Conceptualising a Child Centric Paradigm: *Do we have freedom of choice in donor conception reproduction?*
Author Details

Full name: Damian H. Adams

Affiliation: School of Nursing and Midwifery, Flinders University.

Address: Sturt Road, Bedford Park, South Australia, Australia, 5042.

Qualifications: PhD Candidate, B. Biotech (Hons)

Word Counts

Abstract: 135 words

Main Text: 6830 words
Abstract

Since its inception, donor conception practices have been a reproductive choice for the infertile. Past and current practices have the potential to cause significant and lifelong harm to the offspring through loss of kinship, heritage, identity, family health history and possibly introducing physical problems. Legislation and regulation in Australia that specifies that the welfare of the child born as a consequence of donor conception is paramount may therefore be in conflict with the outcomes. Altering the paradigm to a child centric model however, impinges on reproductive choice and rights of adults involved in the process. With some lobby groups pushing for increased reproductive choice while others emphasise offspring rights there is a dichotomy of interests that society and legislators need to address. Concepts pertaining to a shift towards a child centric paradigm are discussed.

Key Words: Reproductive Techniques, Assisted, Ethics, Policy, Child Welfare

Discipline: Bioethics: Medical ethics
Topic Area: Health policy

Introduction

Choosing when, who with, and how we procreate is often viewed as an inalienable human freedom. It is this freedom to reproduce that has been a cornerstone of society and family life. For those suffering from infertility, the introduction and implementation of donor conception (DC) finally enabled many to create the family they wished for. While the infertile were free legally to procreate they were thwarted biologically. Donor conception provided them with increased freedom to procreate, to choose to start a family via a treatment process if that was their wish. They had improved choice and control over their family creation.

Ethical, moral and legal perspectives of DC practices became institutionalised in Australia during the 1980’s when the first legislations concerning this form of fertility treatment were enacted. Legislation varies considerably between Australian states, providing a mosaic of disproportionate rights to donor conceived offspring. A situation aptly described by Schneller (2005, 244), as ‘chaotic’. The psychological
and medical welfare of any donor conceived person hinges on these rights and subsequently the very state that they were conceived in, and or the era of their conception due to the ever changing landscape of legislation and regulations. During this early bureaucratic period there were suggestions that the physical, medical and psychological wellbeing of a child may be dependent on the ability to find out information on the donating progenitor(s) (Rowland 1985, 391; Vetri 1988, 520). Additionally it was suggested that policy should be predicated by the best interests of the child (Annas 1981, 161) and disclosure should follow the precedent set by adoption (Brandon and Warner 1977, 338). If we are to uphold the claim that offspring have certain rights such as to know their genetic origins (Freeman 1996, 291), then the current practice of DC does not accommodate such a right consistently (Frith 2001, 484). Subsequently the freedom of procreation in this context has the potential to adversely affect the rights of donor conceived offspring.

Should the potential for a donor conceived child/person to suffer negative outcomes thereby influence or hinder an adult’s freedom to procreate as they see fit? This paper seeks to address this question within the Australian context by focusing on the child’s outcomes.

**Current Procreative Freedoms**

A broad definition of procreative autonomy as prescribed by Robertson (1983, 406) is the freedom of choice to either bring or not bring a child into the world. Refining this freedom within a DC legal framework may be more accurately described as the ability to produce a child with the assistance of third party(s) that is not prohibited by law. In effect, any person who fulfills the eligibility requirements to receive fertility treatment from a clinic in Australia could be viewed as having the procreative freedom to conceive a child through DC. There are many who are now also conducting DC within their own homes implementing private arrangements however these will not form part of the discussion as these arrangements fall outside of legislation. While there may be some people who are also technically unable to conceive a child through this technique, they are not excluded based on law or regulation. The aforementioned refined definition of procreative freedom of adults in the context of DC will be used for this analysis.

The ability to start a family may unfortunately have little to do with choice but situational circumstances and our biological ability to produce viable gametes, a subsequent embryo and to carry it to
term. Nature does not provide this as an automatic right, rather a biological function that not everyone is capable of. Donor conception is a means to an end, a choice that circumvents infertility. It provides genetic continuity for one partner which is seen as an overriding and important concern for these parents when opting for DC over adoption (Milsom and Bergman 1982, 128; Daniels 2004, 63), and this biological connection to a child is the reason why couples will choose a process such as intracytoplasmic sperm injection (ICSI) over donor insemination (Schower et al. 1996, 2464), even if there is the possibility of a son inheriting his father’s infertility as a result. An over-riding biological and social desire to raise children forces these parents to make decisions about their child that parents are not normally faced with.

Once these parent(s) have decided to utilise DC, they are then faced with more choices and freedoms. Choice of clinics, which state or country to conceive in (reproductive tourism) as each may have differing legislation or regulations, which donor to use (some clinics may implement donor catalogues), whether or not they intend to tell the child of their origins and if so when, and whether or not to tell anyone else about their choices. This would normally fall into a parent’s freedom of choice, however, due to the complexities and profound effects that this can have on the child, do would-be parents ethically or morally have such freedoms?

Before the complexities or potential harms of being donor conceived can be analysed and used as arguments for or against unconstrained procreative freedoms utilising DC, we must establish whether or not a child’s interests can outweigh those of an adult and what framework is to be used for this analysis.

**Child Welfare Paramountcy**

It is proposed that there is a moral and ethical duty of care to ensure that the wellbeing of any child created through assisted reproductive technologies (ART) including donor conception, is of paramount importance. One of the first states to legislate in this field, South Australia (1988, 7), also documented this countenance by stating; “The welfare of any child to be born in consequence of an artificial fertilisation procedure must be treated as of paramount importance, and accepted as a fundamental principle.” This principle has since also been echoed in Victoria (1995, 14) and the NHMRC Guidelines (2004, 9), while Western Australia (1991, 13) requires that the interests and welfare of the child be taken into consideration. The only other state to have legislation in this field, New South Wales (2007, s38), only refers to the
welfare of the child in respect to receiving contact from the donor and in relation to adults who have a genuine interest in the welfare of the child, but not the welfare of the child as a general principle of the Act. It is the intentionality of procreation through an institutionalised and publicly funded medical procedure that instills a higher level of responsibility on all parties involved, whether they are commissioning parents, donors, clinicians, clinics or government. An analogous elevated duty of care is evident in the field of adoption in Australia whereby adoptive parents undergo screening and assessment of their suitability to parent an adoptee because the state has played an active role in the placement of that child. For the aforementioned states and regulating body, this principle of duty of care in DC appears to have found resonance.

While constraints on procreation occurring within natural conception is deemed unethical, to apply the same rationale to a completely artificial construct which incorporates the input of another person (sperm or egg donation) or two other people (embryo donation) could be viewed as unsound. The addition of third parties has the potential to cloud the relationship between the commissioning parents, between these parents and the child, as well as having profound and life-long effects on the offspring. Therefore DC requires a greater duty of care by the states. As the states already have a duty of care to children in general then a supposition could be that donor conceived children would be appropriately cared for by existing legal frameworks and therefore do not require additional consideration. However, the possibility to induce harm (to be discussed later) as a direct result of these procreative freedoms suggest further consideration is required. So how should we analyse the potential harms in light of the child welfare paramountcy principle?

**Applying Neo-Aristotelian Virtue Ethics**

In an analysis of procreative actions, McDougall (2007) uses neo-Aristotelian virtue ethics to create 3 Parental Virtues (3PVs) which can then be used to determine if reproductive choices are right or wrong based on whether a virtuous person/parent would choose them. The neo-Aristotelian virtue ethics concerns itself with virtuous character and the flourishing of the human being. It has already been established that the welfare or flourishing of the child is paramount through either legislation or regulation in Australia and as such McDougall’s 3PV framework is a suitable model for analysis. It should be noted
that the child welfare paramountcy principle and the 3PVs certainly does not preclude the flourishing or interests of parents, just that when there is conflict that the child’s interests should take precedence. The implementation of McDougall’s framework may be more difficult in other jurisdictions around the world where this welfare paramountcy principle is not enshrined.

Briefly McDougall’s 3PVs are:

1) Acceptingness – that the parent will accept the child for whoever or whatever that child is or represents.

2) Committedness – that the parent undertakes the responsibility to actively parent the child and to be there for the child.

3) Future-agent-focus – the principle that the fetus and child will become adults one day and agents of their own free will, such that the parenting and the decisions made in regard to the child should not adversely interfere with the child’s current and future opportunities, but should also be value structured to reinforce virtue and morals.

McDougall’s premise is that this framework should be used to determine whether a virtuous parent would do something and not based on whether the action will harm anyone. It is my postulation that a virtuous parent in the aim of being virtuous would want to know of any potential harm(s) to their child so as to ensure that they make the appropriate decisions in the best interests of their children. This is the duty of care any committed parent undertakes in the day to day care of their child to assess levels of risk and therefore is not confined to reproductive choices. As such the 3PVs can be used for analysis in conjunction with a harms based approach.

**Potential Harms of Being Donor Conceived**

Procreative freedoms implementing DC have the ability to produce outcomes for the child that would not normally be encountered by naturally conceived children. Therefore it is important to assess these outcomes to determine if they are serious enough to warrant a review and or reduction in these freedoms based on the 3PVs. However, given that parents of donor conceived children go to great lengths to have them (Lorbach 2003, Daniels 2004), it could be argued that they have already passed the
committedness test and therefore the potential harms will be weighed up against the remaining 2 Parental Virtues.

i) Deception of their Origins

Current practice centers around identity release donors and encouragement for the recipient couple to tell the offspring about their conception and to tell early (Johnson and Kane 2007, 119). Yet studies (Golombok et al. 2002, 966; Broderick and Walker 2001, 34; Brewaeyys et al. 1997, 1593; Rumball and Adair 1999, 1395; Lycett et al. 2005, 813) reveal that the majority of parents are unwilling to disclose and prefer to keep the secret. Non-disclosure is typically coupled by a belief that the child does not need to know and that keeping the secret protects the child (Murray and Golombok 2003, 93). During the infancy of DC practice, the trend was to use anonymous donation and for recipients not to tell. Irrespective of the period in which they were conceived, the majority will therefore not be aware of their DC status. The freedom for parents to parent as they see fit, which also includes the choice to disclose, is something that governments are extremely disinclined to legislate in. Certainly the Victorian Law Reform Committee (VLRC 2012, 64) in its inquiry into donor conception was reluctant to recommend the forcing of parents to inform their children of their DC status even though the committee felt that such knowledge was in the child’s best interest. Under current practice, most offspring will never seek information about their progenitor because they will be deprived of and shielded from the truth.

Parents who initially decided not to tell may change their mind in the future, disclosing their child’s method of conception (Daniels, Gillett, and Grace 2009, 1102). Parental attitudes towards disclosure over the years has changed considerably with the majority during the 1980s and 1990’s intending not to tell (Leeton and Backwell 1982, 308-309; Milsom and Bergman 1982, 127; Klock, Jacob, and Maier 1994, 481; Durna et al. 1997, 257) while more recent evidence (Godman et al. 2006, 3025; MacDougall et al. 2007, 526; Shehab et al. 2008, 181) has seen a reversal in this view. Intent however, does not always lead to actual disclosure even within families that support truth telling (Blyth and Ryll 2005, 4), and the majority are still not disclosing (Freeman and Golombok 2012, 197). The freedom of the parents in deciding to deceive the offspring about their conception potentially creates a psychologically and socially harmful environment that is ethically unacceptable (Landau 1998, 75), and creates a level of dysfunction in the family (Paul and Berger 2007, 2568). While improvements are being made in the realm of disclosure, at the
ethical and moral heart of the matter, if children are deceived then ‘they are being wrongly treated’ (Warnock 1987, 151).

There is an argument that if the children are deceived of their origins then there will be no harm caused to them, however Cowden (2012, 122) argues that the concept of ‘no harm, no foul’ (a term she uses to describe this), should not apply and that openness facilitates the respect that the offspring deserve. When donor conceived people have been asked whether they believe they should be told the truth of their conception, the majority do feel this way (Jadva et al. 2009, 1914), suggesting that not only should openness be practiced as a matter of principle but that it is how donor conceived people wish to be treated.

The origin of a person is central to who they are. It is the story of their coming into being. If a parent chooses to deceive the child of their origins I postulate that they are not entirely comfortable with the notion that the child is not biologically related to one or both of them and therefore they have not completely accepted the entirety of the child and everything that the child represents. The child may be seen as a reminder of their infertility. This less than full acceptance fails the acceptingness test and perhaps a more simplistic analysis is that we would commonly associate truthfulness and openness as being virtues rather than deception and lies.

ii) **Kinship Separation**

All offspring, irrespective of their knowledge of their conception are being separated from their next of kin on their donor’s side. For some that are aware of their conception this loss has the potential to be traumatic. The National Health and Medical Research Council (NHMRC) which provides the framework for clinic accreditation states that a donor conceived person is entitled to know their genetic parent(s) and stipulates that all clinics must not use donors unless they have consented to the release of identifying information (NHMRC 2004, 25). This stance was reaffirmed by the Australian Senate Legal and Constitutional Affairs Committee (SLCAC) inquiry into DC practices and whom recommended that there be nationally consistent legislation that ensured the right of a donor conceived person to access not only identifying information on their donor but also their donor half-siblings (SLCAC 2011, xi-xii). Clearly the importance of and reverence to biological kinship is being valued at the level of governance.

Additionally, the majority of offspring believe that they should know the identity of their donors (86% Scheib, Riordan, and Rubin 2005, 246; 87% Mahlstedt, Labounty, and Kennedy 2010, 2242; 77%
Jadva et al. 2010, 525) and also the identity of any half-siblings (89% Scheib, Riordan, and Rubin 2005, 246; 78% Jadva et al. 2010, 525). The parity between the desire to know their progenitor and half-siblings exhibits the value that offspring put into all biological connections and not just with their progenitor.

Discussion regarding offspring’s right to genealogy has typically centralised on the donor, rarely considering what is an equally important factor for them; the disassociation from their entire genetic family. The search and desire for biological family is not borne out through poor sociological parent relationships (Mahlstedt, Labounty, and Kennedy 2010, 2243), thereby also highlighting the importance of genetic kinship to the offspring.

If the importance of biological kinship is indeed profound and an intrinsic component of who we are as humans as suggested by the NHMRC and SLCAC, then surely the deprivation of this kinship is a failure to accept the child and the biological kin that make up their “complete” family, the entirety of who they are. However, I argue that this is not necessarily a failure on the parent’s part but rather one that has been forced upon them to a certain degree. As a general rule in Australia, a child will not be able to access identifying information on their donor until they reach 18 years of age, provided they have been informed of their conception and they choose to seek out this information.

For offspring that may eventually know and meet their donor, the knowledge and interactions obtained may not completely erase their trauma. They may still suffer a lingering loss of not sharing a life together, of not having the intimate knowledge of each other that family members do and of still feeling disconnectedness (Walker 2006, 26). This deprivation of interaction with the donor and associated kin (donor family) during a child’s formative years has reduced the ability for that child to form relationships with them that would be analogous to those normally associated with the immediate family. It has in effect reduced the child’s future options and fails the future-agent-focus test.

Complete acceptingness and future agent-focus has been failed but perhaps through no fault of the parent. A parent who wishes to provide their child with knowledge of the donor family is being prevented from doing so through bureaucracy and therefore in effect may still retain this virtue. Unless the model of DC information exchange is altered to allow earlier identification, this harm cannot be appropriately assessed under the 3PVs criteria.

iii) **Loss of Identity**
Loss of kinship can equate to a loss of heritage and is also associated with identity loss (Weigert and Hastings 1977, 1171). Adolescence is a critical time for a person when forming their identity as it is the transition to adulthood and is often highlighted with confusion (Erikson 1968). The absence of one or both biological links clouds this process by removing the mirror that we see of ourselves, in our looks, personality and behavior that is evident in our progenitors and our kin. When approximately 41% of our behavior is inherited (Malouff, Rooke, and Schutte 2008, 155), it is a substantial sized mirror that is missing from these offspring’s lives. The right to an identity is as much about not being deceived as it is about knowing the truth of one’s origins (Freeman 1996, 288).

Discovering and even meeting ones progenitor after the age of 18 is potentially too late to avoid the damage associated with forcibly removing vital components of a person’s identity. These factors contribute to genealogical or genetic bewilderment (Sants 1964), resulting in a person whose own identity and place in the world remains unclear to them, putting them in a perpetual state of identity limbo. The genetic void created by lack of information about a biological parent is not in the best interests of a person psychologically (Cooper and Glazer 1994).

Not only do most offspring feel a strong need to know the identity of their donor but 62% would also like to meet him at least once (Mahlstedt, Labounty, and Kennedy 2010, 2239). Curiosity concerning the donor appears to slightly outweigh the need for identification, with 96.6% of offspring studied by Scheib, Riordan, and Rubin (2005, 246) desiring a picture of their donor and 89.7% wishing to know other non-identifying information such as vocation, marital status and children. This study focused on teenage offspring which is an important factor in considering identity formation in an individual with results suggesting that curiosity about the donor is intrinsically a component of the identity construction process for these teenagers. It could be postulated that the discrepancy between figures of curiosity about the donor and knowledge of their identity is the result of the imprinting onto and conditioning of many offspring under current and previous ideological climates as to having to feel grateful for their existence, to carry an existential debt (described by Rushbrooke 2004, 20; and Rose 2009, 75), and not wanting to interfere with the donor’s life and for fear of hurting the feelings of their raising parents (Lorbach 2003, 160).

One assessment of the identity loss harm is that it runs in parallel with the kinship loss harm. The two harms are linked through the lack of knowledge and interaction with the child’s donor family providing
the same outcome in the analysis against the 3PVs. An alternative approach is that unless the parents willfully force an identity construct on the child but rather let the child’s identity develop freely then they are being accepting of who the child chooses to become and therefore do not restrict the future-agent even though the identity and the paths the child may choose to take may be different if they had access to the donor family.

iv) Late Discovery

A compounding aspect is late discovery whereby offspring that find out in adulthood through open disclosure or extreme circumstances such as arguments, or after the death of a parent, have altered perceptions of identity and family, creating great distrust, confusion, feelings of deceit and possibly anger between themselves and those that withheld the truth from them (McWhinnie 2000, 18; Turner and Coyle 2000, 2044-2045). It has been reported that less damage may occur by telling the child of their conception at an early age (Hewitt 2002, 16; Jadva et al. 2009, 1913), and is encouraged to occur before the identity construct window of adolescence occurs (Kirkman 2003, 2240). The emotional trauma associated with late discovery is similar to that occurring in the adoption community and may remain unresolved for several decades post-disclosure (Riley 2009, 157).

It is clear that some offspring have difficulty assimilating this new found information and dealing with the changed family and identity constructs that they had previously formed. A substantial argument is that if the donor conceived person wasn’t told of their conception then the harm would be avoided, however, this fails to satisfy Cowden and the offspring themselves. Yet dichotomously, disclosure has not only caused harm but reduced the neo-Aristotelian flourishing of the now adult. We can address this dilemma by returning to the remaining 2PVs. As outlined in the deception of origins harm, by not disclosing for a significant portion of the child’s life the parent has failed the acceptingness test even if this failure has been temporary. A similar temporary failure is the future-agent-focus as described in the kinship separation harm.

v) Incomplete Medical Histories

All offspring have incomplete medical histories in some form. Believing that a non-biological parent is in fact their progenitor is disadvantageous in any clinical setting which can result in poor diagnosis. Even when offspring are aware of their conception, an incomplete medical history through either
having no access to a progenitor’s medical history or access to one that is outdated also creates problems
for any consulting physician. This lack of knowledge has serious implications for early diagnosis (Hastrup
1985, 395; Centers for Disease Control and Prevention 2004, 1044) and life-style choices for the offspring.
Reports of how this can adversely affect a person’s health prospects were highlighted in the VLRC inquiry
which showed that in 2011 there were 3 incidences of a donor or DC person unable to pass on medical
information to those directly affected and in one instance a person was diagnosed with a terminal illness
that possibly could have been screened and treated at an earlier stage if a health history was available
(VLRC 2012, 54-55).

Theoretically and evidentially there is a strong case for the provision of medical information to
DC people. This is also mirrored in the majority of DC people desiring to have an updated medical history
of their donor for their own physical health (Hewitt 2002, 17). For those who are unable to obtain medical
information, some are resorting to expensive and in many instances, inconclusive genetic health analysis to
provide some familial health history to enable lifestyle choices to be made (Adams and Lorbach 2012, 715).

In the instances of the previously mentioned harms, some dispute that those are sufficient grounds
for altering the current paradigm. For example an argument is that non-disclosure will not lead to negative
outcomes provided the child never knows about their conception and is raised in a loving home as
previously discussed and also rejected by some. The non-disclosure effect postulation is difficult to
determine empirically from studies of offspring unaware of their conception; the problem of unethical
treatment of study participants who are unaware of why they are being studied. Additionally in the
psychological and emotional wellbeing studies there can be a wide range of outcomes raising doubt. It is
difficult to envisage however, that the deprivation of a medical health history can ever be viewed as
justified in light of current understanding of how genetics can influence our physical wellbeing. Such
deprivation would fail the future-agent-focus test as the child’s ability to flourish and remain in a physically
healthy state can be severely hampered without knowledge of a complete familial health history.
Interestingly while the majority of donors have for some time agreed to the release of medical records
(Robinson et al. 1991, 307-308; Mahlstedt and Probasco 1991, 749), there is yet to be a system put in place
that ensures that these records are updated and that vital information is disseminated to offspring and
recipient parents. Thereby any possibility of maintaining virtuous future-agent-focus becomes compromised over time.

vi) Physical Harms

Robertson describes conception as usually not being harmful in itself and therefore it could be argued that DC should be a procreative freedom if it is not harmful (1983, 463). However Robertson’s argument was written during a period where our medical knowledge of conception was rather limited compared to now.

Pre-eclampsia (hypertension during pregnancy) is a leading cause of fetal and maternal morbidity and mortality (Backes et al. 2011, 1). There is an increased risk of pre-eclampsia occurring in women that have become pregnant with the assistance of donated gametes or embryos (Smith et al. 1997, 457; Salha et al. 1999, 2270). These studies show that there is an underlying immune response to becoming pregnant with an oocyte that is not your own and to being impregnated with sperm that is not your partners as is supported by further evidence whereby further exposure to the same donor sperm reduces the risk of pre-eclampsia as the immune system has become tolerant of the novel antigen (Kyrou et al. 2010, 1126-1127).

Current DC practice involves the use of frozen gametes so that appropriate screening of donors for transmissible diseases and certain genetic conditions can be undertaken. The mere manipulation of sperm in the laboratory introduces DNA fragmentation (Toro et al. 2009, 2110), as does cryopreservation (Zribi et al. 2010, 162), and the thawing process (Gosalvez et al. 2009, 171-172). This sperm DNA fragmentation results in poorer embryo quality, as well as poorer fertilization and pregnancy rates (Simon et al. 2011, 724). In some instances sperm DNA damage can be repaired after fertilization but it can also persist (Yamauchi, Riel, and Ward 2012, 237), suggesting that these changes can be carried on into the resulting embryo or child. As cryopreservation induced DNA damage is primarily mediated by oxidative stress (Thomson et al. 2009, 2069), and that oxidative stress induced damage is linked with childhood cancer and may make male offspring infertile themselves (Aitken and Krausz 2001, 502-504), there is considerable cause for concern.

Large scale DNA damage may result in either non-fertilization or that the embryo will fail to develop properly and therefore not be carried to term (Robinson et al. 2012, 2911). However, given that single base changes in DNA (single nucleotide polymorphisms) can result in increases in the incidence of
outcomes such as autism spectrum disorders and schizophrenia (Kong et al. 2012, 473), the effect that small scale DNA changes can have on the resulting child should not be underestimated. What is apparent is that the physical long-term health effects on people conceived using donated gametes is somewhat unclear and further research needs to be conducted.

What is apparent is that Robertson’s broad procreative freedom is too broad because his assumption that conception usually causes no harm and that the risk is speculative is flawed as the aforementioned potential physical harms occur during the conception processes associated with DC. While outcomes such as pre-eclampsia can be treated, the incidence of pre-eclampsia occurring in the next generation is also increased (Esplin et al. 2001, 869), and the resultant child has an elevated risk of developing cardiovascular disease and diabetes in adulthood (Simmons 2009). The effects of conception can have far reaching and long-term effects with what is now a widely accepted concept known as the fetal origins of adult disease (Barker 1990, 1111).

The potential physical harm outcome is analogous to the incomplete medical history harm and subsequently fails the future-agent-focus test.

vii) Consanguineous Relationships

Australia precludes consanguineous relationships on moral and biological grounds, and is prohibited by the Australian Marriage Act (Commonwealth of Australia 1961, s23). The current ability of donor offspring to know who their siblings and half-siblings are is severely hampered. Not only must they have been informed of their conception status, they must also have access to the identity of their donor’s biological children born via other donations as well as ‘natural’ children. While current practice restricts the number of recipient families for one donor, for those conceived before restrictions were imposed, there was little concern for the possibility of a consanguine event and with records showing the number of donations for some donors exceeding several hundred (Donor Conception Support Group of Australia 2011, 103-104), there is the very real potential for a donor offspring to have numerous siblings. A compounding factor for these children is that they are often born within a relatively short time-frame when compared to normal sibship construction and generally occurs within geographical boundaries. Coupled with a sizable proportion of a person’s behavior and attributes that are inherited, there is a possibility that these offspring could meet through vocational interests. There has been very little achieved apart from a reduction in the
number of families assisted, to prevent consanguinity from occurring even though it was recognised as a concern over 30 years ago (Curie-Cohen, Luttrell, and Shapiro 1979, 589).

Exacerbating the problem is the possibility of genetic sexual attraction (Gonyo 1987, 1; Greenberg 1993, 5-17) whereby kin who have been separated since birth or conception become attracted to each other due to shared similarities, which normally is quashed due to the Westermarck effect (Westermarck 1921) of co-habitation in early childhood. Removing co-habitation as can occur in donor offspring potentially also removes the kin recognition model of the persons involved and their aversion to consanguinity with the other person which is non-conscious and predicated by their cohabitation and not their beliefs (Leiberman, Tooby, and Cosmides 2003, 825). The onus is then forced on the offspring themselves to ask all potential partners of their conception status and to possibly test them genetically to ensure that they are not related, provided that they know of their mode of conception themselves. Emotional and financial burdens of ensuring non-consanguinity is already being carried by donor offspring but is not being addressed by the states or clinics that hold records that can prevent such an event from occurring. Recently the concern has been highlighted by the Federal and Victorian inquiries (SLCAC 2011, 101; VLRC 2012, 111-112).

Knowledge of kinship reduces the total number of possible relationships a person is able to have when consanguinity is entered into the equation even though the reduction in number is insignificant. At first glance this would appear to be counter to one component of the future-agent-focus test which is concerned with not closing certain doors and keeping as many options as possible open. However, the other component of this parental virtue is to ensure that the child develops into a future moral agent with appropriate virtues which would include being law abiding citizens. Balancing these two outcomes would see the virtuous law abiding agent component as having greater weight than would the removal of the small number of relationship options. Hence the possibility to form a consanguineous relationship by not having knowledge of all next-of-kin fails the future-agent-focus test.

**Reconceptualising the Paradigm**

The outcomes outlined earlier are an analysis of possible (as not all children are equally affected) downstream effects of procreative freedoms which should then be used as a framework for discussing how these potential effects might influence policy and paradigm reconceptualisation. As such, means of
accommodating the welfare of the child for each of the potential harms in a pragmatic context will not be discussed as it is outside the scope of this paper.

In addressing the question of whether adults have freedom of choice in DC reproduction, the current situation follows a Robertson procreative freedom although it is somewhat constrained to fit within the refined legalised and practical freedom described earlier. However, if we apply the 3PVs then it is apparent that the current paradigm fails to be ethically virtuous in a neo-Aristotelian way and that the freedom is in fact too free.

Concurrently the parent’s freedom of reproductive choice is also being restricted. They are being denied through the current DC practice bureaucracy of having the procreative freedom, in the neo-Aristotelian virtue ethics sense described by McDougall, to be the virtuous parents that they may choose to be. This is based on the assumption that a virtuous parent would assess the potential harms that could adversely impact on their donor conceived child and make the appropriate decisions and subsequent actions to ameliorate or reduce those possibilities. Therefore the paradigm should be altered so that parents have the ability to make choices such as providing information and access if so desired, and thereby reclaim the autonomy that they are being deprived.

Supporting such a frame-shift also comes from the offspring themselves. Evidence from studies of adult offspring’s perceptions shows that some are distressed with these current procreative choices and that they can be adversely affected physically, mentally and emotionally (Turner and Coyle 2000, 2049-2050; Lorbach 2003, 153-191; McWhinnie 2006, 59-61 Victorian Law Reform Commission 2007, 37). Additionally, what was originally deemed appropriate to fit an adult’s own agenda may not fit with the welfare of the child (McWhinnie 2001, 815). While progress is slow and the welfare of the child is still not being placed as the primary concern, Australia has moved to an identifiable only donor paradigm while elsewhere there is also an increase in the usage of identifiable donors (Greenfeld 2008, 267). This shows a donor conception culture that is in transition (Daniels 2007, 124), reflecting the research findings of donor offspring experiences. Additionally, some offspring are resorting to lobbying for legislative change, paying for DNA tests and forming social support groups to help each other deal with the effects of current and past procreative freedoms (Adams and Lorbach 2012, 710-718).
There are no regulatory or legislative impositions on adults as to when or how they procreate using normal biological means, and provided that they meet eligibility criteria and are able to pay certain costs, there are no restrictions to their access to fertility treatment either. I posit that reproductive choice, constrained by child welfare interests does not significantly diminish this freedom. With appropriate reconceptualisation of the paradigm virtuous parents could still have a family through DC and use appropriate parental decisions to help ameliorate some of the potential harms their children could face, although the possibility of avoiding the unknown physical harms is somewhat more problematic.

Social change however is creating a push for increased reproductive choice and freedoms. Increasing reproductive freedom in these instances is diametrically opposed to an improvement in the conceptualised welfare of the offspring. Somerville (2007, 181) argues that children from reproductive technologies such as DC have been failed by the processes that create them in so much as that many of the possible consequences to the child have been neglected because they are desirable objects and a component of big business. This argument shows how freedom of procreation coupled with deep rooted desires to procreate can be utilised for commercial gain while ignoring the actual product that they create.

When balancing the opposing rights of individuals or parties, ethically we should provide protection to the party that is most vulnerable, which in donor conception it is the child as recognised through various legislation and regulation. In the issue of welfare, the child’s rights must take precedence and override those of the adult’s (Gollancz 2001, 165). While it may be argued that some children are naturally born into scenarios where they may be equally disadvantaged, it does not automatically provide ethical approval of these harms and justification of the children being a means to an end in a state sanctioned manner (Laing and Oderberg 2005, 342-356). Chisholm (2012, 735) describes this means to an end argument as counter to the Kantian principle, the principle of humanity, in which people should never be treated as a means to an end. Privacy concerns and other agendas of the adults involved should be outweighed by the possible negative consequences of withholding such information and it also violates the offspring’s autonomy (McGee et al. 2001, 2035). Such a moral countenance supports reconceptualisation of the donor conception paradigm.

While some legislative efforts have been enacted to cater for the welfare of offspring and their right to a genetic heritage and knowledge of their progenitors, these efforts have been suppressed to cater
for the desires of the infertile (van den Akker 2006, 98). Public funding of fertility treatments imposes a
greater level of responsibility than would otherwise occur due to the community investment and the
intentionality of the process, thereby the duty of care and welfare of the child principles should indeed
restrict freedom of choice in DC reproduction.

It could be argued that no matter how much the paradigm was recomceptualised towards a child
centric model that there will always be some children that will be unhappy or harmed by their method of
conception and that therefore the whole practice of DC should be banned and this procreative
freedom/choice be removed. Such arguments are counterproductive as DC has been in practice for a long
time, has been accepted by a large portion of Australian society, is entrenched as a common fertility
treatment and is enshrined in legislation and regulation as an acceptable procreative freedom. However, due
to the child welfare paramountcy principle, these freedoms do not have to follow the broad Robertson
definition with an anything goes approach but rather there is an intrinsic legal obligation of the states to
ensure that an appropriate paradigm is implemented that acknowledges this freedom but constrains it in the
interests of not only child welfare but also the interests of the parents to allow them to be as virtuous as
possible. As such a child centric model has the potential to improve the outcomes for not only the child but
also the parent.

Conclusion

Acknowledging the harm and consequences that may have occurred and may continue to occur as
a direct result of the implementation of previous and current models of DC is the first step towards
addressing the question of whether adults should have unmitigated freedom of procreation using DC.
Shifting the focus of these models to a child centric paradigm will enable society to ameliorate some of the
potential harms outlined. The child welfare paramountcy principle should be adopted by all jurisdictions
rather than just a few and reproductive freedoms utilising DC must not be absolute but restrained to cater
for this welfare as an intrinsic applied principle. The purpose of this discussion is not to propose a specific
model that will meet the needs of the Donated Generation in an ethical and moralistic manner, but rather to
provide a framework of fields that require investigation and critical debate in the formation of a child
enabling model incorporating the freedoms deprived of these people. It is shown that the 3 Parental Virtues
can possibly be used as a means for conducting this analysis and aid reconceptualisation based on child welfare paramountcy in a neo-Aristotelian manner.

Competing Interests: The author is an advocate of and lobbies for equitable treatment of donor conceived people.

Funding support: Nil
References


and maternal components of the predisposition to preeclampsia. New England Journal of Medicine
344(12): 867-872.


Freeman, T., and S. Golombok. 2012. Donor insemination: a follow-up study of disclosure decisions,
family relationships and child adjustment at adolescence. Reproductive Biomedicine Online 25(2): 193-203.

Bioethics 15(5-6): 473-484.

Godman, K. M., K. Sanders, M. Rosenberg, and P. Burton. 2006. Potential sperm donors', recipients' and
their partners' opinions towards the release of identifying information in Western Australia. Human


Yamauchi, Y., J.M. Riel, and M.A. Ward. 2012. Paternal DNA damage resulting from various sperm treatments persists after fertilization and is similar before and after DNA replication. *Journal of Andrology* 33(2): 229-238.