

Joint Committee on Health
Pre-Legislative Scrutiny of the General Scheme of the Assisted Human
Reproduction Bill

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Opening Statement by Professor Mary Wingfield,
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Good morning.

I am delighted and honoured to have this opportunity to speak to the Joint Committee on Health about the General Scheme of the Assisted Human Reproduction (AHR) Bill 2017 and I would like to thank the Chairman and Committee for inviting me.

I am a Consultant in Holles Street and the Clinical Director of Merrion Fertility Clinic, which is affiliated with Holles Street.

I was a member of the Commission on Assisted Human Reproduction, which produced its report in 2005, and I am delighted to see that, except for the proposals on parenthood in surrogacy, the draft Bill accords with the recommendations of the Commission.

Before I talk about specifics of the proposed Bill, I would like to clarify some important issues related to infertility and AHR. The first thing I want to say is that the experience of infertility is one of the most distressing and painful experiences that one can have. People who have not been through it often don't appreciate that.

The second point I want to make is that, for many years now, infertility has been recognized by the WHO and other medical bodies as a medical condition. AHR is a medical treatment. It is not an optional luxury. And IVF is probably one of the greatest medical advances of our time.

Sadly, however, AHR is an area of medicine that has become extremely commercialized, partly due to the lack of public funding in countries such as Ireland and partly due to the involvement of multi-national commercial companies in the area. Merrion Fertility Clinic is the only fertility clinic in Ireland, which is not-for-profit and which is linked to a major public teaching hospital.

People with infertility are often desperate to have a child – this makes them very vulnerable – vulnerable to financial exploitation, vulnerable to spurious treatments with no proven value and vulnerable in our courts. For all of these reasons we need legislation.

The Institute of Obstetricians and Gynaecologists has made a submission to the Joint Committee on Health regarding this Bill. I chaired the working group, which prepared the Institute document and I have authority to present that opinion, which mirrors my own. The Institute submission is attached here.

It is impossible in 5 minutes to cover everything in the Bill but key issues include the following.

- AHR is one of the most rapidly evolving areas of medicine and science so it is important that any legislation we introduce is not overly prescriptive and that it does not prevent future adaptation to new medical developments.
- Particularly in the context of the forthcoming referendum on the 8th Amendment, it is important that AHR treatments are not confused with those of early pregnancy. AHR concerns only the *in-vitro* or pre-implantation embryo to which Article 40.3.3. of the Constitution does not apply.
- It is essential to avoid multiple pregnancies following AHR treatments. However the recommendations in the Bill regarding the number of embryos to transfer are not entirely appropriate.
- It is suggested that a person can donate gametes (eggs or sperm) at the age of 18 but cannot receive AHR treatment until the age of 21. We recommend that these ages should be reversed.
- We are delighted to see that posthumous assisted reproduction is being legislated for. The proposal, however, allows this only for women. This is discriminatory to men. A surviving male partner should be allowed to use his deceased female partner's oocytes or their joint embryos, if she consented to this, prior to her death.
- Counselling is an essential part of AHR treatment and must be encouraged. However we do not agree that it should be mandatory for *everyone* having AHR treatment. It should only be mandatory in cases of donor-assisted conception, posthumous assisted reproduction or

surrogacy or where healthcare staff have particular concerns about a patient's emotional wellbeing.

- We agree that Pre-implantation Genetic Diagnosis (PGD) should be allowed. Pre-implantation Genetic Screening should also be included and, while it is currently a very new technique, mitochondrial donation should not be banned.
- With regard to surrogacy, it is clear to us that the restrictive provisions proposed will mean that the demand for surrogacy by Irish citizens will not be met by domestic surrogacy. Irish patients will continue to travel overseas and will bring their children home to Ireland. The legal situation of these children and their intended parents is not addressed in the Bill. We feel it should be.
- A worrying suggestion in the Bill is that professionals will not be allowed to aid people planning surrogacy abroad. I certainly would find it unethical as a doctor, not to be able to help my patients in this regard. I suspect counselors and lawyers would feel similarly.
- Regarding the legal parenthood of children born after surrogacy, we support the recommendation of the Commission on Assisted Human Reproduction, 2005, that it should be the intending parent(s) rather than the birth mother who should be the legal parent(s) from the outset.
- We also make other suggestions to protect the health and legal status of the surrogate.
- Regarding donor conception and surrogacy, I personally wholeheartedly support the view that a donor-conceived person has a right to know his or her biological parent. However, as regards the proposed national surrogacy register and the donor conception register of the Children and Family Relationships Act of 2015, we are totally opposed to the notion that a donor-conceived person who applies for a birth certificate would be told, without his or her seeking that information, that they were donor-conceived. We feel this is irresponsible, dangerous and an invasion of privacy.
- Regarding donor conception and surrogacy, it is important that these services be provided altruistically and non-commercially. However, if we want them to be available in Ireland (which they are not at present) we need to look seriously at ethical ways of encouraging them.

I am going to stop there but, in the Institute document attached, there are many other suggestions – around age limits for treatment, storage limits for gametes and embryos, consent procedures and the proposed regulatory authority.

I and my colleagues in the Institute of Obstetricians and Gynaecologists hope we can have an input into the final Bill, as we are the doctors most intimately connected with this issue and who will need to deliver the services.

Thank you.