M12

Import and export of gametes and embryos

Meeting with Fertility PLUS, Auckland

5 June 2013

Present

Dr John Angus, Chair of ACART

Margaret Merilees, Scientific Director

Helen Nicholson, Counsellor

Megan Downer, Counsellor

Anna Bargiacchi, Nurse Coordinator

In attendance

Stella Li, ACART Secretariat

Note: The points listed below reflect comments by individuals and should not be taken as a consensus by meeting attendees.

Feedback from Fertility PLUS

Accessing assisted reproductive procedures in other countries

- The attendees recognised that an increasing number of New Zealand consumers travelling overseas for assisted reproductive procedures. The choice of consumers to do so is an exercise of their personal autonomy.
- Consumers travel with the knowledge that their choice to access particular assisted reproductive procedures overseas may preclude some future options.
    - For example, consumers are made aware before travelling overseas that surplus embryos created using commercially sourced eggs for IVF treatment overseas cannot be used in New Zealand because they are created in a way contrary to New Zealand's regulatory framework.
    - Should exceptions or flexibility be given for consumers such as those in the above example? It can be argued that they were not unaware of the impact of their choice to go overseas, because they were given information in advance of going offshore. However, the attendees acknowledged that there appears to be inconsistency between being able to bring back embryos created in a way contrary to New Zealand requirements in utero, but not in vitro.
- The attendees were concerned about risky overseas assisted reproductive procedures practice, in particular:
    - inconsistency with standard clinical practice in New Zealand, for example multiple embryo transfer versus single embryo transfer
    - the potential risks for the woman, child, donor, and the flow-on consequences for New Zealand's health system
    - overseas clinics' non-compliance with requirements or best practice within their own country, for example minimum donor age recommendations.

- The attendees are also concerned about exploitation of young overseas donors who may not be well-informed or are under pressure or coercion.
- The attendees recognised they had not seen many patients travelling overseas because they primarily treated publicly funded patients.

Altruistic donation v commercial supply

- Defining 'commercialisation' is broad and subjective. It could be restricted to payment for expenses incurred, or alternatively could mean a fully commercial market. It was noted that there may be scope for 'commercialisation' but not to the extremes of a market.
- The attendees were cautious about allowing greater flexibility in financial compensation for donors.
    - However they felt that more often than not, egg donors were left out of pocket because of the strict adherence to New Zealand's non-commercial policy. For example donors could not be reimbursed for taking time off work to visit the clinic.
    - The participants agreed that we should not assume there is harm done to children born from commercially sourced gametes or embryos.
- They also talked about whether revising financial compensation would influence donor numbers. They agreed increased compensation would not decrease donor numbers, but it is unknown whether it would encourage an increase in donor numbers. The attendees also considered whether any revisions would affect donor demographics.
- The counsellors were of the view that in New Zealand all parties involved find it difficult to discuss money and were very careful not to overstep the line into 'commercial supply'.
- They discussed the United Kingdom's Human Fertilisation and Embryology Authority (HFEA) revision of compensation for egg donors and were interested in how the HFEA settled on an appropriate monetary figure.
    - As a clinic, they are interested in finding out the financial costs incurred by their donors. The costs incurred depend on individual circumstances, for example how far away donors lived from the clinic, or whether they had to take unpaid leave from work
- Currently, embryos created overseas from commercially sourced gametes cannot be imported into New Zealand, but the attendees were of the view there may be some circumstances where this would be permissible.
    - For example, the import might be allowed if the consumers had lived in a different country where this had been permissible but then had moved to New Zealand. They would not have anticipated at the time how their embryos would be affected. The attendees were of the view that the consumer would have to provide evidence that they did not know about New Zealand requirements, but this would be difficult.
    - A counter argument is that if people decided to move to New Zealand, they should be aware that they could not use in New Zealand, gametes and embryos that did not comply with New Zealand requirements.

Identifying information about donors

- The attendees expressed discomfort about using non-identifiable donors, and were of the view that any changes in policy position should not enable people to seek non-identifiable donors.
- They were of the view that if some allowances were made for commercially supplied gametes in creating embryos, the donors must be identifiable.
- The attendees also identified the risk of inequitable access to donor identity information.
    - Donor-conceived children in New Zealand would be able to access identifying information, but those conceived overseas from anonymous donors would not.

Family size requirements

- The attendees acknowledged the complexity of family networks, but considered that for a child to have genetic siblings in ten families is beyond any contemporary understanding of a 'complex family network'.
- They agreed it would be very difficult to police the use of donated gametes or embryos in import/export where it may exceed New Zealand limits on the number of families assisted.
- In response to an example in the discussion document where a hypothetical sperm donor is sending sperm overseas for a friend, but wants to limit the number of children born from his donation, the attendees considered that this was an issue of informed consent, and presumably specific conditions could be set to restrict its use.

Sex selection

- Attendees were concerned about personal or cultural preferences in regard to sex selection through assisted reproduction.
- In particular, one attendee's primary concern was the implications if the sex selection process resulted in a child who was not the preferred sex. She was worried about the implications for the resulting child - there is a risk of potential subsequent rejection because the child was not the boy or girl their intending parent had 'selected'.

Scope of informed consent

- There was a discussion about what happens with consent after the creation of the embryo. Attendees noted that when donors are followed-up, the general response is once they had made a donation, they no longer had a say and the clinics could do what they liked.

New Zealand's donor pool

- New Zealand is restricted in its availability of donors, particularly egg donors.
- Is there room to increase egg donation if there was greater financial compensation?
- They considered whether there is an overarching element of altruism with any egg donation.