

# Intrafamilial medically assisted reproduction

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The ESHRE Task Force on Ethics and Law acknowledges the benefits that IMAR may bring to those choosing this approach and concludes that certain forms of IMAR are morally acceptable under certain conditions. The group advises to evaluate each request for IMAR individually, based on four ethical principles in health care: the respect for autonomy, beneficence and non-maleficence and justice.

The Task Force explains that the right for individual autonomy is elementary: any individual should have the principle of choice with whom to reproduce. It is understandable that couples wish to preserve some sort of [genetic identity](#) with the child, and hence may wish to choose a donor in the family. IMAR may facilitate a child's access to its biological roots and enable it to have contact with the donor or the [surrogate mother](#). Often faced with no realistic alternatives due to long waiting times or lack of donors, IMAR may also be the only option available to these patients.

The ESHRE group recommends that fertility doctors should take into account the relevant regulations in their country when they assist a couple with IMAR. In some countries IMAR is illegal and the relevant laws against incest and consanguinity apply to protect the offspring from genetic risks and to avoid possible social disruptions and conflicts.

"Doctors should assess any possible psychosocial and medical risks related to the treatment," says Dr. Wybo Dondorp, deputy coordinator of the Task Force. "Doctors must therefore consider the principles of beneficence and non-maleficence together and aim at producing net

benefit over harm for all parties involved."

Potential risks may affect several parties, including the future child. These risks can arise from intrafamilial conflict if parents feel threatened in their parental role or if they have different views from the collaborators on how the child should be informed of its [genetic origins](#). Especially in cases of intergenerational IMAR, there are concerns that the child may be confused about his role in the family. The possible pressure on the donor or surrogate to collaborate can also lead to psychological problems. Adequate information on possible risks should be given to all parties. This includes both combined and separate counseling of recipients and collaborators to assess the voluntariness of the donation and to reduce potential conflict situations.

According to the principle of justice, doctors should treat similar cases in the same way. So if sister-to-sister oocyte donation is accepted so should brother-to-brother sperm donation. The justice principle also applies where IMAR may circumvent unjust exclusion if waiting times for donors are long or the treatment costs are too high without intrafamilial donors.

It is of paramount importance that recipients and collaborators give their informed consent. The ESHRE group is in favour of disclosure of information to the child if other relatives are aware of the familial collaboration. The counselor should offer support in any case and various strategies may be equally justified; while some would give priority to the child's right to know, others would be more concerned about the risk of confusion and accept a parental preference for secrecy.

Doctors should not accept a minor relative as a gamete donor or a surrogate. In the case of intended surrogacy the Task Force considers parenthood by the surrogate to be a precondition in order to collaborate in IMAR.

The paper gives special attention to (rare) cases of consanguineous IMAR, involving the mixing of gametes of persons that are genetically closely related. "The Task Force considers consanguineous IMAR between up to third degree relatives as acceptable in principle, subject to additional counseling and risk-reduction," says Professor Guido de Wert, coordinator of the ESHRE Task Force. "Here, genetic counseling is appropriate to assess the increased risk of conceiving a child affected by a serious recessive disease."

Part of adequate genetic counseling and good clinical practice in such cases is to offer carrier screening for those disorders that are more prevalent in the particular ethnic group. Given that fertility specialists have a co-responsibility for the welfare of the child, it may be morally justified to offer such genetic testing as a condition for access to assisted reproduction.

The group concludes that in some situations IMAR is morally acceptable as long as counseling of recipients and collaborators is applied in order to reduce potential psychosocial and medical risks. First-degree intergenerational IMAR needs special scrutiny, also in view of the increased risk of undermining autonomous choice. First- and second degree consanguineous IMAR is at odds with the spirit of anti-consanguinity and anti-incest legislation in most countries and should not be offered. The group encourages more research into the psychosocial implications of IMAR to contribute to adequate and moral guidance.

**More information:** The paper is published online on 20 January 2011 in the journal *Human Reproduction*: [doi:10.1093/humrep/deq383](https://doi.org/10.1093/humrep/deq383)

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