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Sperm donation: time to look forward, not back

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Sir Colin Campbell, founder chair of the HFEA, his successor, Baroness Deech, and Professor Lord Winston, have now joined the debate on the UK's donor 'crisis'. All three regard the 'crisis' as emanating from the government's 2005 decision to abandon donor anonymity. Sir Colin and Baroness Deech have unequivocally demanded a policy reverse (1, 2), while Lord Winston asserts that 'as a consequence of this legislation, more couples undergoing these treatments state their firm intention to keep the method of conception secret from any child'(3).

To attribute both the shortage of donors and reduced information sharing on the part of parents to government legislation is at odds with the evidence-based philosophy of the fertility industry. At the very least, in the absence of any credible evidence, such assertions are premature(4). Donor shortages are evident globally, including in countries where donor anonymity receives legal 'protection'.

In countries where donor anonymity has been abolished, claims regarding the effects of this change have been more sanguine than in the UK. In Australia, guidelines of the Reproductive Technology Accreditation Committee introduced in January this year required all fertility clinics to cease using anonymous donors. Commenting on the impact of this policy, Martyn Stafford-Bell, the medical director of Canberra Fertility Centre (where the supply of sperm donors had decreased over the previous three years), said 'I would love to blame that for the reduction in donors, but the reality is it has not made much difference' (5). In the Netherlands, donor anonymity was abolished in 2004, although a reduction in the recruitment of anonymous donors had been in evidence since 1990 (6). In Sweden, the reduction in the supply of sperm donors immediately following the abolition of donor anonymity was attributed at least in part by the unwillingness of a significant number of fertility specialists to support the new legislation, who stopped recruiting donors and referred their patients abroad (7).

In the UK, the number of children born as a result of DI peaked in 1994, ten years before the government announced the pending abolition of donor anonymity (8). As far back as 1987, the UK government raised the possibility that, while it then favoured the preservation of donor anonymity, this was not guaranteed in perpetuity (9), although the Human Fertilisation and Embryology Act did provide that any **retroactive** removal of donor anonymity would require fresh primary legislation. During parliamentary passage of the then Human Fertilisation and Embryology Bill during 1990 (10),

and again in 1995 during parliamentary debate on the Children (Scotland) Bill (11), government ministers made explicit first the possibility and, subsequently, the intention, to review the provisions concerning donor anonymity. A failure to anticipate the possibility that the law on anonymity might well change is surprising at the very least. In practice, of UK clinics that ever recruited sperm donors, most stopped doing so well before the change in law in 2005.

The major professional groups representing medical interests in fertility (BFS (12), RCOG (13) and BMA (14)) were opposed to the abolition of donor anonymity on the grounds that this would adversely impact on donor supply. Indeed, once the change in legislation had been implemented, the BFS formally requested a review to enable 'reconsideration' of its preferred option, the so-called 'twin track' approach. The BMA's position was - and remains - of particular interest. While the BMA's Medical Ethics Committee supported the abolition of donor anonymity because 'on balance, the interests of the children born following donation to have access to information about their genetic heritage should take precedence', the Association's Representative Body favoured the retention of donor anonymity because of 'concerns about the effect on the number of donors available and on parents' willingness to inform their children that they were conceived using donated gametes'.

It would be very easy for those who never supported the removal of anonymity in the first place to do nothing and so ensure the realisation of their predictions. However, to do so and allow events to take their course rests uneasily with any claims to have the best interests of patients and children at centre stage. Now is not the time for ill-considered calls to replace principle with expediency, to repeal legislation that demonstrated the government's commitment to the rights and interests of donor-conceived people. As Mark Hamilton of BFS has recently advocated (15), greater efforts need to be put into recruiting identifiable donors. This challenges the Government to renew its support for these efforts and clinics that are genuinely committed to improving services for their patients and their children to learn from those that are succeeding to recruit identifiable donors.

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