**The point of no return – up to what point should we be allowed to withdraw consent to the storage and use of embryos and gametes?**

**Abstract**

This paper will discuss when it is ethically acceptable to withdraw consent for the storage and use of embryos and gametes. Currently, the law in the UK states that consent to use of a gamete or embryo can be withdrawn up to the point of embryo transfer to the recipient’s uterus or when the gamete is used in providing treatment services – that is the ‘point of no return’. In this paper, we will consider other ‘points of no return’ and argue that having a single ‘point of no return’, a ‘one size fits all’ form of consent can, in some cases, lead to restrictions on individuals’ autonomy and cause particular types of harm. Therefore, having different ‘points of no return’ that better fit different circumstances, could extend autonomy and allow people to enter into agreements that are more tailored to their own particular needs and circumstances.

**Introduction**

Currently, the law in the UK states that consent to the use of a gamete or embryo can be withdrawn up to the point of embryo transfer to the recipient’s uterus or when the gamete is used in providing treatment services – that is the ‘point of no return’, where consent cannot be withdrawn or altered. In this paper we will consider other ‘points of no return’ and how these could be applied to different cases of storage and intended use of gametes and embryos. Our aim is to argue that having a single ‘point of no return’, a ‘one size fits all’ form of consent can preclude options that people may wish to pursue and, in some cases, lead to restrictions on individuals’ autonomy and cause particular types of harm. Therefore, having different ‘points of no return ‘ that better fit different circumstances, could extend autonomy and allow people to enter into agreements that are more tailored to their needs and circumstances.

Gametes and embryos are generally covered by the same consent provisions in UK legislation. The HFE Act, Schedule 3, refers to: ‘Consent to use or storage of gametes, embryos or human admixed embryos etc.’ There are specific clauses that refer solely to embryos, such as Section 2 (1) ‘A consent to the use of any embryo must specify one or more of the following purposes….’ [[1]](#footnote-1) However, as the two entities are subject to the same consent regulations and therefore the same ‘point of no return’, for the purposes of this paper it is necessary to consider both embryos and gametes. We will also consider the use of gametes and embryos both for the use of those whose genetic material it is (i.e. for the use in their own fertility treatment) and donation to others for their family building. Again, as the consent provisions in terms of withdrawal do not distinguish between these different situations, in this paper we will consider both donation and personal use. We will focus on the use of embryos and gametes for reproductive purposes and not consider issues related to use for research.

There has been little consideration of the issue of withdrawing consent in the storage and use of gametes and embryos in the literature.[[2]](#footnote-2) This paper will contribute to the debate by focussing attention on where, ethically, the ‘point of no return’ should be drawn and the implications this has for how we manage the, possibly, competing demands of the different parties involved and support autonomous decision-making about the use and storage of embryos and gametes.

**Background**

As noted by Sozou et al [[3]](#footnote-3) There is a diverse range and type of circumstances and reasons why gametes and embryos are stored. Embryos are usually created by a couple during their fertility treatment and stored for their possible future use. They can also be stored for use by other in their fertility treatment, i.e. donated. Women may wish to store embryos (created either from their partner’s gametes or from a donated gamete) or eggs to preserve their fertility, either due to illness or for social reasons. Gametes can also be stored for the future use of the individual whose genetic material it is and also can be donated under the provisions of the HFE Act through a licenced clinic and stored for the future use of others.

There are clearly significant practical, social and ethical differences between these different circumstances. For example, there are significant differences between embryo donation and both sperm and oocyte donation in a number of key respects. First, embryos are created[[4]](#footnote-4) from two people’s gametes and, at least at the outset, this means that two people under UK law are involved in consent to storage, usage etc. of the embryo – this is, in practice, an important element that distinguishes an embryo from a gamete – where only one person’s consent is needed and it is only one person’s genetic material. The first feature is uncontroversial – there may be differences in views on whose interests in the embryo should take precedence (i.e. the woman’s or man’s) but there is still a recognition that there are two parties who have created the embryo and have some form of interest in the embryo.

The second feature relates to the differences in the social context of the embryo, how embryos come to be and the social meaning they can have for their creators. There are often differences in the motivations between embryo and gamete donors. From a donor’s perspective, donation of sperm or oocytes is usually a choice that they are able to make without any time pressure, with no urgent medical indication and they are not undergoing an arduous and stressful medical procedure. Those who store embryos after their own treatment are often subject to such pressures. This may be different for egg sharers, who donate eggs to others to finance or support their own treatment, but generally – particularly sperm donors – present as donors rather than as prospective patients and parents. Donation of embryos for family-building typically arises when the donors have undergone fertility treatment themselves and have unused cryopreserved embryos at the completion of their own treatment. Therefore, embryo donors, generally do not start out as donors, but as recipients of fertility treatment who are aiming to start or complete their family.

The relationship status of those creating and storing embryos can also differ. As noted above embryos are often stored by heterosexual couples after their treatment and this can lead to difficulties if the couple disagree about the future use of the embryo that has been created from their gametes. A different scenario is a single woman who creates an embryo with her egg and a donor sperm, or with both a donated egg and sperm, and stores this embryo for her own future use. Hence, there could be a number of parties involved who have an interest in a stored embryo.[[5]](#footnote-5)

In sum, we have argued that there are many different circumstances in which gametes and embryos are stored and what the intentions are for their future use. These different circumstances need to be reflected in how consent options and ‘the point of no return’ are managed in practice. We will now consider the consent regulations as set out in the HFEA Code of Practice [[6]](#footnote-6) (based on the Human Fertilisation and Embryology Act 1990 as amended). [[7]](#footnote-7)

**Withdrawal of consent**

As the Code of Practice states:

The person obtaining consent should tell the gamete provider and recipient(s) that the gamete provider may withdraw or vary their consent up to when the gametes or embryo(s) are: a) transferred to a woman; b) used in a research project (defined as being under the control of the researchers and being; cultured for use in research) c) used for training, or d) allowed to perish.[[8]](#footnote-8)

Patients with embryos are advised:

It can be difficult if you and the person you’ve created embryos with don’t agree about whether or not those embryos should be used. In these cases, where one person wants to use the embryos and the other person doesn’t, you’ll have a one year ‘cooling off period’ where both parties can think through all the issues and come to a final decision. Your clinic should support you both in reaching a resolution.[[9]](#footnote-9)

We argue that the current provision that consent may be withdrawn or varied up to the point where the gametes or embryo(s) are transferred to a woman can be problematic in a number of situations, for example in relation to embryos formed from donor gametes. The debate here is determining the ‘point of no return’, where consent can no longer be withdrawn. There has to be some point, after which consent cannot be withdrawn, but deciding where that line should be drawn needs to be thought through carefully. In different individual circumstances there may be justifiably different ‘points of no return’, depending on the situations in which those who have stored gametes, donors and intended parents[[10]](#footnote-10) find themselves. In practice, this may make regulation more complex, but we argue that, ethically, different options should at least be explored.

There are a number of possible options for where the ‘point of no return’ could be drawn: [[11]](#footnote-11)

1. Before treatment begins.
2. After creation of the embryo, at the point of fertilisation, and the freezing of gametes.
3. When gametes or embryos enter the donation process – if someone decides to donate their embryos or gametes and they are made available to others to choose, this constitutes entering the donation process.
4. When gametes or embryos are released to specific recipients – consent could be withdrawn when the gametes and embryos are available for donation, but once they have been released to potential recipients consent could no longer be withdrawn.
5. Up to the point of implantation – this is the current position in UK law, consent can be withdrawn up to the point the embryo or gamete is transferred to the woman’s uterus.

We will now consider how the ‘point of no return’ can be applied in different circumstances. In each circumstance there cannot be more than one ‘point of no return’. For example, parties may wish to make an agreement on what happens to their embryos or gametes that might be earlier in the process (i.e. before treatment). However, there has to be some point after which consent cannot, under any circumstances, be withdrawn and, therefore, in each case there can be only one ‘point of no return’.

*Donated gametes*

At what point should the gamete donor be unable to withdraw consent? There has been little consideration of the issue of this type of consent withdrawal in the literature. Sozou et al[[12]](#footnote-12) in a short piece informally investigated the withdrawal of consent by sperm donors before or after release to a specific couple or individual (recipients). They found that this had occurred in three fertility centres since 2005 and the reason, where given, was the influence of a new female partner.

For donated gametes,[[13]](#footnote-13) we argue that the fourth ‘point of no return’ is the most ethically justifiable option. In the first and second ‘point of no return, before and when the gametes have been stored, a consent agreement could be drawn up that specified the future use of the gametes that could not be subsequently changed.[[14]](#footnote-14) However, as the gametes have not entered the donation process or been allocated to a third party, then the gamete donor’s withdrawal of consent at this stage will not represent harm to any specific third party or parties and therefore, the donor’s autonomy to decide if they wish to continue storing their gametes can be respected. The third ‘point of no return’ specifies that consent cannot be withdrawn after the gametes have been released for donation. At this point the gametes have not been allocated to any particular recipient but are held by a storage facility, such as a fertility centre or sperm or egg bank. Again, if the withdrawal of consent to storage and subsequent use could result in harms to any third parties then the donor’s right to decide the fate of their gametes has to be weighed up against this and as in points one and two there are no harms to any specific third parties and consent can be withdrawn up to these points.

After the fourth ‘point of no return’ we argue that consent should not be able to be withdrawn. The recipients have chosen a donor and made plans and assumptions of future treatment on this basis. It is also worth noting that choosing donors is often a fraught and time consuming process and usually not a quick or casual decision. [[15]](#footnote-15) Thus, even if the recipients have not used the donor they have still made a significant emotional investment in having access to that gamete. A couple who have successfully used the donor gametes to have a child may want to use the same donor to create a fully genetically related sibling to that existing child. Hence, it could be argued that once they have been released to the recipients consent should not be allowed to be withdrawn. This is the fourth point of no return. Sozou et al, make a similar suggestion in that the donor can specify that: ‘No new families to be begun;….sperm to create full siblings of children created from his sperm to be retained.’ [[16]](#footnote-16)

The benefits of this proposal are first, that once the gametes are released to specific recipients, the recipients have an interest in them and will make future plans and decisions on the basis of having access to these gametes. Second, in the case where a child has been created from the gamete and the recipients want to use the gametes for further children, this could, arguably be of benefit to the existing child and any future child, that they have full or partial genetic siblings and a further donor is not brought into the family unit. Thus, this proposal could prevent a potential harm to any resulting children.

There are objections to the fourth ‘point of no return’. First, it may be that the recipients have not used the gametes in their treatment, and therefore the ‘release point’ does not represent any significant loss to the recipients, if consent is withdrawn after this. However, as noted above, even if they have not used the gametes, the withdrawal of the donor’s consent can still represent a significant loss. It also might be suggested that as long as recipients know that the gametes will only be available for each treatment then they will not make future plans based on access to those gametes. However, under current UK legislation, where consent can be withdrawn right up to the point of transfer of the gametes to the woman, there is no guarantee that they can use the gametes in any treatment until it has actually happened. Although, such withdrawal of consent may be rare, we argue that this introduces an unnecessary uncertainty into the process. A further argument against this proposal is that the donor’s interests become secondary, that they cannot change their mind about donating their gametes.[[17]](#footnote-17) The counter to this is that this represents no further restriction on the donor’s interests or autonomy than saying that they cannot withdraw consent after their gametes have been used in providing treatment. There has to be a point beyond which consent cannot be withdrawn and as long as donors are fully aware of when that is and are counselled accordingly then no point is ethically more justifiable than another from the perspective of the donor. However, allowing donors the option of deciding right up to the wire as it were, potentially results in a harm to the recipients. They cannot be completely sure that they will have access to a particular donor’s gametes and there is a potential harm to the future family in that it could reduce the possibility of a child having full genetic siblings.[[18]](#footnote-18) Therefore, these potential harms are not outweighed by any gains in respecting the donor’s autonomy, as the donor’s autonomy is respected by them making an informed decision; it is just that decision becomes binding at the point their gametes are released to recipients rather than at the point of transfer. Therefore, it should not be possible to withdraw consent after the fourth point of no return.

*Embryos formed with donated gametes*

In cases where embryos are formed with donated gametes (sperm), [[19]](#footnote-19) the ability to withdraw consent up to the point when the embryo is implanted in the woman, could have serious implications for the recipient. As the law currently, stands a woman could form an embryo with a donated sperm and her own egg, store the embryo for her future use and then at a later stage the sperm donor could withdraw consent (before implantation). This is a situation that the law should seek to prevent. There are a number of ‘points of no return’ that could be set that would prevent this scenario and we will discuss them in turn.

Consent could be withdrawn up to the point the embryo is created, at our second ‘point of no return’. There are two main arguments in support of this claim. First, fertilisation is the point at which the gametes are ‘used’, rather than as the current law stands, when they are implanted in the uterus. The regulators have recognised other points of ‘use’ of gametes that represent a point after which consent cannot be withdrawn, for example, with the advent of mitochondrial DNA replacement, the HFEA Code of Practice now states: ‘The person obtaining consent should tell the gamete provider and recipient(s) that consent to providing gametes solely for use in mitochondrial donation treatment cannot be withdrawn or varied once the patient’s nuclear DNA has been inserted into the egg or embryo.’[[20]](#footnote-20) The point of fertilisation is arguably when the sperm is used and this marks an important point when, as in the case of mitochondrial DNA replacement, the gamete is transformed and becomes something else and this process is irreversible. Making a specific provision for no withdrawal of consent after this second ‘point of no return’ makes this clear.

Second, embryos involve two parties in their creation and the woman whose egg was used to form the embryo has an important stake in the embryo that should be given weight. The procedures the woman has to undergo to produce eggs is invasive, expensive and psychologically challenging. [[21]](#footnote-21) Therefore, her stake in maintaining control of the usage of her embryo is significant. Of course the other party, the sperm donor, also has a stake in how their gametes are used – and therefore they should be given information and counselled to ensure that when they consent to the formation of an embryo they know they cannot go back on this decision and they are entirely happy with that and all the associated implications.

Another ‘point of no return’ could be the fourth point when the gametes are released to a specific recipient (and then used to create an embryo). This would do the job and protect both parties. Temporarily, this point would come before the second ‘point of no return’ and there seems no reason to distinguish this form of donation, using gametes to create embryos, than other forms, gametes are stored and then used. The second ‘point of no return’ does draws attention to a key consideration, where the woman’s investment becomes immutable, once her egg has been fertilised and becomes an embryo she cannot pull out of that arrangement and if consent is withdrawn by the sperm donor she cannot reuse her egg and find another donor. However, the fourth ‘point of no return’ protects the woman whose egg has been used to create the embryo and removes the uncertainty that the current law allows.

*Embryos created by couples who are being treated together*

Our discussion has so far focussed on embryos created with donor gametes (sperm). But as noted most embryos are stored by a couple who had planned to use them to build their own family and then find that they have finished their treatment with embryos remaining in storage. So the question becomes, when is the ‘point of no return’, where consent cannot be withdrawn, for couples who create an embryo together?[[22]](#footnote-22)

We will consider two possible scenarios: first, couples where one party wishes to use the embryo and the other objects; second, couples with unused stored embryos who wish to donate them to others for family-building. The case of a couple who create an embryo ‘together’ when they were originally intending to be parents, rethinking the ‘point of no return’ has been explored by Sozou et al.[[23]](#footnote-23) They are concerned about situations where consent is withdrawn by one genetic parent of the embryo that prevents the other member of the couple from using the embryo. This situation occurred in the case of Natalie Evans, who had created embryos with her then fiancé, who then withdrew his consent for continued storage and use of the embryos following their separation. Although Evans appealed this withdrawal of consent, as this was her only chance of having genetically related children, following treatment for cancer that rendered her infertile, she lost the case and the embryos were destroyed. [[24]](#footnote-24) Sozou et al suggest that alongside the existing consent provisions, ‘We propose…[an] additional option in which one genetic parent can agree to cede control of the embryos to the other... Couples would agree, before fertilisation, whether they choose to share control over the future use of embryos, or alternatively, one of them will have sole control.’[[25]](#footnote-25) This is our first ‘point of no return’.

Sozou et al consider a number of objections to their proposal, that it could harm a third party, the future child or society as a whole, as the argument goes that it is better to create children whose genetic parents are together and who will be parented by two parents, rather than a single parent. As they state, the potential for such harm is not a significant objection to their proposal, as research does not bear out these fears. The most pertinent objection is that, ‘it is wrong to allow someone to sign away his or her rights to future control over such an intimate choice. The thought here would be that there is something so deeply significant and personal about reproductive choices that the law should preserve individuals’ rights to change their minds, even if so doing overrides their current wishes.’[[26]](#footnote-26) This could also be used as an objection to our fourth ‘point of no return’ that once gametes are released to recipients consent should not be able to be withdrawn. In response to this Sozou et al argue that the solution is to strengthen consent procedures, so that when people take these decisions they are fully informed and have been given the opportunity to think through all the issues and possible implications of their decision. There has to be some ‘point of no return’ – under current legislation this is the point where the embryo is transferred to the woman – this is the point that the person cedes control over the embryo they co-created. Therefore, it is not ultimately the ceding of control over one’s embryo that is at issue, but the point in the process at which it is ceded.

We agree with Sozou et al’s suggestion that one of the parties should be able to cede their rights over the embryo at an early stage. However, it does not solve the root of the conflict, if one of the parties does not agree to such a ceding of rights, they are no more likely to do so before treatment, than during the storage period. Further, if the couple disagree about the fate of the embryo – then one of the couple will not be able to exercise their ideal choice – it is not possible in this situation to have a solution in which both parties’ preferences are satisfied. Where a couple disagree over the use of the embryos by one of them, each member of the couple should have a veto on their use – with joint agreement needed on how they might be used – and this veto can be exercised up to the point of implantation. In disagreements over one of the couple using the embryo themselves – the party who refuses to give consent effectively has the veto. This is unfortunate but is the case in any personal situation. If one party X wants to enter into a relationship with another Y, and Y refuses – Y effectively has the veto.

In this first scenario, where the couples disagree over the use of the embryo, it is a different situation from a parental project begun with donated gametes or embryos. When a donor donates they have, from the offset, no future stake in the parental project, it seems reasonable for them, as we have argued, that at the fourth ‘point of no return’ once their gametes are transferred to the third party they have no further rights to withdraw consent. However, in the circumstance of embryos created by couples, who originally did so in anticipation of intending to parent any resulting child, consent should be able to be withdrawn by either party to the use of the embryo – however distressing that might be – at the fifth point of ‘no return’ as the law currently stands. The justification for this ‘point of no return’ rather than the fourth ‘point of no return’, is that the embryo was stored in order to fulfil the couple’s parental project – so that they could have a child together – and that is something that has to be established by mutual consent. To continue that parental project, even if the other party is not expected to be involved in any practical meaningful way, to which they do not consent, is in our view unwarranted. Having the fourth ‘point of no return’ in this scenario, after the embryos had been stored – in effect already released to the intended parents – would result in the continuation of a parental project that one of the parties had not consented to.

In the second situation, where couples have unused stored embryos and they want to donate them to others for family building, we argue that the consent of both of them should be necessary. If there is disagreement and, like the first case, if one party does not want the embryos used (either by their partner or anyone else) then that view should act as a veto. Assuming this proviso, at what point should the couple who are donating their embryos be able to withdraw consent (either together or individually)? For potential couple embryo donors, we argue that the point of ‘no return’ as noted above for gamete donors, should be when the gametes are released to specific individuals (point four), and if there is sufficient information and counselling of the couple there is no reason this could not be accepted for embryo donors.

**Conclusions**

We have argued for re-thinking the point where consent can be withdrawn to the storage and use of gametes and embryos. Currently, in UK law there is a ‘one size fits all’ approach that cannot cover all the many different situations and relationship constellations under which gametes and embryos are stored. This paper has only considered a limited number of circumstances and it is clear, even from these examples, that different consent options are needed. In particular circumstances there may be justifiably different ‘points of no return’, after which consent cannot be withdrawn, as outlined in this paper, depending on the situations in which donors and intended parents find themselves. The legislation in this area and the HFEA have put a lot of emphasis on consent and it is consent to treatment with someone that demarcates parenthood from the act of donation and signals agreement with the treatment procedures and use of gametes.[[27]](#footnote-27) We have argued that there are good reasons for tailoring consent options to particular circumstances and that the options we have suggested do not create harms or burdens for others and, on the contrary, can prevent certain harms.

The law as it currently stands can create difficulties for those in receipt of gametes or embryos and these issues can be addressed without sacrificing the interests or autonomy of other parties. In forming families with gamete and embryo donors and storing them for future use, there are a number of different parties, the donor, the intended parents and any resulting children, whose interests have to be taken into account. Further, it is important that consent processes facilitate fully informed and autonomous decision-making and ensure that individuals’ autonomy is respected and that harms to other parties minimised. Our proposals would enhance clarity about the longer term implications and reduce the opportunity for earlier decisions being rescinded further down the track. The first change we suggest, that gamete and embryo donors cannot withdraw consent after the fourth ‘point of no return’ would be of most benefit to recipients/intended parents, as they would know which gametes and embryos they had access to and be reassured that the donor could not change their mind. Arguably, this change would also benefit donors, as it would make the decision point clear, and make the need for clear information and consideration apparent, rather than being able to put off the decision (i.e. the current situation where there is the option to reconsider at some future unspecified point) when they may not be in contact with any clinic or support staff and therefore have limited access to support for their decision-making. There has to be some ‘point of no return’, this is the point that the person cedes control over their gametes or the embryo they co-created. Therefore, it is not, ultimately the ceding of control over one’s gametes or embryo that is at issue, but the point in the process at which it is ceded. The point after which consent cannot be withdrawn, the ‘point of no return’ must be clear to all parties and making this clear is of central importance in ensuring the ethical conduct of gamete and embryo storage and use.

Although in practice, these suggestions may make regulation more complex, we argue that, ethically, different options are appropriate and would have substantial benefits for all parties involved in gamete and embryo donation.

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1. The Human Fertilisation and Embryology Act 1990, as amended 2008. Hereafter we will call this the HFE Act. https://www.legislation.gov.uk/ukpga/2008/22/contents [↑](#footnote-ref-1)
2. Sozou, P. Sheldon, S. Hartshorne, G. Consent agreements for cryopreserved embryos: the case for choice. J Med Ethics 2010; 36:230e233. doi:10.1136/jme.2009.033373 [↑](#footnote-ref-2)
3. Op Cit, note 2 [↑](#footnote-ref-3)
4. We are using ‘created’ to mean made, brought into being, not created in any religious sense. This terminology is also used in the HFEA Code of Practice. HFEA Code of Practice, 8th Edition, https://www.hfea.gov.uk/media/2062/2017-10-02-code-of-practice-8th-edition-full-version-11th-revision-final-clean.pdf [↑](#footnote-ref-4)
5. For the purposes of this paper we will not discuss the welfare of the future child in detail, except where our proposals could have a specific impact such as in circumstance as outlined on page 8. This is for the following reasons. First, under UK legislation any person accepted for fertility treatment will have undergone a welfare of the child assessment, hence our proposals do not affect who might be offered treatment. Second, our proposals are unlikely to have any impact on the welfare of any future child – as there is currently a ‘point of no return’ and our proposals are concerned with where that should be drawn and this does not in itself effect any future child. The caveat to this is the argument that it might be desirable to have a fully or partially genetically related sibling (see discussion on page 8). [↑](#footnote-ref-5)
6. HFEA Code of Practice, op cit note 4 [↑](#footnote-ref-6)
7. The HFE Act. Op cit note 1 [↑](#footnote-ref-7)
8. Op cit note 4, Section 5.28 (Code of Practice) [↑](#footnote-ref-8)
9. Patient information HFEA website https://www.hfea.gov.uk/choose-a-clinic/consent-to-treatment/ [↑](#footnote-ref-9)
10. We will use the term ‘intended parent’ to mean someone who is undergoing treatment with the intention of parenting any resulting child. [↑](#footnote-ref-10)
11. Please see table I for a detailed explanation of these different points. [↑](#footnote-ref-11)
12. Sozou et al Withdrawal of Consent by Sperm Donors, BMJ 2009; 339 doi: https://doi-org.liverpool.idm.oclc.org/10.1136/bmj.b4297 (Published 20 October 2009) [↑](#footnote-ref-12)
13. Here we are referring to eggs and sperm and our proposals would also apply to egg sharers. [↑](#footnote-ref-13)
14. We will discuss this point in more detail when we discuss Sozou et al’s proposals, op cit note 2. [↑](#footnote-ref-14)
15. See Frith, L. Sawyer, N & Kramer, W. (2012) Forming a family with sperm donation: a survey of 244 non-biological parents, Reproductive Biomedicine Online, 24 (7) 709-718. [↑](#footnote-ref-15)
16. Sozou et al, op cit note 2. [↑](#footnote-ref-16)
17. We would like to thank the anonymous reviewer for raising these objections to our claims. [↑](#footnote-ref-17)
18. We do not have space in this paper to argue for why it might be beneficial to have full genetic siblings. This aspect may be of importance to some families and not others. Therefore we are just raising it as a consideration to be born in mind. There has been research that has found some complications experienced by families who have children from different donors, but this is by no means generally a negative experience, see Blyth, E., Lui, S. and Frith, L. (2017) Relationships and boundaries between provider and recipient families following embryo adoption. Families, Relationships and Societies. DOI: https://doi.org/10.1332/204674317X15088483681897 [↑](#footnote-ref-18)
19. We will use this example, as a man who wishes to create an embryo with his sperm and a donated egg, will need a surrogate to achieve a pregnancy and this introduces other issues related to surrogacy, such as parental orders and motherhood conditions, which are not our main focus here. [↑](#footnote-ref-19)
20. HFEA Code of Practice 5.25, op cit note 4 [↑](#footnote-ref-20)
21. Verhaak CM, Smeenk JM, Evers AWM, Kremer JM, Kraaimaat FW, Braat DM. Women's emotional adjustment to IVF: a systematic review of 25 years of research. Human Reproduction Update 2007; 1:27–36. [↑](#footnote-ref-21)
22. For clarity of argument we will consider cases of couples who have created the embryo with their own gametes. [↑](#footnote-ref-22)
23. Sozou, P. et al, op cit note 2 [↑](#footnote-ref-23)
24. European Court of Human Rights Evans v the United Kingdom (Application no 6339/

05) Judgment. Strasbourg, 10 April 2007. [↑](#footnote-ref-24)
25. Op cit note 2 [↑](#footnote-ref-25)
26. Op cit note 2 p232 [↑](#footnote-ref-26)
27. See HFEA website section on consent – https://www.hfea.gov.uk/choose-a-clinic/consent-to-treatment/ [↑](#footnote-ref-27)