, not some weeks, months or years down the line and certainly not on the child’s 18th birthday, but *from birth*.”¹⁵³

When applying the right to embryo donation, the biggest stumbling block is the term “parents”. It is unclear whether the term refers to the offspring’s genetic or social parents. I think “parents” must be read in conjunction with the words “from birth”. At birth recipients are the legal parents of offspring due to statutory presumptions in the Status of Children Act 1969.¹⁵⁴ Thus Article 7 could be read as giving donor offspring the right to know and be cared for by the recipients; rather than conferring a right to access information about their genetic parents from birth.

This can be contrasted with adoption where the child’s parents at birth are its genetic parents. Hence Article 7 gives adoptees a right, as far as possible, to know and be cared for by their birth parents. Adoption occurs because it is not possible for birth parents to care for their child. Nonetheless it would still be possible for adoptees to know their birth parents. Open adoption has disproved the fear that children who know their genetic family will not bond with their social parents. As the right to know one’s parents arises from birth, the age restriction in the Adoption Act is inconsistent with Article 7.

The application of Article 7 to adoption but not to embryo donation is concerning. In both adoption and embryo donation children have no genetic relationship to their social parents. Granting adoptees, but not donor offspring, the right to know their genetic parents without conferring a similar right on donor offspring, discriminates against offspring on the basis of gestation. Nevertheless this dissertation is not intended to critique UNCROC and given that Article 13(1) does appear to give donor

¹⁵³ Andrew Bainham, above n 147, 159.

¹⁵⁴ Section 17 of the Status of Children Act 1969 presumes that a woman who becomes pregnant is the mother of any resulting child even though the embryo used may have been derived from another woman’s egg. If the pregnant woman underwent the assisted reproductive procedure with her partner’s consent, her partner is also deemed to be a parent of the child: section 18.

offspring the right to access genetic information, I will proceed to consider that Article.

Article 13(1) is expressed as follows:

The child shall have the right to freedom of expression: this right shall include freedom to seek, receive and impart information and ideas of all kinds....

While freedom of expression is typically associated with the imparting of information, Article 13(1) also grants children a right to seek and receive information of any kind. The right is qualified by Article 13(2) which allows legal restrictions to be placed on the right in order to respect the rights or reputations of others. Allowing under 18 year olds to access their donors' identifying information, does not appear to disrespect the rights of either recipients or donors.

5.3 Alternatives to the age restrictions

The Swedish Insemination Act 1985 allows offspring to access information about donors when they are "sufficiently mature".¹⁵⁵ The difficulty with capacity-based testing is that someone with limited knowledge of the child has to judge the child's maturity and understanding.¹⁵⁶ A subjective approach risks evolving into an onus that the donor conceived person must discharge.¹⁵⁷ This may further disempower donor offspring as it should not be necessary to fight for information about one's origins.¹⁵⁸

If an onus is desired, this would be more appropriately cast on those seeking to maintain anonymity. Donors and recipients would need to justify why anonymity is necessary until the child's 18th birthday.¹⁵⁹ Openness in adoption has proven to be *beneficial* for all involved.¹⁶⁰ There is no reason why it would not be beneficial in the context of embryo donation.

¹⁵⁵ Bianka Atlas, above n 36

¹⁵⁶ Law Commission "New Issues in Legal Parenthood: A Discussion Paper" (2004) NZLC Preliminary Paper 54, 71

¹⁵⁷ Ibid.

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ Refer to above n 71

To avoid the subjectivity of a maturity based test, the age limit on access to information could be dispensed with altogether.¹⁶¹ The basis of this approach is that children who are old enough to ask are old enough to know the truth.¹⁶² Removing the age restriction would be consistent with Article 13 which gives “the child” the right to seek or receive information. Child is defined in Article 1 as “every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier”; the definition is unrelated to levels of maturity.

These criticisms should not overshadow the achievements of the HART Act, which have significantly removed donor anonymity. By comparison, offspring in Canada can only access identifying information with the written consent of the donor.¹⁶³ Whereas Canada continues to discuss the benefits of anonymity versus disclosure, the HART Act has reduced the New Zealand debate to: disclosure, but when?

The HART Act prevents providers giving identifying information to offspring under the age of 18. While this is an unnecessary age restriction, it does not prevent recipients from telling offspring the identity of their donors. Until the age restriction is removed, it is comforting to know that the guidelines encourage parties to consider ongoing contact and information sharing with offspring.¹⁶⁴

¹⁶¹ Law Commission, above n 147, 153; Department of Health, above n 108, para 6.15; Law Commission “Adoption: Options for Reform (A Discussion Paper)” (1999) NZLC Preliminary Paper 38, 111; Andrew Bainham, above n 147, 168

¹⁶² Law Commission, above n 156, 71

¹⁶³ Assisted Human Reproduction Act, s15

¹⁶⁴ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(b)(vii)

CHAPTER SIX

OPENNESS ABOUT CONCEPTION

Donor offspring should be made aware of their genetic origins... – section 4(e)
HART Act

As section 4(e) implicitly recognises, it is pointless to have good access to information provisions unless offspring know there is information to be accessed. The question of how to inform offspring of their conception has generated much debate in the contexts of both adoption and gamete/embryo donation. Compared with adoption, it is much easier for embryo recipients to conceal the truth about their child's conception as they have a biological link to the child through gestation.¹⁶⁵ Whereas adoptive parents start to tell children about their conception from a young age, gamete and embryo recipients often do not tell children at all.¹⁶⁶ In a recent study of 21 embryo donation families only 9% of mothers had told their child how they had conceived, 24% planned to tell their child in the future, 43% had decided never to tell their child and 24% were undecided.¹⁶⁷ A study undertaken at the University of Auckland revealed that only a quarter of parents had told children how they were conceived.¹⁶⁸

Embryo recipients conceal the truth for a variety of reasons. Having experienced pregnancy and child birth, recipients often feel strongly that the offspring is 'theirs' and that it is unnecessary to tell the child of its genetic origins.¹⁶⁹ Others lie to their children because they fear the child's reaction or the reaction of others, because they want to protect their child from perceived discrimination, or because they feel profound shame and grief about their inability to beget their own children.¹⁷⁰

¹⁶⁵ Fiona MacCallum, above n 64, 279

¹⁶⁶ *Ibid.*, 279

¹⁶⁷ *Ibid.*, 283

¹⁶⁸ Dr Vivienne Adair "Interim Report on Parents of Donor Children" (University of Auckland, undated approx 2002) cited in Law Commission above n 156

¹⁶⁹ Erica Haines "Gamete and Embryo Donation: Ethical implications for families" (2008) 1 *Human Fertility* 32.

¹⁷⁰ Fiona MacCallum and Susan Golombok "Embryo donation families: mothers' decisions regarding disclosure of conception" (2007) 22 *Human Reproduction* 2888.

6.1 The importance of openness

If “what you don’t know can’t hurt you”, why is openness about conception so important? A study of donor conceived 12 year olds found that children perform well despite being unaware of their conception.¹⁷¹ However the authors cautioned that these results do not mean it is *better* to conceal the truth from donor offspring. There are numerous reasons to support this warning.

Firstly, the majority of recipients in the study had disclosed the truth to other family members or friends. If offspring learn of their conception from an outside source there is a risk that their relationship with the recipients will be damaged. Conversely studies have shown that children who are told of their conception from a young age generally respond positively or with disinterest to the information.¹⁷²

Secondly, adoption research has shown that adoptees benefit from information about their birth parents. Like adoptees, children conceived from donated embryos will face difficult questions concerning their identity. Years of secrecy in adoption have shown that children who do not know their genetic ancestry find it difficult to make the necessary connections between the past and the future, which allow people to develop into a cohesive self.¹⁷³ Being disconnected from one’s ancestry has been described as one of the loneliest experiences known: “[i]t is like floating in time and space without an anchor”.¹⁷⁴ The guidelines recognise the significance of these connections in section 4(b), which states that “[t]he human health, safety and dignity of present and future generations should be preserved and promoted”.

¹⁷¹ S Golombok “Parenting and the psychological development of the child in ART families” in E Vayena et al (eds) *Current Practices and Controversies in Assisted Reproduction* (Report of a Meeting on Medical, Ethical and Social Aspects of Assisted Reproduction, 2001) 17-21 cited in Bianka Atlas, above n 36

¹⁷² Lycett E, Daniels K, Curson R and Golombok S “Offspring created as a result of donor insemination: a study of family relationships, child adjustment, and disclosure” (2004) *Fertil Steril* 82, 172-179 cited in Fiona MacCallum, above n 170, 2888-2895

¹⁷³ Keith Griffith, above n 14, 92 -103F

¹⁷⁴ *Ibid.*, 103D

Thirdly, openness is vitally important for medical reasons. If donor offspring believe that their social parents are also their genetic parents, they will unknowingly provide doctors with a false genetic history.¹⁷⁵

Finally, to conceal the truth from a child is to deprive them of essential information about their personal history: “Our stories belong to us and we are entitled to the truth”.¹⁷⁶ Regardless of whether UNCROC gives offspring the right to know their genetic parents, nobody should have to prove that they are entitled to know the truth about their own lives.¹⁷⁷ Withholding information implies that there is something shameful to hide.

6.2 Informing offspring of their conception

Parents could be placed under a statutory duty to tell offspring about their conception. Whilst this is often suggested, it is usually also dismissed as it would be almost impossible to guarantee compliance.¹⁷⁸

A more popular alternative is to remind parents about the importance of disclosure through education and counselling.¹⁷⁹ This is the approach seen in the guidelines. Clause 2(b)(vii) requires ECART to take into account whether the parties have considered, discussed and understood each other’s attitudes to openness about the donation. The parties must also consider each other’s needs, wishes, expectations and plans regarding ongoing contact and information sharing. This includes understanding the child’s right to access information about their genetic origins and to contact the donors. The guidelines encourage the extended family, whanau or children of the parties to participate in counselling, which also makes the process more open.¹⁸⁰

¹⁷⁵ Bianka Atlas, above n 36

¹⁷⁶ David Gollancz “Time to stop lying” (2 August 2007) *The Guardian* <<http://www.guardian.co.uk/society/2007/aug/02/childrenservices.humanrights>> accessed 11/09/07

¹⁷⁷ Ibid.

¹⁷⁸ Law Commission, above n 156, 68-69; Joint Committee on the Human Tissue and Embryos (Draft) Bill “First Report” (2007) <<http://www.publications.parliament.uk/pa/jt200607/jtselect/jtembryos/169/16902.html>> accessed 10/09/08

¹⁷⁹ Law Commission, above n 156

¹⁸⁰ Proposed Guidelines on Embryo Donation for Reproductive Purposes, cl. 2(b)(iii)

Although these provisions are good, they may not be enough. Even with counselling, the recipient's good intentions to tell the truth may change after the child is born.¹⁸¹

If this is the case, donor offspring have no way of knowing the truth.¹⁸² Deep concerns have been expressed about role of the state in this concealment. By failing to ensure that offspring are informed of their conception, the state effectively withholds important information from offspring.¹⁸³ Since assisted conception involves the state, the state should not be "colluding in a deception".¹⁸⁴

To ensure that offspring are informed of their origins, the state could require an annotation to be placed on the child's birth certificate. Although this suggestion is not new, it has received fresh interest since July 2007 when the Joint Committee published a report on the United Kingdom's Human Tissue and Embryos (Draft) Bill.¹⁸⁵ The Committee recommended that the Government should consider the annotation of birth certificates as a matter of urgency. While there is some concern that this will "force people to tell", the Committee considered it would give parents an "incentive" to disclose the truth.¹⁸⁶

The annotation need not provide all the details about the child's conception; it could simply indicate that the parent is not the genetic or gestational parent of the child. An annotation might read "by donor" or it may refer to a relevant statute such as "Status of Children Act 1969".¹⁸⁷ The child could then approach the Registrar-General for further information. In the interests of privacy this information would be accessible by only the offspring and social parents.¹⁸⁸

¹⁸¹ Erica Haimes, above n 169, 30-34

¹⁸² Except by way of inadvertent or deliberate disclosure by someone other than the parents.

¹⁸³ House of Commons Science and Technology Committee "Human Reproductive Technologies and the Law" (2005) Fifth Report of Session 2004-2005, Vol. 1; Joint Committee on the Human Tissue and Embryos (Draft Bill), above n 178

¹⁸⁴ Joint Committee on Human Tissue and Embryos (Draft Bill), above n 178

¹⁸⁵ Ibid.; Mark Henderson "Birth certificates 'should tell donor children who their real parents are'" (1 August 2007) *The Times* <<http://business.timesonline.co.uk/tol/business/law/article2176357.ece>> accessed 11/09/08; David Derbyshire "Children born of sperm or egg donors 'should have birth certificates stamped'" (10 December 2007) *Daily Mail* <<http://www.dailymail.co.uk/news/article-500989/Children-born-sperm-egg-donors-birth-certificates-stamped.html>> accessed 11/09/08; David Gollancz, above n 176

¹⁸⁶ Joint Committee on Human Tissue and Embryos (Draft Bill) above n 178

¹⁸⁷ Law Commission, above n 156, 69

¹⁸⁸ Under section 61 of the HART Act, the Registrar-General cannot give donors identifying information about offspring without the offspring's consent.

There has been debate about whether annotations should be optional or compulsory.¹⁸⁹ Adoptive parents can choose whether or not to have the label “adoptive parent[s]” included on their child’s birth certificate.¹⁹⁰ Those who support a similar optional system for donor offspring argue that annotations would invade the privacy of parents and offspring.¹⁹¹ However, it is more important for children to be told the truth than to protect the feelings and privacy of parents. The privacy of *offspring* is a concern, but this could be addressed by giving offspring the right to remove the annotation at any time. If the purpose of annotations is to ensure offspring learn of their conception, optional annotations are senseless.

The guidelines show a preference for educative rather than legislative measures to promote openness. Through counselling, the guidelines seek to educate parents about the importance of disclosing their child’s conception. This improves significantly on the attitude of secrecy that has surrounded adoption. Nevertheless, like the United Kingdom it might be time for New Zealand to consider legislative provisions that ensure offspring learn of their genetic history. For various reasons, some no doubt benevolent, parents may fail to tell children the truth. Since the state allows assisted reproduction, it should take responsibility for ensuring offspring are informed of their origins. Annotating the birth certificate of donor conceived children would alert offspring to the circumstances of their conception and enable them to access information about their donors. With this information offspring can develop a coherent sense of self and ensure that they receive appropriate medical treatment when required.

¹⁸⁹ David Derbyshire, above n 185; Law Commission, above n 156, 69-70;

¹⁹⁰ Births, Deaths and Marriages Registration Act 1995, s63(2)(b) and s24(3)(a)

¹⁹¹ Law Commission, above n 156, 69

CONCLUSION

Embryo donation is fraught with polarities: genetics versus gestation; privacy versus openness; education versus legislation; state versus parents; parents versus offspring. It seeks to balance these interests in a context where the rights of those concerned are manifestly unequal: unlike recipients and donors, embryos are not afforded the full protection of the law. Nevertheless some of these embryos will grow into autonomous adults with their own needs and interests.

The most important interest for donors is their right to give and withdraw informed consent. Part Two emphasized that the existing informed consent framework is unsuitable for embryo donation, which raises welfare as well as health concerns. Rather than trying to fit embryo donors within the Code, regulations similar to Canada's Assisted Human Reproduction (Section 8 Consent) Regulations would better protect donor interests.

The interests of embryo recipients may be similar to the interests of gamete recipients, since both share biological bonds with their offspring through ART procedures. Foremost among these interests is likely to be the protection of family privacy and parental authority. However unlike gamete donation, embryo donation also raises significant concerns about the well-being of offspring who will bear no genetic relationship with either of their parents. For this reason, I concluded in Part One that embryo donation should follow adoption into the public realm where the welfare of offspring is more important than the autonomy, infertility or privacy of recipients.

While the guidelines generally take this approach, other components of the ART framework are less admirable. The HART Act's age restriction on access to identifying information illustrates the state's unwillingness to interfere with parental autonomy until the offspring has attained the age of majority. Similarly, the tension between privacy and openness still plagues the issue of how to inform offspring of their conception. Despite wide support for the annotation of birth certificates, the state

has been unwilling to intervene post-donation and override the autonomy of parents to inform offspring as and when they desire.

ACART has taken a much stronger welfare focus in its embryo donation guidelines. Part One explained how restricting the embryos that can be donated preserves and promotes “the human health, safety, and dignity of present and future generations”.¹⁹² And although I concluded clause 2(a)(ii) is overly restrictive, limiting embryo donation to one family nonetheless shows that ACART is more concerned with the well-being of offspring than the treatment of infertility.

Similarly, the guidelines’ requirement for joint counselling takes embryo donation out of the private sphere and reflects a desire that children grow up knowing their genetic family. This mandatory process of engagement between donors and recipients has been hailed as an “enlightened, sensitive policy”¹⁹³ and a “world first”.¹⁹⁴

Clause 2(b)(i) also highlights the importance the genetic relationship between donors and offspring. Prior to donation, the parties must understand the offspring’s right to access information about his or her origins and contact the donors. The donor’s and recipient’s own needs, wishes, expectations, and plans regarding ongoing contact and information sharing must also be considered. In addition the parties are encouraged to discuss each other’s attitudes to openness about the donation, especially with any resulting child.

However there is one aspect of the guidelines that does not fit neatly within a welfare model. Unlike adoption, no screening process is required for the selection of embryo recipients. I was unable to find any justification for treating the selection of adoptive parents differently to the selection of embryo recipients. Although the guidelines require police vetting information on recipients, it is unclear whether this criterion is intended to strike a balance between the autonomy of adults and the welfare of

¹⁹² HART Act, s4(d)

¹⁹³ Carol Nader “Plan to introduce ‘adoption’ of IVF embryos” (20 August 2007) *The Age* <<http://www.theage.com.au/news/national/plan-to-introduce-adoption-of-ivf-embryos/2007/08/20/1187462178139.html>>

¹⁹⁴ Antony Blackburn-Starza “Victoria considers New Zealand approach to embryo donation” (29 August 2007) *BioNews* <http://www.ivf.net/victoria_considers_new_zealand_approach_to_embryo_donation-o2927-en.html> accessed 19/03/08

offspring, or whether ACART is simply adopting a safe middle ground between privacy and politicization to avoid creating controversy.¹⁹⁵

While it is important to balance the rights of concerned parties, a ‘middle ground’ is not tolerable. My fear is that embryo donation will repeat the mistakes of adoption, where the wants of adoptive parents were placed above the needs of children. Just as adoption emphasised environment over hereditary, embryo donation threatens to emphasize biology over genetics. At the heart of all decision making must be the “health and wellbeing of children” born as a result of embryo donation.¹⁹⁶ Although toes may need to be trodden to achieve this ideal, ACART should not be afraid to get its feet dirty.

¹⁹⁵ A screening process for recipients is likely to be met by opposition from potential recipients and fertility clinics; it would be seen as yet another hoop for infertile couples to jump through and would lengthen the embryo donation process. However as these difficulties must be endured by applicants for adoption, ACART should justify why they should not be endured by embryo recipients.

¹⁹⁶ HART Act, s4(a)

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CCS Disability Action	Maria Jones
David Fisk	Ministry of Social Development
Diane Yates	Name withheld
ECART	Name withheld
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Fertility New Zealand (Canterbury branch)	Paul Elswell-Sutton
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Helen Davies	Right to Life New Zealand Inc
Hilary Stace	Robert Ludbrook
Hugh Moran	Susan Fraser
Humanist Society of New Zealand	The Nathaniel Centre
Interchurch Bioethics Council	Toi te Taiao - the Bioethics Council
	Voice for Life
	Women’s Health Action

APPENDIX

Proposed Guidelines on Embryo Donation for Reproductive Purposes

1. When considering an application for embryo donation, ECART must be guided by the principles of the Human Assisted Reproductive Technology Act 2004:

Section 4: Principles

All persons exercising powers of performing functions under this Act must be guided by each of the following principles that is relevant to the particular power or function:

- (a) the health and well-being of children born as a result of the performance of an assisted reproductive procedure or an established procedure should be an important consideration in all decisions about that procedure:
 - (b) the human health, safety, and dignity of present and future generations should be preserved and promoted:
 - (c) while all persons are affected by assisted reproductive procedures and established procedures, women, more than men, are directly and significantly affected by their application, and the health and well-being of women must be protected in the use of these procedures:
 - (d) no assisted reproductive procedure should be performed on an individual and no human reproductive research should be conducted on an individual unless the individual has made an informed choice and given informed consent:
 - (e) donor offspring should be made aware of their genetic origins and be able to access information about those origins:
 - (f) the needs, values, and beliefs of Maori should be considered and treated with respect:
 - (g) the different ethical, spiritual, and cultural perspectives in society should be considered and treated with respect.
2. When considering an application for embryo donation:
 - (a) ECART must determine that:
 - (i) The embryos being donated are:

- Existing embryos created as part of the donors' own IVF treatment.
 - Created from the donors' own gametes.
 - Surplus to the donors' own reproductive needs.
- (ii) Embryo donation is limited to producing full genetic siblings in no more than two families.
 - (iii) The recipient or the recipient's partner has a medical condition affecting his or her reproductive ability, or a medical diagnosis of unexplained infertility, that makes embryo donation appropriate.
 - (iv) The profile/s provided by the recipients for the donors include/s any police vetting information.
 - (v) Legal reports indicate that the parties understand the legal issues associated with embryo donation.
 - (vi) Legal reports indicate that the parties understand the legal issues associated with embryo donation.
 - (vii) There has been discussion, understanding, and agreement between the parties on matters relating to the use and storage of embryos and disposal of any unused embryos.
 - (viii) The parties understand that donors have the right to vary the agreed terms of donation or withdraw from the donation until the embryos have been placed in the uterus of the recipient woman.
 - (ix) Each party has received counselling in accordance with the Code of Practice for Associated Reproductive Technology Units, or, when it comes into effect, the current Fertility Services Standard.

(b) ECART must take into account all relevant factors, including:

- (i) Whether the donors have completed their family.
- (ii) Whether there has been written consent to the embryo donation.
- (iii) Whether counselling has:
 - Included implications counselling for all parties.
 - Included joint counselling.
 - Been culturally appropriate.
 - Provided for whanau / extended family involvement.

- Provided for the inclusion of any children of the parties.
- (iv) Whether counselling will be accessible to all parties throughout the donation process.
- (v) Whether the residency of the parties safeguards the well-being of all parties, and especially any resulting child.
- (vi) Whether the donors have been subjected to coercion or pressure.
- (vii) Whether all parties have considered and discussed the implications of the following, and, in the professional opinion of counsellor/s and/or medical specialists, have understood:
 - The rights and needs of any resulting child/ren, including their rights to access information about their genetic origins and contact the donors.
 - Each other's needs, wishes, expectations, and plans regarding ongoing contact and information sharing.
 - Any specific issues that may affect the health and well-being of any of the parties, and especially any resulting child.
 - Each other's attitudes to openness about the donation, especially with any resulting child.
 - The implications of possible termination of the pregnancy by the recipient/s.
 - Issues relating to storage, use, and disposal of embryos.
 - The requirements regarding information sharing under the Human Assisted Reproductive Technology Act 2004.
 - That embryos may not be able to be refrozen if donors decide to withdraw from the donation after embryos have been thawed.
 - Their reasons now, and feelings they may experience in the future, concerning the donation of embryos.
 - The impact of donating embryos on their existing child/ren.