

Donor-conceived children: the view ahead

Sir,

In response to the opinion expressed in Pennings (2017), 'Disclosure of donor conception, age of disclosure and the well-being of donor offspring,' we support the arguments of Crawshaw *et al.* and present an alternative opinion to that posed by Pennings. Pennings asserts that there is insufficient evidence on which to base the recommendation that parents share the use of donor gametes with their children. Further, he argues that mental health professionals make this recommendation based not on evidence, but on their own morals, and that such morals-based advice violates the general principles of non-directiveness and respect for autonomy. The essential problem we see with Pennings' view is that he ignores the major scientific advances emerging from the Human Genome Project in 2003 and the growth of direct-to-consumer (DTC) genetic testing (Harper *et al.*, 2016; Phillips, 2016). In their recent Human Reproduction paper, Harper *et al.* highlight the exponential growth in the number of people using DTC genetic testing and the centralization of genetic information in large worldwide DNA databases. Thus, at any point in their life, a donor-conceived person can order a simple, inexpensive saliva DNA test and learn that their DNA does not match their presumed ancestry, putting into question their genetic relatedness to their parents. Furthermore, with the emergence of genome-based personalized medicine, it is anachronistic to propose that donor-conceived people will not obtain information about their DNA and its medical relevance.

These scientific advances render untenable the assumption that it is solely the parent's choice to determine whether their child learns of their donor origins. Given that it is unrealistic to believe that secrecy can be maintained throughout the lifespan of a donor-conceived person, Pennings' arguments about whether existing psychological evidence indicates that disclosure or nondisclosure is better for children seem irrelevant and should be replaced by questions about how potential inadvertent disclosure will affect parents and families. The field of reproductive medicine should no longer practice gamete donation under old, now faulty assumptions about the viability of secrecy as an option for parents. We should consider that it is our duty to offer information and guidance to prospective parents about the likely possibility that regardless of whether they share the use of gamete donation with their child, the child may discover it anyway.

We object to Pennings' portrayal of mental health professionals as counseling about disclosure based solely on their 'moral convictions.' On the contrary, it is our view that when parents are provided with

carefully delivered and complete information, it remains the parents' choice how, when and even whether they want to address the topic of gamete donation with their child. Our clinical experience tells us that a parent's comfort with the idea of sharing the details of their child's conception is dependent on whether their fears have been addressed (Daniels *et al.*, 2007). Two common fears are that their children will reject them or will consider their donor as a parent. Mental health counseling serves intended parents by addressing these fears and by laying out the different scenarios and difficulties that may occur with both disclosure and nondisclosure. We have found that this discussion is often a response to unmet needs expressed by the parents themselves. The task of a mental health professional is not to make moralistic arguments about what is best for children, but it is certainly not to guide parents in how to lie to their child, as was suggested by Pennings. Our task is instead to help prospective parents grapple with the reality that choosing donor conception has implications for their family and child that may be unforeseen at the time of conception.

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