Towards a Creative Response to Infertility

Towards a Creative Response to Infertility

A Detailed Response

of the

Irish Catholic Bishops' Conference

to the

Report

of the

Commission on Assisted Human Reproduction

VERITAS

First published 2006 by
Veritas Publications
7/8 Lower Abbey Street
Dublin 1
Ireland
Email publications@veritas.ie
Website www.veritas.ie

ISBN 1 84730 019 7
978 1 84730 019 5 (from January 2007)

A catalogue record for this book is available from the British Library.

Designed by Colette Dower
Printed in the Republic of Ireland by Paceprint, Dublin

Veritas books are printed on paper made from the wood pulp of managed forests. For every tree felled, at least one tree is planted, thereby renewing natural resources.

Introduction

No reasonable person would question the very natural desire of a couple to have a child who flows, as it were, from their own love. One can only imagine the disappointment and even perhaps the sense of failure, which many couples experience when it is not possible for them to have a child. Against that background, assisted human reproduction therapy, in its various forms, must seem like a godsend.

The recommendations of the report of the Commission for Assisted Human Reproduction extend well beyond the issue of infertility and touch on a wide variety of sociological and scientific issues which are, so to speak, consequences of the availability of human gametes and human embryos generated by assisted human reproduction. We will respond in some detail to each of these recommendations. Before doing so we wish, without in any sense minimising the complex emotions involved, to recall a number of key principles which underpin the approach of the Catholic Church, among others, to all these issues.

a. Key Principles

The Catholic Church has a particular vision of human sexuality, which is rooted in the understanding of the human person found in the Scriptures, as well as in the natural law. This document is addressed primarily to those who consider themselves members of the Catholic Church. We are confident, however, that it will also be welcomed by many others who share our faith in the God of Creation. Similarly, there will be many who, although they may not be religious, will share the belief (which traces its roots to the philosophy of ancient Greece) that our human reason enables us to discern a law written in nature itself, which leads us to recognise what is good.

Assisted human reproduction gives rise to a number of issues which have to do with fundamental human rights, issues such as respect for human life, and respect for the family. In exploring questions such as these, the bishops intend to engage in dialogue, not just with members of the Catholic Church, but with Irish society as a whole.

i. The Right to Life and Bodily Integrity

One of the fundamental rights promulgated in the Universal Declaration of Human Rights[1] is the right of every human being to life and bodily integrity. Although the right to life finds a particularly strong foundation in Christian faith, it is a right which is acknowledged by people of all faiths and none. In the final analysis, respect for the right to life is reciprocal in nature. My requirement that my right to life should be respected by others logically implies that I should afford a similar respect to their right to life.

At what point should this respect begin? Biologically speaking, life is a continuum. Genetically speaking, however, and in terms of philosophy, each human life has a beginning, a point at which this distinct individual comes into being. Genetic science has contributed to our awareness that each human being has a unique identity, related to but distinct from either of his/her parents. The obligation to respect life begins at the point when individual human life begins, or even when there is a reasonable possibility that it may have begun.

Once fertilisation has been completed a new human being exists, and this brings with it an obligation of respect. It is clearly in the interests of justice and the common good that this obligation should be reflected in civil law. Recent embryological studies indicate that fertilisation is a process rather than an instantaneous event. The beginning of cell division marks the end of this process. The stage prior to cell division is described as the pronuclear stage. The question has been raised in recent discussions as to whether the same respect should be afforded to the human embryo at the pronuclear stage as is afforded to the embryo at the two-cell stage and later.

The process of the fusion of two gametes involves many minute stages. When the acrosomal filament of the spermatozoon touches the surface of the ovum, and the protective membranes are penetrated,

> the parts of the plasmalemma of the spermatozoon and the egg, outside the zone of contact, fuse together in a continuous sheet. The cytoplasmic contents of the two gametes are now in direct continuity. Although the shape of the spermatozoon may yet be distinguishable, the two gametes have at this stage become one single cell.[2]

---

1 United Nations Organisation, *Universal Declaration of Human Rights*, New York, 1948, 3.
2 B.I. Balinski, *An Introduction to Embryology*, New York: CBS, 1981, 112.

The pronuclear embryo is clearly far more than a sperm cell and an ovum. It has an organic unity and is, as one unit, oriented towards on-going development. It is also, of course, biologically human. It has been possible for some years to successfully freeze the human embryo at the pronuclear stage. It is worth noting, however, that it has proved significantly more difficult to freeze the ovum without destroying it. This simple fact also serves to demonstrate that, by the pronuclear stage, very significant development has already taken place as a result of the fusion of the sperm and the ovum. It has become a single organism and has already begun to develop.

Once fertilisation is complete, the organism has become a human being. There is nothing else it can be. It continues to develop and grow, of course. But all development or change necessarily involves some continuity; something in which the change takes place. This 'something' is the human individual. It has its own genetically unique body. It has its own substantial form, the human soul, which is its first principle of life. It is this principle of life which facilitates and directs the development of the person throughout the lifetime of the organism.[3]

---

3 It will be helpful to deal briefly with some of the arguments put forward by those who suggest that it is not necessary to afford personal rights to the embryo until some weeks after fertilisation.

Totopotentiality of cells: It is not clear until the pregnancy is established which cells will actually become the embryo and which will become the placenta, chorion etc. This is not particularly relevant to the issue of respect. All of the cells are essential to the existence of the embryo at the time. Equally none of the cells which are present in the first few days survive through to birth. Personal identity is not dependent on the survival of individual cells.

Twinning and re-combination: It is argued that, in the early days of pregnancy, the organism may divide and/or re-combine. The organic mechanisms of monozygotic twinning are not fully understood, but there are good indications that they are genetic, and that certain organisms contain the potential for this kind of twinning, *ab initio*. A new human organism, on coming into existence, would have its own substantial form (or soul). The soul is, of course, a metaphysical rather than a physical reality, and is not itself subject to the laws of biology.

The death of any living creature involves the separation of body and soul. It is reasonable to suggest that, on the 'death' of a twin in the very first days after fertilisation, biological material may be absorbed by the remaining organism. The possibility of twinning and re-combination does not change the reality that the early embryo (or zygote) is a living being, generated and growing as a whole. The so-called primitive streak simply marks the latest stage at which monozygotic twinning can take place. If, as suggested above, monozygotic twinning is genetically based, then we have no reason to believe it hasn't begun earlier, simply because we haven't seen it earlier.

In the final analysis, where doubt exists on the level of fact, the integrity of conscience requires that the presumption be in favour of the life. The classical example often cited is as follows: if a hunter hears a rustling noise in the bushes and is unsure whether it is a deer or another human being, he must assume it is a human being, until such time as he can establish that it is not. Similarly, we may accept the argument that there is scientific uncertainty as to the precise moment when an individual human life begins. That uncertainty, however, does not remove the obligation of care and respect for what certainly has the potential to become, *and may already be*, a distinct human individual.

ii. The Right to an Identity of Origin

The *Universal Declaration of Human Rights* acknowledges the right of men and women 'to marry and to found a family'.[4] This is best understood as a right *not to be prevented* from founding a family. It is not an absolute right to have children. As is clear from the same article of the Declaration, the family as 'the fundamental group unit of society' is entitled to protection. This would include protection from any form of reproductive therapy which, however well intentioned, would have the effect of weakening the bonds of family.

Parenthood is not simply a matter of life giving. There is an essential natural link between the life-giving role of parents and their responsibility to care for and educate their young. This ongoing responsibility of parents is not exclusive to the human species, but is found to a greater or lesser degree in very many species of birds and animals. In human nature, however, the period of time between birth and maturity is relatively longer than in any other species. The process of growth to maturity involves far more than mere survival. The human child is dependent on his/her parents for emotional, spiritual, social, and moral formation. Inevitably some elements of the parental role will be delegated to others (e.g. teachers), but the primary responsibility rests with the parents. The only justification for permanently handing this responsibility over to others would be the incapacity of a parent to respond adequately to the needs of the child.

---

4 *Universal Declaration of Human Rights*, 16.

In recent years we have witnessed the phenomenon of a great many adopted people who have wanted to discover who their genetic parents are, and even to establish a relationship of some kind with these parents. This phenomenon should not be seen in any sense as a denial of the goodness and generosity of adoptive parents. It is simply an affirmation of the fact that, as autonomous human individuals, our identity and our self-understanding is, to a significant extent, dependent on our genetic origins.

Why should we assume that this desire to know who one's natural parents are is any less likely to surface in people who are born following the donation of sperm, or ovum, or both. The right to this information, later in life, might well be found to conflict with the practice of guaranteeing anonymity to donors.

Like all fundamental human needs, the need for ongoing parenting, and for a recognisable identity of origin, gives rise to a corresponding right. This right has always been acknowledged by the Church and is expressed in the document *Donum vitae*.

> The child has the right to be conceived, carried in the womb, brought into the world and brought up within marriage: it is through the secure and recognised relationship to his own parents that the child can discover his own identity and achieve his own proper human development.[5]

While the primary consideration must be the good of the individual child, the close connection between genetic parenthood and the responsibility of care is also in the interests of society, and this has long been recognised in our social legislation. A stable family unit, founded on a committed relationship, plays a role of fundamental importance to society. It is in the family first and foremost that children discover their identity and their individuality, that they learn respect for themselves and for others. It is in the family that cultural and moral values are learnt. Any procedure which undermines the unity and integrity of the

---

5 Congregation for the Doctrine of the Faith. *Donum vitae* (*Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation)*, 1, Vatican City: Libreria Editrice Vaticana, 1987.

family also damages the fabric of society, because the institution of the family is the foundation on which society is built.

iii. The Essential Meaning of Human Sexuality

Human sexuality is designed in such a way that the coming together of man and woman *as one flesh* is both an expression of intimacy and self-giving *and* the privileged context in which new life begins. This is not simply a statement of religious belief. It is evident from any realistic reflection on the facts of biology, physiology and human psychology.

It is arguable that the term *reproduction* is not the most appropriate term to describe what happens when a new human being comes into existence. The concept of *reproduction* captures well enough the biological dimension of human generation, but it is not really capable of expressing the mystery of how man and woman, through their own human loving, cooperate with the creative action of God. An alternative term, which may better express this personalistic dimension of human life giving, is *procreation*.

Technology has an important contribution to make to almost every area of modern medicine, including the treatment of infertility. There is a valid distinction to be made, however, between situations in which technology plays a supporting role and situations in which technology becomes dominant. In every area of healthcare, people express their frustration and discomfort when they experience the intrusiveness of technology.

This is no less the case where the treatment of infertility is concerned. The more dominant technology becomes, the more the personalistic dimension of human sexuality tends to be separated from the act of life giving and the more easily the creative act of God is obscured. We have to ask ourselves whether a procedure which is completely controlled, which tends towards predictability and which may also be highly selective is a true expression of what human life giving is about. Is the intrusiveness of technology too high a price to pay?

Parents are naturally proud of their children, anxious about their children and sometimes disappointed in their children. In the final analysis, however, children are not *for* their parents. Their value is in themselves and in their vocation as the sons and daughters of God who

created them. There is a risk, in all our relationships, that we seek to possess the one we love. It is arguable that this risk is increased when technology becomes dominant, because the child who is born has been carefully planned, with the outlay of considerable emotional energy and economic resources. What if the end result doesn't measure up to our hopes and expectations?

The desire for success, both professionally and on a human level, means that doctors and scientists are also liable to disappointment, although in a different way. Once they have the possibility and the opportunity to intervene in human reproduction, there follows a natural desire to improve things. In all of this, the child who is born as a result of technological intervention is no less worthy of love or respect than any other child. Nonetheless, technology, often unawares, introduces into the act of life-giving elements which do not sit well with the dignity of the human person.

iv. Conscience

In the matter of assisted human reproduction, as in all other matters, each individual must make and be guided by a judgement of conscience. *Conscience* is sometimes taken to mean *personal opinion*, as opposed to an official institutional position. Properly understood, however, conscience is a judgement:

- made about a particular situation
- against the background of one's own value system or vision of life
- based on the best available knowledge of the facts.

The capacity to know good from evil (or right from wrong) is a natural quality with which all normally developed human beings are endowed. It does not depend specifically on religious belief. The making of a judgement of conscience does, however, presuppose some coherent set of values or vision of life. In the case of a believer, religious faith will be an important element in that vision of life.

In so far as the quality of a judgement of conscience depends on the level of information available, healthcare professionals have an obligation, as part of their professional responsibility, to ensure that patients are fully informed, in terms which they are capable of

understanding. Couples whose infertility is treated by IVF are primarily concerned with having a child. To that extent at least, it can be said that their set of values is oriented in favour of life. It is important that couples who are candidates for treatment be fully informed by the providers of the service as to the implications and consequences of IVF, both for the embryo and for themselves. It is only in the light of such information that a fully free decision can be made about the treatment being proposed.

While law is one of the elements which influences the judgement of conscience of individual members of society, it is not the ultimate determinant of conscience. Its purpose is to ensure that the fundamental rights of some are not infringed upon by the decisions of others. The right to freedom of conscience is a fundamental human right, and is not restricted to private individuals. Healthcare professionals, legislators and others who serve the public have both a right and a duty to act in accordance with the judgement of conscience. This judgement is rooted in truth, not in expediency or in the dynamic of supply and demand.

b. What the Church asks of the Civil Authority

The Church addresses its teaching, in the first instance, to her own members. She calls on those who are committed to following Christ to respond to issues of fertility and infertility, and indeed to a whole range of other human challenges, in a manner which is consistent with the gospel.

The Church does not ask or expect the civil authority to legislate in accordance with her teaching, but hopes that legislators and all those who have an influence in the formation of public policy will recognise that the common good, which is their specific responsibility, can only be achieved when the rights of every human individual and the rights of the family are fully respected.

The keynote Vatican document, *Donum vitae*, (*On Respect for Human Life in its Origins*), makes the Church's case to legislators as follows:

> The inviolable right to life of every innocent human individual and the rights of the family and of the institution of marriage constitute fundamental moral values, because they concern the

natural condition and integral vocation of the human person; at the same time they are constitutive elements of civil society and its order. For this reason the new technological possibilities which have opened up in the field of biomedicine require the intervention of the political authorities and of the legislator, since an uncontrolled application of such techniques could lead to unforeseeable and damaging consequences for civil society.

The inalienable rights of the person must be recognized and respected by civil society and the political authority. These human rights depend neither on single individuals nor on parents; nor do they represent a concession made by society and the State: they pertain to human nature and are inherent in the person by virtue of the creative act from which the person took his or her origin. Among such fundamental rights one should mention in this regard:

a. every human being's right to life and physical integrity from the moment of conception until death;
b. the rights of the family and of marriage as an institution and, in this area, the child's right to be conceived, brought into the world and brought up by his parents.[6]

We believe that there is indeed a need for legislation to control the technology of assisted human reproduction. We are no less certain that any new legislation which would permit these fundamental rights to be eroded would ultimately be contributing to a serious decline in the standards of justice and equity in every aspect of our civil society.

6 Ibid., Ch. 3.

The Report of the Commission on Assisted Human Reproduction

a. A Detailed Response to the Specific Recommendations[7]

1. The CAHR recommends that: A regulatory body should be established by an Act of the Oireachtas to regulate AHR services in Ireland.

   Our response: We would have no objection in principle to the establishment of a body to oversee the implementation of the law in respect of AHR. We believe, however, that the Oireachtas alone has the authority and responsibility to make law and, especially in matters which concern respect for fundamental rights, this authority and responsibility cannot be devolved to any other agency.

2. The CAHR recommends: National statistics on the outcome of AHR techniques in Ireland should be compiled and made available to the public.

   Our response: Accurate information is always useful. We would point out, however, that positive outcomes alone would not establish the goodness of an AHR technique.

   If statistics are to be compiled, they should include – for purposes of comparison and indeed objectivity – statistics on all the available methods of dealing with infertility, including approaches such as Napro technology (see Appendix 2).

   In the final analysis, the best response to infertility is prevention. For this reason, we would also recommend that statistics should be compiled which indicate the proportion of cases of infertility in which there is evidence of present or previously treated sexually transmitted disease, previous use of chemical contraceptives and IUCDs or previous abortion.

3. The CAHR recommends: Longitudinal studies of children born as a result of AHR should be established, in accordance with standard

---

7 The CAHR has used an asterisk (*) to denote those recommendations which were not unanimous.

ethical/legal requirements and with the consent of families, in order to facilitate long-term monitoring.
Our response: We accept that this makes good sense from a scientific point of view. We would be concerned, however, that such longitudinal studies should not contribute to making such children feel that they are, in some sense, different or indeed inferior in some way.

4. The CAHR recommends: Appropriate guidelines should be put in place to govern the freezing and storage of gametes and the use of frozen gametes. The regulatory body should, in accordance with statutory guidelines, have power to address cases where gametes are abandoned, where the commissioning couple cannot agree on a course of action, where couples separate or where one or both partner(s) dies or becomes incapacitated.
Our response: Gametes are not human beings and, while there are certainly moral questions related to their being harvested outside the context of natural intercourse, there is no particular reason why they should not be frozen once they have been harvested in this way. If there is evidence that the subsequent use of frozen gametes in AHR procedures increases the likelihood of abnormalities in the embryo, then we believe they should not be used for AHR. We believe that respect for the family and for the meaning of parenthood also requires that gametes which will not be used to achieve a pregnancy by the couple from whom they have been harvested should be destroyed.

5. The CAHR recommends: Superovulation should be allowed according to well-established clinical protocols. Appropriate guidelines should be put in place by the regulatory body to govern superovulation and the harvesting of ova following ovarian stimulation.
Our response: We recognise that a common cause of infertility in women is a disorder of ovulation. Where non-ovulation is at the root of infertility, drug therapy is provided, using clomiphene citrate or preparations of gonadotrophin, which stimulates the ovaries, and the woman may achieve pregnancy without any further medical

intervention. The use of clomiphene or gonadotrophin preparations assists rather than replaces the natural reproductive function. Dr Hilgers comments that most of the drugs currently available have limitations as well as advantages.[8] Clomiphene citrate, for example, although it induces ovulation, tends to inhibit cervical mucus. Medications such as Pergonal and Metrodin, which are used to stimulate ovulation, are associated with high multiple births. Where ovulation stimulation is being used, it is recommended that monitoring be carried out, to prevent hyperstimulation of the ovaries, which may lead to serious complications.

Any ethical evaluation of drug therapy must take into account the likely effect of the treatment on the woman. One concern we would have, given the emotions associated with infertility and the desire for a child, would be that couples who had previously had IVF treatment without success might persist with further attempts including the associate superovulation and that the health of the woman might be compromised.

Over and above this, the other ethical concern associated with superovulation is that it tends to be associated with the generation and subsequent storage of human embryos. Quite frequently these embryos are subsequently designated as 'surplus' embryos, a designation which is then used to justify their donation to other couples, their use for research or ultimately their disposal.

6. The CAHR recommends: Service providers should facilitate users who wish to avoid any treatment that might result in the production of 'surplus' embryos.

   Our response: We agree absolutely with this recommendation. In our view, many of the ethical difficulties which arise in assisted human reproduction result from the decision to produce so-called 'surplus' embryos. We have some reservations about the terminology here. While some embryos may be *surplus* to the requirements of the couple, we don't believe that any human embryo can really be considered as *surplus* because each embryo is primarily for itself and not for anyone else.

---

8 cf. Thomas W. Hilgers, *Medical Applications of Natural Family Planning*, Omaha: Pope Paul VI Institute Press, 1991, X1, 143.

7. The CAHR recommends: Appropriate guidelines should be put in place by the regulatory body to govern the fertilisation of ova.
Our response: It is not clear what this recommendation actually means. In the first place, it is not clear whether this recommendation refers to the fertilisation of ova *in vitro* or whether it also includes intra uterine insemination. We assume that it doesn't refer to the fertilisation of ova in the course of the natural procreative process. Will the guidelines refer to the professional qualifications of those who will fertilise the ova, or the condition of the ova themselves, or the procedures and technical standards to be observed?

8. The CAHR recommends: Appropriate guidelines should be put in place by the regulatory body to govern the number of embryos to be transferred in any one treatment cycle and when to transfer embryos.
Our response: We recognise that the transfer of more than three embryos in one treatment cycle poses an obstetric risk to the mother and that the preferred option seems to be to use two embryos. Clearly the health of the adult patient is more important than the achievement of a pregnancy and any imprudent obstetric risk should be avoided. Any practice which involves the deliberate destruction of a human embryo is, however, morally unacceptable and, in our view, constitutes medical malpractice. This includes the so-called 'reduction' in the number of pregnancies or the destruction of so-called 'surplus' human embryos. We also note that, while multiple transfers (within reason) increase the chances of achieving a pregnancy, they tend to reduce the survival rate of the individual embryo.

9. The CAHR recommends: Appropriate guidelines should be put in place by the regulatory body to govern the freezing of excess healthy embryos.
Our response: As already indicated above, we do not believe that embryos should be produced in excess of the number that can safely be transferred in one treatment cycle. We do not believe that frozen storage is consistent with the dignity of a human embryo. It

is too early yet to know for certain what long-term impact freezing may have on the physical (or even psychological) well-being of an embryo which is subsequently implanted in the womb and born. Freezing may well be considered preferable to the wanton destruction of embryos which might otherwise take place and, in so far as the freezing of embryos is allowed by law, it must certainly be regulated.

10. The CAHR recommends: *Appropriate guidelines should be put in place by the regulatory body to govern the options available for excess frozen embryos. These would include voluntary donation of excess healthy embryos to other recipients, voluntary donation for research or allowing them to perish.
Our response: As already indicated above, we do not believe that embryos should be produced in excess of the number that can safely be transferred in one treatment cycle. Serious ethical problems are associated with each of the three options proposed.

    - ***Use for research***: Biomedical research is an essential element of healthcare and contributes to the saving of human lives on a daily basis. In the normal course of events, research involving human subjects is classified under two headings, therapeutic (i.e. that which offers the prospect of benefit to the subject) and non-therapeutic (i.e. that which holds no prospect of benefit to the subject). In cases where research is therapeutic, and the patient is unable to give consent, this consent may be given by his/her legal guardian. In the case of non-therapeutic research, however, the person who is the subject of the research must be a volunteer.[9] A human embryo, by definition, is incapable of giving consent.

      The right to conduct research is not an absolute right. Irrespective of what positive law may decide, human embryos – as genetically distinct individuals of the human species – have natural rights which cannot be ignored. The end does

---

9 cf. *Declaration of Helsinki*, revised 1975 (Introduction; I.11; and III.2).

not justify the means. The goodness of research is vitiated when, as a necessary pre-condition, it requires the destruction of human embryos.

- ***Allowing embryos to perish***: Parenthood brings with it a responsibility of care. In the normal course of events, we would always recommend that the implications of this responsibility should be considered carefully *before* people become parents. In the case of assisted reproductive therapy, fertilisation takes place in a laboratory rather than in the mother's body. This distancing of the embryo from its parents does not, however, justify any abdication of the responsibility of care. The parents and, together with them, the 'quasi-parents' (those who assist them in the process) have no less an obligation to care for the embryo and to provide it with every possible opportunity of developing normally and coming to birth. To suggest that the embryos are 'surplus' is disingenuous if we have been responsible for the process which made them 'surplus' in the first place.

- ***Donation to other recipients***: In many jurisdictions, subsequent to IVF or ICSI, it is common practice for 'surplus' embryos to be used, with the consent of the natural parents, to provide children for other infertile couples. It must be said at the outset that to allow 'surplus' embryos to survive in this way is infinitely preferable to disposing of them or making use of them as objects of research. This is not to say, however, that there are no ethical implications involved.

  The practice of placing an embryo or embryos in the uterus of a woman who is not the natural mother and in the care of parents who are not the natural parents does separate parenthood from the responsibility of care. It creates a whole new complex relationship in which family is redefined to include two sets of parents. This inevitably gives scope for some confusion about the identity of the child who will be born.

Parents may, of course, die or separate. Children may be born to and brought up by single mothers. They may be adopted. None of these circumstances lessens in any way the dignity of the child. There is a fundamental difference, however, between responding constructively and lovingly to a child who already exists (in or out of the womb) and deliberately creating a situation in which a child's sense of identity and family membership is blurred. What is significant, once again, is the initial decision to generate 'surplus' embryos, a decision which is taken in isolation from any coherent plan for the future personal care of the human individuals concerned.

11. The CAHR recommends: The regulatory body should, in accordance with statutory guidelines, have power to address cases where embryos are abandoned, where the commissioning couple cannot agree on a course of action, where the couple separates or where one or both partner(s) dies or becomes incapacitated.
Our response: Once again, this recommendation presumes the production of embryos which are not transferred in the same treatment cycle. Clearly, in circumstances such as those which are described, somebody must be authorised to decide on the course of action to be followed and must be held legally accountable for such decisions. We believe that such decisions cannot be merely pragmatic or prudential, but that they must be informed by objective moral principles. The decisions and actions of any such regulatory body must be accountable to the legislature and fully open to public scrutiny.

12. The CAHR recommends: Counselling should be provided before, during and after treatment to those considering AHR treatment so that they are adequately informed of the risks involved, the potential benefits that may be obtained and the possibility of success in their particular situation. Suitably qualified professionals should adequately convey the complex medical and scientific ramifications of different treatment approaches in verbal and written form.
Our response: We recognise the contribution which counselling can make to couples considering having a child and indeed to

individuals who consider making any serious decision. The purpose of counselling, as we see it, is to facilitate people in making a decision which is truly free. We believe that such freedom goes hand in hand with truth. For that reason we see no value in any form of education or counselling which embraces feelings but excludes the essential facts about the nature of the human embryo.

13. The CAHR recommends: It should be obligatory for all recognised providers of AHR services in Ireland to obtain written informed consent for all the services they provide. Each stage of the AHR process should be covered by comprehensive consent procedures. A set of guidelines should be drawn up setting out the specific types of consent that need to be obtained and it should be obligatory for all service providers to observe the terms of these guidelines.
Our response: We agree that written informed consent should be obtained for all procedures. In keeping with good practice generally, participants would normally also be free to revoke their consent. In the case of assisted human reproduction, however, a difficulty arises in that, if a couple (or indeed one party) withdraws consent for embryo transfer when fertilisation has already taken place, this withdrawal of consent can have serious and perhaps even fatal implications for another human being. This scenario is by no means unknown in other jurisdictions. We are not, of course, suggesting that a woman should be obliged or forced against her will to accept an embryo in her womb. We simply wish to point out, once again, that the decision to generate embryos outside the womb, or to place them in storage, makes them particularly vulnerable to the attitudes and the agenda of adults.

14. The CAHR recommends: Best practice infertility treatment guidelines should be developed for general practitioners and gynaecologists working outside specialist clinics. These guidelines should be reviewed on a regular basis.
Our response: Best practice guidelines should be in place wherever healthcare professionals work. It is our view that the regulatory bodies of the healthcare professions are best placed to develop

these guidelines, the implementation of which would then be subject to public scrutiny.

15. The CAHR recommends: Centres that collect and store gametes and that generate and store embryos should be regulated and licensed by the regulatory body. The regulatory body should lay down quality assurance standards for such centres. Information on the range of services provided by the specialist clinics should be available to the general public.
Our response: While not wishing in any sense to convey approval for the storage of human embryos, we do accept that any agency which is involved in the collection or storage of gametes or human embryos should be well regulated and closely monitored. It is not clear what 'quality assurance standards' means in this context. If it includes the suggestion that embryos should be subject to quality control and that those which fall short of certain standards should be disposed of or used for research, we would certainly be opposed to that.

16. The CAHR recommends: *The embryo formed by IVF should not attract legal protection until placed in the human body, at which stage it should attract the same level of protection as the embryo formed *in vivo*.
Our response: As we stated quite categorically in our initial response to the report of the CAHR, this recommendation is totally unacceptable to us. No commission report can change the reality that the right to life belongs to all, irrespective of race, sex, religion or age.
This is not simply a matter of Catholic teaching. It concerns the common good of our society. While it is a responsibility in which all citizens have a share, it is the specific responsibility of government, one which cannot be delegated to any other agency or commission. The common good is not simply the good of the State or the good of the majority; it must take into account the good of all, collectively and individually, including human embryos.
Advances in genetics and embryology serve to confirm that every human embryo is an individual human being. There is certainly no

scientific or philosophical basis for distinguishing between an embryo in the womb and one in a glass dish or in frozen storage. The recommendation of the Commission that 'the embryo formed by IVF should not attract legal protection until placed in the human body' appears, therefore, to have a purely utilitarian and pragmatic motivation, namely to ensure that embryos are available for research and to allow for the selective disposal of those embryos which do not measure up to certain standards. The notion that 'the end justifies the means', if accepted in principle, has implications which extend far beyond the issue of assisted human reproduction.

17. The CAHR recommends: Services should be available without discrimination on the grounds of gender, marital status or sexual orientation subject to consideration of the best interests of any children that may be born. Any relevant legislation on the provision of AHR services should reflect the general principles of the Equal Status Acts 2000–4 subject to the qualifications set out in section 4.8.

Our response: As we stated in our original submission to the Commission, the nature of human sexuality is such that it is the norm for a child to be born into a family where he/she has a mother and father who are in a stable relationship with one another and who are in a position to offer a stable environment in which the child can grow and mature. This is why marriage is so fundamental to the well-being of children and of society. It is not possible to guarantee absolutely the stability or permanence of any human relationship. In so far as it relates to the transmission of human life, however, we would have a serious moral concern that this stability should not, by default, come to be regarded as being in any sense optional. Any legislation to provide for Assisted Reproductive Therapy (ART) should recognise and protect the right of every child to be born to a mother and father who are permanently committed to one another.

We have no difficulty whatsoever with the concept of equal status in the sense that all human beings are equal in dignity. We would point out, however, that all human beings are not the same. Men and women, by virtue of their difference of sex, have different roles

and responsibilities where reproduction and parenthood are concerned. We would also argue that the argument for equal status will be more credible if fundamental human rights are extended to the human embryo, notwithstanding its small size and early stage of development.

18. The CAHR recommends: Where there is objective evidence of a risk of harm to any child that may be conceived through AHR, there should be a presumption against treatment.
Our response: We agree. We find it curious and illogical, however, that the concerns of the Commission do not extend to the risk of harm to the embryo, that vulnerable human being who, as a result of AHR may be used for research or allowed to perish.

19. The CAHR recommends: Donation of sperm, ova and embryos should be permitted and should be subject to regulation by the regulatory body.
Our response: This matter has been substantially addressed under the heading of CAHR Recommendation 10 (above). In so far as donation of sperm, ova and embryos is permitted it should be regulated by law in accordance with the common good.
We believe, however, that the donation of embryos and gametes is inconsistent with respect for the family and the identity of origin of the child. It fundamentally changes the meaning of parenthood by separating life giving from the responsibility of care. It also raises serious questions about the 'identity' of the child and his/her access to information about that identity.
In recent years we have witnessed the phenomenon of a great many adopted people who have wanted to discover who their genetic parents are and even to establish a relationship of some kind with these parents. This phenomenon should not be seen in any sense as a denial of the goodness and generosity of adoptive parents. It is simply an affirmation of the fact that, as autonomous human individuals, our identity and our self-understanding is, to a significant extent, dependent on our genetic origins.
We cannot assume that this desire to know who one's natural parents are is any less likely to surface in people who are born

following the donation of sperm, or ovum, or both. We note that a right to this information, later in life, might well be found to conflict with the current practice of guaranteeing anonymity to donors.

20. The CAHR recommends: Suitably qualified professionals should provide appropriate counselling in advance to all donors of gametes and embryos. Such counselling should be a pre-condition for informed consent by donors.
Our response: Taking account of our response to CAHR Recommendations 10 and 19 (above) we believe that ambivalence or uncertainty on the part of donors can only give rise to problems for any children who are born arising out of donation. We agree that donation should certainly not take place in the absence of fully informed consent.

21. The CAHR recommends: Appropriate guidelines should be put in place to govern the selection of donors; to screen for genetic disorders and infectious disease; to set age limits for donors and to set an appropriate limit on the number of children to be born by the use of sperm or ova from a single donor.
Our response: In so far as donation of sperm, ova and embryos is permitted this recommendation makes practical common sense. A good deal hangs on the interpretation of the word 'appropriate'. It would be inappropriate if guidelines or limits were to become a vehicle for eugenics or social engineering.

22. The CAHR recommends: Any child born through use of donated gametes or embryos should, on maturity, be able to identify the donor(s) involved in his/her conception.
Our response: We agree in principle. We recognise, however, that this natural right of children is not without implications for the husbands/wives and other children of donors, especially in cases where it has not been previously discussed. We refer to our earlier comments and to our belief that children should be born into a family in which the social parents are also the genetic parents.

23. The CAHR recommends: Donors should not be paid nor should recipients be charged for donations *per se*. This does not preclude payment of reasonable expenses and payment for AHR services.
Our response: We agree.

24. The CAHR recommends: In donor programmes, the intent of all parties involved – that the donor will not have any legal relationship with the child and that the woman who gives birth to the child will be the child's mother – should be used as the basis for the assignment of legal parentage.
Our response: This recommendation would appear to assume that it is the intent of all parties 'that the donor will not have any legal relationship with the child and that the woman who gives birth to the child will be the child's mother'. This would appear to be a reasonable assumption, but it may not always be the case.
We accept that the law must, for the sake of the child, recognise certain individuals as having parental rights and responsibilities. When genetic parents abdicate these rights and responsibilities the law must make appropriate provision in the best interests of the children.
We would point out that there is a fundamental difference between a situation in which children are adopted or taken into care in circumstances in which the natural parents are unable to provide adequately for their needs and donation when individuals choose to become the natural parents of children for whom they will have no further responsibility.

25. The CAHR recommends: In cases involving sperm donation, there should be a requirement that the partner, if any, of the sperm recipient also give a legal commitment to be recognised as the child's parent.
Our response: While this recommendation does not resolve our concerns about donation *per se*, it does make practical common sense. The alternative would place the child at a disadvantage within the family home and would probably undermine the stability of the partnership between the recipient and her partner.

26. The CAHR recommends: In the case of a child born through ovum donation and in the case of a child resulting from an embryo donation, the gestational mother should be recognised as the legal mother of the child and her partner, if any, should be recognised as the child's second legal parent.
Our response: While this recommendation does not resolve our concerns about donation *per se*, it does make practical common sense. Any alternative would place the child at a disadvantage within the family home.

27. The CAHR recommends: Donors should not be able to access the identity of children born through use of their gametes or embryos.
Our response: While this recommendation does not resolve our concerns about donation *per se*, it does make practical common sense. Any future contact between the child and his/her natural parents should be at the initiative of the child, having reached the age of majority.

28. The CAHR recommends: Donors should, if they wish, be told if a child is born through use of their gametes.
Our response: We agree. We are of the view that any other children of a donor also have the right at least to be made aware, when they reach an appropriate age, that they have other siblings. Among the reasons for this are the genetic implications of inter-marriage between close relations.

29. The CAHR recommends: In general, donors should not be permitted to attach conditions to donation, except in situations of intra-familial donation or the use of donated gametes/embryos for research.
Our response: Once people donate embryos or gametes, they have abdicated their parental responsibilities. It would seem inappropriate that they should at the same time retain parental rights.
In so far as this recommendation refers to the use of embryos for research, we wish to refer at this point to our response to CAHR Recommendation 34 below.

30. The CAHR recommends: *Surrogacy should be permitted and should be subject to regulation by the regulatory body.
Our response: Surrogacy compounds the ethical difficulties associated with assisted human reproduction. We note that, in Recommendation 26 the Commission proposes that, in the case of ovum donation 'the gestational mother should be recognised as the legal mother of the child and her partner, if any, should be recognised as the child's second legal parent'. In this case, presumably, the opposite would be the case, and the gestational mother, contrary to common perception, would not be recognised as the legal mother of the child. The net effect of these recommendations is to suggest that children are property, the control and ownership of which can be agreed between adults, in a manner approved by law. We argue, on the contrary, that children are persons in their own right, whose primary purpose is not the fulfilment of their parents.

31. The CAHR recommends: Women who decide to participate as surrogate mothers should be entitled to receive reimbursement of expenses directly related to such participation.
Our response: Taking account of our response to CAHR Recommendation 30 (above), we have nothing further to add under this heading.

32. The CAHR recommends: The child born through surrogacy, on reaching maturity, should be entitled to access the identity of the surrogate mother and, where relevant, the genetic parents.
Our response: We agree.

33. The CAHR recommends: *The child born through surrogacy should be presumed to be that of the commissioning couple.
Our response: Taking account of our response to CAHR Recommendation 30 (above), we have nothing further to add under this heading.

34. The CAHR recommends: *Embryo research, including embryonic stem-cell research, for specific purposes only and under stringently

controlled conditions, should be permitted on 'surplus' embryos that are donated specifically for research. This should be permitted up to fourteen days following fertilisation. The regulatory body should stipulate under what conditions and for what purposes embryo research is permitted. Those donating embryos for research must receive pre-donation information and counselling and they must give informed consent for the use of donated embryos for research. No inducement, financial or otherwise, should be offered/accepted for the donation of embryos for research. Once embryos are used for research their subsequent use for reproductive purposes should be prohibited. The generation of embryos through IVF specifically for research purposes should be prohibited.

Our response: It is frequently suggested that destructive research on human embryos can be justified by the prospect of developing new responses to infertility or to the causes of genetic abnormality, or the possibility through stem-cell research of developing new treatments for a wide variety of diseases.

While we certainly welcome the proposal to prohibit the generation of embryos through IVF specifically for research purposes, we find the recommendation as a whole to be quite illogical. We would point out that either embryos are entitled to have their right to life respected, in which case this recommendation is appalling, or they are not so entitled, in which case there is no reason for the restrictions. The illogicality of the recommendation is a result of the Commission's never having faced up to the fundamental question of the status of the embryo.

The value of an embryo is not dependent on why it was generated, on the purpose which we assign to it or on how we feel about it. As we stated in our submission to the CAHR, a human embryo is the new organism which comes into existence at fertilisation. This organism is not simply a collection of cells, but a genetically distinct human individual 'which is oriented towards further development'.[10] Its value derives from its nature. The fact that some embryos are already in storage and may otherwise be destroyed

---

10 Australian Senate Select Committee, *Human Embryo Experimentation in Australia*, 1986, 3.4 to 3.8.

does not in any way lessen their intrinsic value. The problem begins, as we have stated above, with the decision to generate more embryos than can be safely transferred in one treatment cycle.

In addition we wish to point out that, in the normal course of events, research involving human subjects is classified under two headings, therapeutic (i.e. that which offers the prospect of benefit to the subject) and non-therapeutic (i.e. that which holds no prospect of benefit to the subject). In cases where research is therapeutic and the patient is unable to give consent, this consent may be given by his/her legal guardian. In the case of non-therapeutic research, however, the person who is the subject of the research must be a volunteer.[11] A human embryo, by definition, is incapable of giving consent.

We wish to reiterate in the strongest possible terms our belief that the human embryo must be regarded as a subject and not an object. It is an end in itself and not a means to an end. Embryos ought not to be used as raw material for research, however beneficial that research may appear to be. The fundamental issue at stake is that of respect for human life.

35. The CAHR recommends: Human reproductive cloning should be prohibited.

Our response: Human cloning is the laboratory production of a genetic copy of another human being. We believe that *all* human cloning should be prohibited.

While this recommendation of the CAHR is framed as a prohibition of 'reproductive' cloning, it is clearly intended to allow for so called 'therapeutic cloning'. We wish to point out that human cloning, irrespective of its ultimate purpose, would always be reproductive in that the immediate result of cloning would be the generation of a human embryo. Any distinction between 'therapeutic' and 'reproductive' cloning is purely spurious.

Cloning is most frequently associated with the provision of human embryos for research. Stem cells, which are very versatile, are taken

---

11 cf. *Declaration of Helsinki*, revised 1975 (Introduction; I.11; III.2).

from the embryo in the hope that they can be used to treat people suffering from a range of conditions such as Alzheimer's or Parkinson's Disease. In this context, cloning is generally referred to as therapeutic cloning. It is clearly not therapeutic in the sense understood by the Declaration of Helsinki, because any therapeutic outcome is for the benefit of the other person involved; and the embryo is inevitably destroyed in the process. The possibility of achieving a good outcome for another person does not justify treating the embryo as a means to an end rather than as a human subject.

We are also concerned that discussion surrounding the issue of human cloning has not kept up with developments in medical research. Stem cells reside in human bone marrow, which has a long history in the successful treatment of leukaemia, and also in umbilical chord blood. It is now widely recognised that these 'adult' stem cells have an advantage over embryonic stem cells in the healing process since they are destined to this purpose. Embryonic stem cells, by contrast, are destined to divide until a whole new organism is created and their versatility, often hailed as an advantage, can also lead to unpredictable outcomes.

The use of human bone marrow is tried and tested; it is known to be safe. In addition, the taking of a bone marrow sample is much easier than extracting stem cells from embryonic tissue. The procedure involving bone marrow can be taken out of the laboratory and into clinical trials immediately, which is not the case for embryonic stem cells. Bone marrow cells have been re-injected into people who have suffered damage to heart muscle, and have been shown to bring about a significant improvement. A further advantage in using a person's own bone marrow stem cells is that there is no risk of rejection.

Research and subsequent treatment involving stem cells from bone marrow can be carried out without the destructive consequences entailed by embryo research and the extraction of stem cells from embryos.[12]

---

12 cf. Linacre Centre, *Cloning and Stem-Cell Research*, a submission to the House of Lords Select Committee on Stem-Cell Research, June 2001.

We repeat here the recommendation which we made to the government in December 2003 that Ireland should take a lead in advocating that the EU should give significant research funding to adult stem-cell research, which is very promising and which carries with it none of the ethical difficulties associated with research involving human embryos.

36. The CAHR recommends: *Regenerative medicine should be permitted under regulation.
Our response: The report of the CAHR (page VIII) specifically identifies regenerative medicine with therapeutic cloning and goes on to say that it involves the creation of a cloned embryo using non-diseased donor cells from a patient with a degenerative disease or disorder. The objective is to use the cloned embryo to generate a stem-cell line immortalising those cells that, in turn, can be used to generate a particular tissue for treatment of the disease in question.
As indicated in our response to CAHR Recommendation 35 (above), we fully support the development of medical treatments which are consistent with the life and dignity of the human person. We are, however, implacably opposed to the development of medical treatments which are dependent on the exploitation and destruction of human embryos. Regenerative medicine in so far as it involves the use of human embryos should not be permitted.

37. The CAHR recommends: The generation and use of interspecies human embryos should be prohibited.
Our response: We agree.

38. The CAHR recommends: Preconception sex selection should be permitted only for the reliable prevention of serious sex-linked genetic disorders but not for social reasons.
Our response: We agree that preconception sex selection should not be permitted for social reasons. We note the growing tendency to distinguish between conception and fertilisation, and to identify conception with the implantation of the embryo in the uterus. We have no wish at this point to enter into a discussion about the

precise use of the term 'conception'. We wish to state quite clearly, however, that the selective or deliberate destruction or disposal of human embryos at any stage, either before or after implantation, is grossly immoral, irrespective of the reason.

39. The CAHR recommends: Research on gametes should be permitted provided it is governed by strict conditions set out by the regulatory body and subject to informed consent from donors. Specific consent should be required from the regulatory body for specific valid research.
Our response: We agree. We would be opposed, however, to the subsequent use for reproductive purposes of gametes on which research had been carried out.

40. The CAHR recommends: *Pre-implantation genetic diagnosis (PGD) should be allowed, under regulation, to reduce the risk of serious genetic disorders. PGD should also be allowed for tissue typing only for serious diseases that cannot otherwise be treated. Each licence issued for PGD should specify the proposed procedure. The regulatory body should oversee and monitor developments in PGD.
Our response: Pre-implantation genetic diagnosis can only reduce the risk of genetic disorders if it allows for the possibility of destroying embryos which are diagnosed as unhealthy. As stated in our response to Recommendation 38 (above), the selective or deliberate destruction or disposal of human embryos at any stage, either before or after implantation, is grossly immoral, irrespective of the reason.
It will inevitably be argued that, if AHR technicians knowingly transfer a genetically abnormal embryo to the mother's womb, they would not be acting in the best interests of their patient and would expose themselves to the risk of litigation. We would simply point out that this difficulty arises precisely because people seek to replace the natural procreative process rather than to assist it. This dilemma exposes a fundamental flaw in IVF and related technologies.

b. Some Brief Comments on the Fundamental Vision and Methodology of the Commission on Assisted Human Reproduction

1. In her introductory comments, the Chairperson of the Commission, Prof. Donnelly, remarks that 'in our emerging multicultural society it is unlikely that any one set of ethical/moral principles could be completely acceptable to all. In making its recommendations the Commission sought to put forward a framework broad enough to be generally acceptable to all individuals and groups in society'. This statement does not take account of the fundamental question as to whether some ethical/moral principles form part of the foundation on which society, however multicultural, is built. The Commission begins its deliberations by accepting that everything is a matter for political compromise. Some of the implications of this assumption become clear as the document proceeds to draw conclusions.

2. The Report consistently accepts the usage whereby procedures which neither cure nor improve the condition of infertility are described as 'treatment'. Interventions such as IVF are not 'treatments' in the sense that the problems underlying the infertility remain untreated.

3. The Report consistently, from the very beginning, refers to embryos as 'surplus'. We would question how the Commission can then claim to show the slightest respect for those whose views it purports to consider later in the report, who see the human embryo as entitled to the respect due to every living human being.

4. The report, on page xii, notes that Article 40.3.3 of the Irish Constitution provides constitutional protection for the 'unborn' and then goes on to say that: 'It is not clear whether protection applies from fertilisation or from some subsequent point in the process. This lack of clarity has implications for the provision of AHR services in Ireland. Clarification can only be sought in two ways: either from the Supreme Court or by way of constitutional referendum.' We would point out that the Supreme Court can only 'clarify' in the very questionable sense of interpreting the words of

the Constitution in the light of what it believes or imagines to be 'prevailing ideas and concepts', but not in the sense of determining what the people intended when they enacted the Constitution and its amendments.

5. The report, again on page xii, states that 'the evidence from the surveys indicates that public opinion ranges from total opposition to all forms of AHR on the one hand to uncritical acceptance of any assistance that science can give to infertile people on the other. Two main intermediate positions on that continuum were identified'. We would point out that the use of the term 'continuum' is inappropriate. There is no continuum, but rather a complete contradiction, between those who recognise the fertilised embryo as entitled to the respect due to every human being and those who do not.

6. The report tells us, on page xiii, that 'the Commission took the view that the welfare of the child should be a primary consideration in the provision of AHR services. In fact, the welfare of the child was a major factor in the Commission's thinking on the need for statutory regulation of AHR services'. This formulation shows how far the Commission is from any understanding of, not to speak of respect for, those who believe that the first requirement of the welfare of the child is that he/she should not be deliberately 'allowed to perish'.

7. In describing how the Commission went about its work, the report describes, on page 3, the holding of a large public conference in February 2003, at Dublin Castle. The conference, we are told, was intended 'to examine the current state of AHR in Ireland and abroad on the basis of presentations from acknowledged experts in the field'. What the report does not make clear, however, is the fundamental bias of the conference. The large panel of 'acknowledged experts' was composed for the most part of people who have a vested interest in the promotion of assisted human reproduction. Most of the presentations either implicitly or explicitly denied the human rights of the embryo.

8. The Commission 'recruited a market research organisation to carry out a survey of a quota sample of people over the age of 15 living in Ireland, classified by gender, age, socio-economic status and location'. We do not believe that serious ethical issues about respect for the life and dignity of the person can or should be decided on the basis of opinion polls.

Appendix 1

Original Submission to the Commission on Human Reproduction by the Irish Episcopal Conference – December 2001

We believe that Assisted Reproductive Therapy (ART) should be regulated by law, in order to protect both the right to life of the unborn and the unique status of the family founded on marriage. We welcome this opportunity to make some recommendations to the Commission.

For general background, we refer the Commission to the recent publication ***Assisted Human Reproduction, Facts and Ethical Issues***,[13] which has already been sent to you for your consideration.

We wish to make the following specific observations and recommendations:

a. Research involving Human Embryos

i. Ethical Background (General)

A human embryo is the new organism which comes into existence at fertilisation. This organism is not simply a collection of cells, but a genetically distinct human individual 'which is oriented towards further development'.[14] Research on human embryos is frequently motivated by the desire to understand and to be able to respond to the problem of infertility or to the causes of genetic abnormality. It is felt that this possible benefit to humanity provides a justification for the destructive consequences for the embryo itself, of research. The human embryo must, however, be regarded as a subject and not an object. It is an end in itself and not a means to an end. The fundamental issue at stake is that of respect for human life.

In the normal course of events, research involving human subjects is classified under two headings, therapeutic (i.e. that which offers the prospect of benefit to the subject) and non-therapeutic (i.e. that which

---

13 Bishops' Committee for Bioethics, *Assisted Human Reproduction, Facts and Ethical Issues,* Dublin: Veritas, 2000.

14 Australian Senate Select Committee, *Human Embryo Experimentation in Australia,* 1986, 3.4 to 3.8.

holds no prospect of benefit to the subject). In cases where research is therapeutic and the patient is unable to give consent, this consent may be given by his/her legal guardian. In the case of non-therapeutic research, however, the person who is the subject of the research must be a volunteer.[15] A human embryo, by definition, is incapable of giving consent.

ii. Research and the Cloning of Human Embryos

Cloning is frequently associated with stem-cell research. Human cloning is the production of a genetic copy of another human being. Stem cells are versatile cells in the body which are able both to reproduce themselves and to produce more specialised cells. One possible motivation for human cloning is the possibility of using the new embryos to obtain human stem cells for the treatment of people suffering from a range of conditions such as Alzheimer's or Parkinson's Disease. In this context, cloning is generally referred to as therapeutic cloning. It is clearly not therapeutic in the sense understood by the Declaration of Helsinki, because any therapeutic outcome is for the benefit of the other person involved; the embryo is inevitably destroyed in the process. The possibility of achieving a good outcome for another person does not justify treating the embryo as a means to an end rather than as a human subject.

We are concerned that discussion surrounding the issue of human cloning has not kept up with developments in medical research. Stem cells reside in human bone marrow, which has a long history in the successful treatment of leukaemia. It is now widely recognised that these stem cells have an advantage over embryonic stem cells in the healing process since they are destined to this purpose, while embryonic stem cells are destined to divide until a whole new organism is created. This may explain why a high incidence of tumours has been noted when embryonic stem cells have been used. By contrast, the use of human bone marrow is tried and tested; it is known to be safe. In addition, the taking of a bone marrow sample is much easier than extracting stem cells from embryonic tissue. The procedure involving

---

15 cf. *Declaration of Helsinki*, revised 1975 (Introduction; I.11; and III.2).

bone marrow can be taken out of the laboratory and into clinical trials immediately, which is not the case for embryonic stem cells. For example, in the last few months, bone marrow cells have been re-injected into people who have suffered damage to heart muscle and have been shown to bring about a significant improvement. A further advantage in using a person's own bone marrow stem cells is that there is no risk of rejection.

Research and subsequent treatment involving stem cells from bone marrow can be carried out without the destructive consequences entailed by embryo research and the extraction of stem cells from embryos.[16]

iii. Recommendations

- Medical intervention on human embryos should only be permitted if it is designed to protect the life and health of the specific embryo being treated. At the present state of scientific knowledge, research involving human embryos is non-therapeutic in nature (i.e. it offers no benefit to the individual embryo, but rather involves the destruction of the embryo for the sake of advances in medical science).
- The production of embryos specifically destined for research is unethical and should be prohibited by law.
- The cloning of human embryos for so-called therapeutic purposes, e.g. stem-cell research, should be prohibited by law.

b. Donation of Human Reproductive Material/Embryos

The donation of human reproductive material generally takes place in the context of the treatment of infertility, e.g. where the husband's sperm is deficient or where there are difficulties relating to ovulation on the part of the wife. Depending on the circumstances, sperm cells, ova, or indeed complete human embryos are donated. These donations may, at times, be associated with the payment of money.

---

16 cf. Linacre Centre, *Cloning and Stem-Cell Research*, a submission to the House of Lords Select Committee on Stem-Cell Research, June 2001.

i. Ethical Background

A donor of human reproductive material or of an embryo, while remaining in a very real sense the parent of any child who is born as a result of this donation, no longer has any possibility of exercising parental responsibility.

Every child has a right to an identity of origin, i.e. to know who are his/her parents. This is increasingly recognised in the management of adoption. This right of children would necessarily conflict with any attempt to guarantee the confidentiality of donors of reproductive material.

The donation of human reproductive material or embryos introduces an additional relationship into the social structure of the family. When biological parenthood is separated from social parenthood, this has the capacity to introduce a lack of clarity into the identity of the child. It may well be argued that this is substantially what happens in the case of adoption or remarriage after the death of a spouse. The fundamental difference, however, is that in these circumstances people are responding to a situation which has already arisen. By contrast, the donation of reproductive material sets out to create that situation.

ii. Recommendations

- In the treatment of infertility, the donation of human reproductive material or human embryos should be prohibited by law.
- In cases where the donation of reproductive material or embryos has already taken place, the right of a person to know the identity of his/her biological parents should take precedence over the right to confidentiality of the donor.

c. Committed Relationship

i. Ethical Background

The nature of human sexuality is such that it is the norm for a child to be born into a family where he/she has a mother and father who are in stable relationship with one another and who are in a position to offer a stable environment in which the child can grow and mature. This is why marriage is so fundamental to the well-being of children and of society. It is not possible to guarantee absolutely the stability or

permanence of any human relationship. In so far as it relates to the transmission of human life, however, we would have a serious moral concern that this stability should not, by default, come to be regarded as being in any sense optional.

We have already referred to the ethical issues associated with the cloning of human embryos for research or 'therapeutic' purposes. We would also have many serious moral concerns about the prospect of using cloning as a means to transmit human life. We believe that, quite apart from any concern about the reliability or safety of such a procedure, the cloning of human beings would reduce human procreation to the level of a manufacturing process. It would conflict with the dignity of the person and would fundamentally alter the meaning of parenthood.

ii. Recommendation

- Any legislation to provide for Assisted Reproductive Therapy (ART) should recognise and protect the right of every child to be born to a mother and father who are permanently committed to one another.
- The cloning of human embryos for the purposes of reproduction should be prohibited by law.

d. Storage and Disposal of Human Reproductive Material/Embryos

i. Ethical Background

The storage of human reproductive material/embryos most commonly arises either with reference to donation or with reference to research. As there is no ethical difficulty *per se* with research involving sperm or ova, so there is no ethical difficulty with the storage of same, for research purposes, provided the appropriate consent has been obtained.

The storage of sperm and/or ova for the future reproductive use of those from whom they have been obtained may be seen as desirable in certain medical circumstances, as, for example, prior to radium treatment or chemotherapy. This possibility, however, raises important ethical issues to which reference has been made in the booklet *Assisted Human Reproduction: Facts and Ethical Issues.*[17]

---

17 Irish Catholic Bishops' Committee on Bioethics, Dublin: Veritas, 2000.

The ethical discussion of the storage of embryos should be guided by the fundamental principle that the relationship between parents and their embryo is one of guardianship rather than one of ownership. The storage of embryos is most frequently proposed because of the fact that, in the course of fertility treatment, more embryos are produced than can be used safely in one treatment cycle. The hope is that these embryos can be used in the future if the first treatment is unsuccessful or if the couple wish to have another child at a later stage.

It seems to us, however, that there is no practical way to protect the right to life of these embryos other than by ensuring that they are replaced in the mother's body in a location where they are likely to survive. Any other course of action leads to a very real ethical dilemma. Once embryos are placed in storage, the possibility must be taken into account that they will remain in storage because of a change of circumstances or a change of mind on the part of the couple. Because of such a possibility, legislation in other jurisdictions tends to make provision for the disposal of these embryos, for their donation to other couples or for their use in research.[18] We have already addressed the issues of research and donation. The perceived need to provide for the disposal of human embryos after a set period of time has elapsed highlights our conviction that the production and storage of 'surplus' embryos raises insuperable ethical problems.

ii. Recommendations

- The storage and disposal of human sperm or ova, if permitted by law, should be governed by appropriate legislation.
- In any form of ART, steps should be taken to avoid the production of more human embryos than can be safely transferred to the womb of the mother in any one treatment cycle.
- The deliberate destruction of human embryos should be prohibited.
- Any fertilised ovum should be used for normal implantation.[19]
- The storage of embryos should be prohibited.

---

18 cf. Mary Warnock (ed.), *A Question of Life*, Oxford: Basil Blackwell, 1985.
19 cf The Medical Council, *Guide to Ethical Conduct and Behaviour*, 1998, 26.4.

e. The Allocation of Resources

The regulation of assisted reproductive therapy gives rise to the question of whether ART should be regarded as healthcare in the ordinary sense of the word and therefore as something to which citizens have a right, just as they have a right to other forms of healthcare, according to the general principles of distributive justice.

The crux of the matter is that, while infertility is often a grave disappointment and even a source of stress for couples who wish to have a child, it is not a life-threatening illness. In the context of limited healthcare funding, and in particular when there are lengthy waiting lists for life-saving treatment, it is hard to see how the State could justify diverting limited resources to the provision of assisted reproductive therapy. The alternative scenario is not ideal either, because if ART is not publicly funded, then it becomes a privilege of the wealthy.

We would strongly recommend that, in so far as the State sees fit to make resources available to this area of healthcare, serious attention needs to be given to identifying the causes (including social or lifestyle causes) of infertility; and to treating infertility itself, rather than simply to the facilitation of circumventive procedures.

Appendix 2

(NAPRO – An Effective and Ethical Response to Infertility)
NaProTechnology is not so much a particular treatment, as an approach to treatment which incorporates elements of fertility awareness, surgery and drug therapy. The term NaProTechnology refers to the use of Natural Procreative Technologies. To quote one of the leading proponents of the approach:

> It [NaProTechnology] can be defined as a science which devotes its medical, surgical and allied health energies and attention to cooperating with the natural procreative methods and functions. When these mechanisms are working properly, NaProTechnology works cooperatively with them. When these mechanisms are functioning abnormally, NaProTechnology cooperates with the procreative mechanisms in producing a form of treatment which corrects the condition, maintains the human ecology and sustains the procreative potential.[20]

An essential element of NaProTechnology is to identify the time of fertility, using a variation of the ovulation method *CrM NFP*, so that couples whose fertility is low have the optimum chance of achieving a pregnancy. This is effective in treating both male and female infertility. Where particular defects are identified, which can be treated by surgery or drug therapy, the aim of NaProTechnology is to do this without suppressing or destroying the procreative system or dynamic.

A primary goal is to make treatment couple-centred. The husband and wife attend medical consultations together and work on this project as a team, hoping to realise their ultimate goal of achieving a successful pregnancy. Treatment is reserved for married couples to protect the best interests of the child and promote a secure family life. NaProTechnology does not claim to be able to resolve infertility in every situation, but it has been used very successfully to treat couples who have previously

---

20 Thomas W. Hilgers, *Medical Applications of Natural Family Planning*, Omaha: Pope Paul VI Institute Press, 1991, XI, 143.

had up to eight unsuccessful attempts at IVF or multiple recurrent miscarriages.

Like any form of treatment, NaProTechnology does make demands on the couple. Because of its focus on the natural process, however, it is possible to sustain treatment over a period of time, sometimes even twelve to eighteen cycles. The goal is to achieve a pregnancy, but not at any price, and certainly not at the expense of the couple's health, relationship or psychological well-being. It seems that, even when couples do not achieve a pregnancy, NaProTechnology frequently helps them to adjust to and accept involuntary childlessness, which may be the final outcome despite the best attempts.

Further information on this approach to fertility care and the treatment of infertility can be found on the web at www.fertilitycare.net.

We would strongly recommend that funding be made available for further research into the potential of natural procreative therapies and for the further development of existing NaProTechnology services.