European Journal of Obstetrics and Gynecology 284 (2023) 169–174

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.journals.elsevier.com/european-journal-of-obstetrics-and-gynecology-and-reproductive-biology

Full length article

Assisted human reproduction legislation: Listening to the voice of patients

S. O'Brien [a,b,c,*], L. Schaler [a,b,c], A. Giblin [a,c], L.E. Glover [a,c], M. Wingfield [a,b,c]

[a] Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2, Ireland
[b] Department of Obstetrics and Gynaecology, National Maternity Hospital, Holles Street, Dublin 2, Ireland
[c] School of Medicine, University College Dublin, Dublin 4, Ireland

ARTICLE INFO

Keywords:
Assisted reproduction
Legislation
Regulation
Policy
Gamete

ABSTRACT

Objective: Legislation and policies regarding assisted human reproduction (AHR) vary widely across nations and societies. As one of only 5 European countries which currently lacks legislation, Ireland now has a unique opportunity to learn from other jurisdictions and introduce AHR law that is reflective of the ongoing myriad developments in this complex field. Draft legislation, initially published in 2017, was revised in 2022 with strong political commitment to enacting in the same year. This study sought to ascertain the views of fertility patients (service users) to the proposed AHR legislation in its current format, prior to its implementation.

Study design: A survey questionnaire, previously designed to investigate the attitudes and perceptions of healthcare professionals (HCPs) towards a broad range of issues contained within the draft AHR Bill, was adapted for a patient/service user population. The survey link was distributed via secure email to all patients that had a doctor consult at our fertility clinic in 2020–2021.

Results: The survey link was sent to 4420 patients/service users, of whom 1044 (23.6%) responded. A majority had experienced AHR treatment. Service users indicated strong support for AHR regulation and for access to all AHR techniques for all patients, irrespective of relationship or gender status. A majority of respondents disagreed with aspects of the draft bill regarding mandatory counselling, the timing of assignment of parentage in surrogacy, the exclusion of international surrogacy and the exclusion of men from posthumous AHR. Interestingly, the fertility patient cohort were more liberal in their views and opinions regarding AHR than the Irish HCPs previously surveyed.

Conclusion: This study demonstrates the views of a large group of AHR patients/service users towards proposed AHR legislation. Many of their views concur with but others differ from those of the drafters of the legislation and from those of healthcare professionals. Consideration of the views of all these groups and a collaborative approach would help ensure that Ireland has AHR legislation that is inclusive and fit for purpose in the 21st century.

Introduction

The World Health Organisation (WHO) recognises infertility as a disease, affecting an estimated 48 million couples worldwide. Legislation is crucial to protect AHR (Assisted Human Reproduction) providers and those accessing fertility services [1]. Above other medical specialties, AHR treatments raise important ethical, legal and social issues regarding parentage in donor or surrogacy programs and technologies or research involving embryos. Many agree that AHR treatments should not be governed by medical guidelines alone, but also by state law [2,3]. In Australia and the U.S., regulation and legislation are applied differently within states. This can restrict domestic treatment access, while also complicating cross-border fertility and antenatal care [4].

AHR legislation and policies vary considerably across nations. Contributing factors include funding or affordability, cultural and belief dimensions and customary law [5]. Most countries where assisted reproduction technology (ART) is practised have national regulation and legislation. Regulatory authorities such as the HFEA (UK) assist in providing regulation, maintaining standards and contributing to education and support for patients and providers. Ireland is a European outlier, as one of only five countries lacking specific AHR legislation, a feature that contributed to its recent low ranking (40th) out of 43 European countries [2].

The urgent need for Irish AHR legislation has long been recognised. A

* Corresponding author at: Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2, Ireland.
E-mail address: sobrien@merrionfertility.ie (S. O'Brien).

https://doi.org/10.1016/j.ejogrb.2023.03.020
Received 11 November 2022; Received in revised form 9 January 2023; Accepted 18 March 2023
Available online 21 March 2023

Commission on AHR was established in 2000, reporting in 2005. Compounded by lack of legislation, several individuals resorted to the courts to resolve AHR-related issues. Legal status of the human embryo and surrogacy have been subjects of landmark cases in the Irish High Court and Supreme Court [6–8]. In 2015, the Children and Family Relationships Act (CFRA) was introduced, with sections relating to ART commencing in 2020. This Act clarified legal parentage for families created by donor-assisted reproduction, outlawed anonymous donation and established a donor-assisted conception register. It did not address family limits permitted by donors, donor compensation or donor age requirements. A General Scheme of a more comprehensive AHR Bill was published in 2017 and a revised publication (March 2022) is awaiting enactment. A separate Government Committee, recently established to advise on legislation around international surrogacy, concluded this should be included in the AHR Bill. This may further stall enactment.

We believe it is important to involve key stakeholders such as service users/patients, in addition to healthcare professionals (HCP) and service providers, in discussions regarding complexities of AHR legislation. There are several international examples where prior consultation with professionals in the field might have averted considerable frustration and disputes [9–13]. The concept of Patient and Public Involvement (PPI) in research is well established and has been shown to positively influence study design, engagement and outcomes [14]. The PPI approach can also be beneficial in legislation design, as demonstrated by The Citizens Assembly (2016–2018) and its influence on Irish abortion legislation. The Assembly comprised one hundred people (non-politicians), selected nationally, to consider repeal of the Eighth Amendment of the Irish Constitution [15].

Some attempts have been made to evaluate views of service users and providers regarding AHR legislation in Ireland. A 2013 Irish study of 1003 members of the public showed that 63% supported introducing AHR legislation [16]. Our group recently investigated opinions of healthcare professionals (HCP), including Obstetrician/Gynaecologists, General Practitioners and Fertility Clinic staff, towards the proposed national AHR legislation [17]. In our study, the first conducted among Irish HCP, 93% of respondents supported legislation, overseen by a regulatory authority. However, a recent study of an Irish fertility patient cohort revealed an overall lack of knowledge regarding the proposed AHR Bill and absence of ART legislation [18]. Interestingly, patients felt legislation and subsequent regulation would improve knowledge, transparency, safety and access amongst those requiring ART.

The aim of this study was to ascertain opinions and attitudes of a large fertility patient/service user cohort regarding proposed Irish AHR legislation. It is important that this voice is heard, prior to implementation.

Materials and methods

Patient and public involvement and questionnaire design

A survey previously designed to investigate HCP attitudes towards the draft AHR Bill of 2017 was adapted for a patient/service user population. The questionnaire focused on six themes: (I) national AHR regulatory authority, (II) AHR treatment type and availability, (III) age limits, (IV) counselling prior to ART, (V) surrogacy and (VI) posthumous use of gametes/embryos. The survey questionnaire is available on request.

Study participants and recruitment

All patients/service users (≥18 years) who had a doctor consult in 2020 or 2021 at Merrion Fertility Clinic, a not-for-profit university-affiliated clinic associated with a publicly funded teaching hospital, were identified using the electronic patient management system. An anonymous questionnaire was distributed via secure email link. The survey remained open for 22 days, with reminders sent after 10 days. The questionnaire was based on a 3-point Likert Scale (Agree, Disagree, Unsure). Overall group responses were further analysed based on respondents' age, gender, number of children (if any) and treatment status. The study was approved by the Research Ethics Committee at the National Maternity Hospital, Ireland (EC19.2021).

Statistical analysis

Data was analysed based on age, gender, previous children and prior treatment access. GraphPad Prism was used to explore descriptive statistics and frequencies. Categorical variables were analysed using χ^2 test or Fisher's exact test; a p-value of < 0.05 was considered significant.

Results

Demographics

The survey invitation was circulated to 4420 patients/service users. Of the 1044 who responded (response rate 23.6%), 78.1% were women (n = 815) and 21.5% were men (n = 224). Respondent demographics are detailed in Table 1. Fifty seven percent had at least one child and 85% (n = 891) had previously had fertility treatment. A vast majority (99.7%) support establishment of a national regulatory body for oversight of ART provision. Only one respondent disagreed, two were unsure.

AHR treatments: Availability and access

Almost all respondents believe that currently available own-gamete ART treatments (IVF, ICSI, sperm freezing, egg freezing, embryo freezing; see Table 2 for definitions) should be available in Ireland, with 95% supporting gamete donation, 87% embryo donation, 92% surrogacy and 89% PGT. A lower proportion (74%) support embryo research. When responses were analysed by gender, age, number of children and treatment status, no differences were noted.

Over 90% of patients agree with AHR treatment for couples

Table 1
Survey Participant Demographics.

Demographic	n	%
Age (n = 1044)		
Under 30	6	0.6
30–34	165	15.8
35–39	473	45.3
40–45	358	34.3
Over 45	42	4.0
Gender (n = 1044)		
Male	224	21.5
Female	815	78.1
Transgender	1	0.1
Other	1	0.1
Unanswered	3	0.3
Has children (n = 1044)		
Yes	595	56.9
No	449	43.0
If yes (n = 595), how were they conceived?		
Spontaneously	146	24.5
With ART	384	64.5
Both	64	10.8
Unanswered	1	0.2
Fertility treatments (n = 891)		
Fertility surgery	44	4.9
Fertility drugs	82	9.2
IUI	41	4.6
IVF/ICSI	724	81.3

Table 2
Definition of Fertility Treatments.

Treatment		Definition
IUI	intrauterine insemination	A procedure in which laboratory processed sperm are placed in the uterus to attempt a pregnancy.
IVF	*in vitro* fertilization	A series of laboratory procedures to allow eggs and sperm fertilise and form embryos
ICSI	intracytoplasmic sperm injection	A type of IVF where a sperm is injected into each egg
PGT	preimplantation genetic testing	Screening of eggs or embryos for genetic or chromosomal abnormalities

(regardless of genders) and for single women (92%) (Table 3). However, 14.3% and 21.5%, respectively, are unsure about treatment for single men and transgender individuals. Male respondents are less likely than females to support treatment for single men ($p = 0.0014$), single women ($p = 0.0002$) and for transgender patients ($p < 0.0001$). Over half (55.3%) agree that couples should be able to access AHR treatment if they are not in a relationship (i.e. not married, co-habiting or in a civil partnership) but wish to co-parent together, while 22.4% of respondents are unsure regarding this. Gender-based differences are noted again, with males more likely than females to believe that couples should be married, co-habiting or in a civil partnership.

Age limits in ART

Overall, only 42.5% (n = 419/985) of respondents feel there should be upper age limits for women compared to 35% (n = 344/983) for men. Suggested upper age limits showed wide variation (18–65 years) with a mean of 46.4 years for women and 48.5 years for men. The majority based their view on medical advice and medical safety issues, with surprisingly little comment on broader social issues regarding age at parenting and potential impact on the child or children themselves.

Counselling

There is strong overall support for counselling services to be offered to all individuals undergoing fertility treatment (95.2%; Table 4). However, only 24% support mandatory counselling for all those having

Table 3
Access to AHR Treatments.

Survey question	Response	Total	Gender			Has children		
			Male	Female		Yes	No	
		n (%)	n (%)	n (%)	P-value	n (%)	n (%)	P-value
Do you think the following treatments should be accessible in Ireland?								
Treatment to enable a child/family for opposite sex couples (n = 991)	Yes	965 (97.4)	203 (96)	758 (97.7)	ns	552 (97.7)	413 (96.9)	ns
	Unsure	21 (2.1)	7 (3.3)	14 (1.8)		11 (1.9)	10 (2.4)	
	No	5 (0.5)	1 (0.5)	4 (0.5)		2 (0.4)	3 (0.7)	
Treatment to enable a child/family for same sex females (n = 990)	Yes	914 (92.3)	181 (85.8)	729 (94.1)	P = 0.0018	519 (92.2)	395 (92.5)	ns
	Unsure	54 (54.5)	19 (9)	35 (4.5)		32 (5.7)	22 (5.2)	
	No	22 (2.2)	11 (5.2)	11 (1.4)		12 (2.1)	10 (2.4)	
Treatment to enable a child/family for same sex males (n = 991)	Yes	904 (91.2)	182 (86.3)	718 (92.5)	P = 0.0076	516 (91.3)	388 (91.1)	ns
	Unsure	59 (6.0)	17 (8.1)	42 (5.4)		32 (5.7)	27 (6.3)	
	No	28 (2.8)	12 (5.7)	16 (2.1)		17 (3)	11 (2.6)	
Treatment to enable a child/family for single women (n = 992)	Yes	913 (92.0)	176 (83)	734 (94.6	P = 0.0002	514 (90.9)	399 (93.4)	ns
	Unsure	55 (5.5)	23 (10.9)	31 (3.9)		34 (6)	21 (4.9)	
	No	24 (2.4)	13 (6.1)	11 (1.4)		17 (3)	7 (1.6)	
Treatment to enable a child/family for single men (n = 990)	Yes	786 (79.4)	146 (68.9)	637 (82.3)	P = 0.0014	428 (75.8)	358 (89.4)	P = 0.0467
	Unsure	142 (14.3)	43 (20.3)	98 (12.6)		95 (16.8)	47 (11.1)	
	No	62 (6.3)	23 (10.8)	39 (5)		42 (7.4)	20 (4.1)	
Treatment to enable a child/family for transgender men (n = 990)	Yes	692 (70)	126 (59.4)	562 (72.6)	P < 0.0001	366 (64.8)	326 (76.3)	P = 0.0494
	Unsure	213 (21.5)	54 (25.5)	159 (20.5)		142 (25.1)	71 (16.6)	
	No	85 (8.6)	32 (15.1)	53 (6.9)		55 (9.7)	30 (7)	
Treatment to enable a child/family for transgender women (n = 990)	Yes	690 (69.7)	126 (59.4)	561 (72.4)	P < 0.0001	368 (65.4)	322 (75.4)	P = 0.0364
	Unsure	213 (21.5)	53 (25)	160 (20.7)		138 (24.5)	30 7)2	
	No	87 (87.9)	33 (15.6)	54 (6.9)		57 (10.1)	75 (17.6)	
Fertility treatment should be allowed for 2 people:								
Only if they are spouses, civil partners or cohabitants (n = 986)	Yes	335 (34)	98 (46.7)	234 (30)	P = 0.0008	207 (36.8)	128 (30.3)	P = 0.0133
	Unsure	133 (13.5)	29 (13.8)	434 (56.2)		81 (14.4)	52 (12.3)	
	No	518 (52.5)	83 (39.5)	104 (13.5)		275 (48.8)	243 (57.4)	
Who wish to co-parent but who are not spouses, civil partners or cohabitants (n = 985)	Yes	545 (55.3)	97 (46.4)	447 (57.9)	P < 0.0001	283 (50.4)	262 (61.9)	P < 0.0001
	Unsure	221 (22.4)	44 (21.1)	176 (22.8)		132 (23.5)	89 (21)	
	No	219 (22.2)	68 (32.5)	149 (19.3)		147 (26.1)	72 (17)	

Table 4
Counselling.

Survey question	Response	Total	Gender			Has children		
			Male	Female		Yes	No	
		n (%)	n (%)	n (%)	p-value	n (%)	n (%)	p-value
All persons having fertility treatment should be offered counselling (n = 984)	Yes	937 (95.2)	192 (91.4)	741 (96.2)	ns	535 (94.9)	402 (95.7)	ns
	Unsure	23 (2.3)	11 (5.2)	12 (1.6)		13 (2.3)	10 (2.4)	
	No	24 (2.4)	7 (3.3)	17 (2.2)		16 (2.8)	8 (1.9)	
Counselling should be compulsory for all persons having any fertility treatment (n = 980)	Yes	239 (24.4)	32 (15.5)	206 (26.8)	P = 0.0006	126 (22.4)	113 (27)	P < 0.0001
	Unsure	153 (15.6)	35 (16.9)	118 (15.3)		362 (64.4)	79 (18.9)	
	No	588 (60)	140 (67.6)	445 (57.9)		74 (13.2)	226 (54.1)	

any type of fertility treatment. Men were more opposed to mandatory counselling than women (67.6% v 57.9%; p = 0.0006), as were respondents without children (54.1% v 13.2%; p < 0.0001). Interestingly, those who previously had IVF/ICSI versus other forms of fertility treatment were also more opposed to mandatory counselling.

Surrogacy

The draft Bill does not address international surrogacy. As outlined in Table 5, 59% of patients disagree with this. The draft Bill also mandates intending parents must provide at least one, if not both, gametes, excluding those requiring donor embryo (double donor) treatment. Over 60% of respondents disagree with this.

77% (n = 741/961) of respondents disagree that legal parentage in Ireland, of children born via surrogacy, would not be assigned until at least 6 weeks after birth, at which point a parental order would be passed. A large majority (86.7%; n = 838/967) believe that this should be a pre-birth order, effective at birth. When responses regarding surrogacy were analysed by gender, age, number of children and treatment status, no differences were noted.

Table 5
Surrogacy.

Survey question	Response	Total,
		n (%)
Irish legislation should only address domestic surrogacy (n = 970)	Yes	204 (21)
	Unsure	194 (20)
	No	572 (59)
Irish legislation should address international surrogacy (n = 972)	Yes	871 (89.6)
	Unsure	83 (8.5)
	No	18 (1.9)
Egg or sperm must come from one of the intending parents. This would exclude people who need donor eggs and sperm (donor embryos). How do you feel about this? (n = 974)	Yes	143 (14.7)
	Unsure	213 (21.9)
	No	618 (63.4)
The surrogate who gives birth to the child should be the legal mother at birth (parental order granted minimum 6 weeks after birth) (n = 961)	Yes	62 (6.5)
	Unsure	158 (16.4)
	No	741 (77.1)
The intending parents should be the legal parents from birth (pre-birth order) (n = 967)	Yes	838 (86.7)
	Unsure	91 (9.4)
	No	38 (3.9)

Posthumous AHR

The draft Bill stipulates that upon death of a male partner in an opposite sex couple, a surviving female may use, posthumously, any stored gametes belonging to the deceased partner, or embryos created using such gametes. Similarly, a surviving female in a same-sex relationship may use her gametes and embryos posthumously. This is permissible if the deceased partner had consented to posthumous use prior to their death or incapacitation. In contrast, a surviving male partner (whether in an opposite or same sex relationship) is not allowed to engage in posthumous conception – for the purposes of this section, the draft Bill defines a 'surviving partner' as exclusively female. In formulating this question in the survey, patients/service users were advised that, in order to use gametes or embryos posthumously, men would need to engage a surrogate, or a new female partner to carry the pregnancy.

As shown in Table 6, most respondents agree with the posthumous use of sperm, eggs or embryos by female partners. A lower proportion, but a majority (73%), agree with posthumous treatment for the male partner, clearly disagreeing with the Bill's exclusion of men. Interestingly, those with children were less supportive of posthumous treatment for males than those without (p < 0.0001). When responses were analysed by gender, age and treatment status, no differences were noted.

Discussion

The current study is, to our knowledge, the first to survey a large cohort of fertility patients/service users regarding specific sections of a draft national Bill on AHR. Our findings reveal that patients almost unanimously support availability of all current ART techniques, access to treatment for all patient populations and appropriate regulation.

Support among fertility patients for all AHR techniques reflects a growing progressive and liberal trend in Irish society in recent years [19]. Support for egg and sperm donation and PGT among patients was 94.9%, 94.6% and 89.4%, respectively, markedly increased from a previous study of the public [16] and largely in keeping with our recent findings of 91%, 91% and 96% support respectively among HCP [17]. Notably, many of these practices, such as egg/embryo donation and PGT, are restricted or unavailable in several European countries. Many restrict treatment access to heterosexual couples only. The strong majority view in our study is that AHR treatments should be available inclusively to all groups in society, including single men and women, same-sex couples and transgender individuals. This reformist view reflects Ireland's progressive status as the first country globally to legalise same sex marriage by popular vote. Interestingly, men appear more conservative than women with regard to conception in 'non-traditional'

Table 6
Posthumous Conception.

Survey question	Response	Total	Gender			Has children		
			Male	Female		Yes	No	
		n (%)	n (%)	n (%)	p-value	n (%)	n (%)	p-value
Posthumous use by Surviving Female partner (n = 978)	Yes	843 (86.2)	182 (87.1)	658 (86)	ns	463 (82.9)	380 (90.5)	ns
	Unsure	105 (10.7)	23 (11)	82 (10.7)		76 (13.6)	29 (6.9)	
	No	30 (3.1)	4 (1.9)	25 (3.3)		19 (3.4)	11 (2.6)	
Posthumous use by Surviving Male partner (n = 978)	Yes	710 (72.6)	158 (75.6)	550 (71.9)	ns	373 (66.8)	337 (80.2)	<0.0001
	Unsure	171 (17.5)	38 (18.2)	132 (17.3)		70 (12.6)	56 (13.3)	
	No	97 (9.9)	13 (6.2)	83 (10.8)		115 (20.6)	27 (6.4)	

family situations.

In general, respondents support most aspects of the draft Bill, but several key issues arise. These include opposition to universal mandatory counselling and strong views that men should also have access to posthumous conception, mirroring views of the parliamentary health committee that reviewed the Bill in 2018/2019. They align with views of HCPs surveyed in our previous study. The parliamentary health committee felt that, for individuals undergoing standard treatment without involvement of a third party, the decision to undertake counselling is more appropriately decided between clinician and patient(s) [20]. We are not aware of any other medical condition, not involving third parties, where counselling is mandated legislatively. Regarding posthumous conception for men, the parliamentary health committee [20] asked further consideration be given to "*inconsistencies (in the draft Bill) with regard to excluding male surviving partners (in opposite sex and same sex couples) from accessing posthumous AHR treatment.*" Draft legislation limits treatment to those in legally recognised relationships together i.e., married, co-habiting or in a civil partnership. However, 55% of our patients/service users believe treatment should be allowed for two people who wish to co-parent but who are not spouses, civil partners or cohabitants. This is a higher proportion than HCPs (49% [17]).

Surrogacy is complex and controversial, not only in Ireland but internationally. It is notable that many EU countries prohibit surrogacy [5]. Contrary to proposed legislation, most patients (86.7%) believe parentage should be assigned to intended parents from birth, similar to the majority view of HCP (83.8%) in our previous study. Patients also favour inclusion of international surrogacy in Irish AHR legislation. The need for uniform private international law regarding legal parentage in international surrogacy is recognised internationally [21]. In Ireland, a parliamentary Joint Committee on International Surrogacy (JCIS) was established in February 2022 to address issues arising from international surrogacy. Following wide consultation with national and international experts they produced an impressive report [22]. While maintaining a post-birth parental order, it stipulates that this must be granted within 7–21 days of birth. The draft legislation (which currently addresses only domestic surrogacy) stipulates that one/both gametes must come from the intending parent/s. Our survey respondents disagree with this. It is interesting that, while the JCIS favours retaining this link for international surrogacy, they advise against it as a requirement for domestic surrogacy.

A major strength of our study is its setting. As one of only five European countries lacking ART legislation, our findings provide valuable information on views of fertility patients in Ireland *prior to* legislation implementation. It is hoped these views will be heard and heeded. The study size of over 1000 respondents is significant. Approximately 85% have had fertility treatment and 72% have had IVF/ICSI, making this a relevant and well-informed group. Interestingly, the patient cohort were more liberal in their attitudes than Irish HCPs previously surveyed, particularly on mandatory counselling and legislation covering both surrogacy and access to treatment for transgender people. This may indicate that those providing fertility care are misaligned with consensus amongst patient populations, giving added weight and validation to patient involvement and input in such matters. Some limitations of this study include the urban location of the clinic. By their nature, fertility centres tend to be located in urban zones. They do, however, cater for a broad population, with patients travelling from varied geographic locations, rural and urban. Additionally, we did not delineate the religious or ethnic background of those surveyed. While the clinic does not specifically record religion in demographics, religious beliefs that may conflict with elements of ART are explored at initial consultation i.e some may have concerns about embryo discarding or testing. Ireland has been moving towards separation of State and Catholic Church for many years with respect to education and healthcare. While geographic origin and ethnicity was not a data point in this study, we are confident that there is a spread of urban and rural dwelling patients.

AHR encompasses an array of complicated medical, social and legal issues. Legislation and regulation of practice is critical to protect children conceived by AHR, but also intending parents, donors of gametes and embryos, surrogates and their families and ART service providers. The 2018 EIM survey [5] demonstrates varied practices across Europe. Legislation is described as "hard" or "soft", the former focusing on inspections and penalties, the latter on improving standards by changing the mindset of those involved in operations [23]. Hard legislation in a rapidly evolving field such as AHR may struggle to keep up with advances and can foster reproductive tourism, encouraging couples to seek care outside their country of origin to avail of emerging treatments which have not yet been implemented into domestic legislation [24,25]. The complex situation in Ireland and many European countries regarding international commercial surrogacy is a prime example of this. In many ways, with its lack of legislation and its status as a socially progressive country, Ireland is now positioned to learn from international experience and benefit from PPI methods as used here.

These variances with the current draft legislation have been communicated to involved civil servants, politicians and legislators so that amendments can be considered before legislation is finalised and implemented. This will aim to ensure culturally appropriate and future-proofed legislation that is fit for purpose. Regarding surrogacy, the reluctance of our legislators to consider the option of granting legal parentage to the intending parents from birth and their insistence on retaining the post-birth parental order arrangement, conflicts with the views not only of our study group, but also those of the UK and Scottish Law Commissions. After 20 years of a post-birth parental order arrangement, the UK public and legislators are moving towards a system of parentage from birth. It will be unfortunate if our legislators ignore this history.

In conclusion, the views of fertility patients in Ireland support liberal and equitable approaches to availability of AHR treatments in the context of appropriate, balanced legislation and regulation. In framing this extremely complex legislation, it is important to 'get it right', and Ireland has a unique opportunity to do this.

Authorship and contributorship

S. O'Brien; substantial contribution to conception and design, drafting of the paper and final approval, agrees to be accountable for all aspects of the work.
L. Schaler; substantial contribution to conception and design, drafting of the paper and final approval, agrees to be accountable for all aspects of the work.
A. Giblin; substantial contribution to conception and design, drafting of the paper and final approval, agrees to be accountable for all aspects of the work.
L. Glover; substantial contribution to conception and design, drafting of the paper, revising and final approval, agrees to be accountable for all aspects of the work.
M. Wingfield; substantial contribution to conception and design, revising and final approval, agrees to be accountable for all aspects of the work.

Funding

No funding was received for this research.

Data availability statement

The data underlying this article will be shared on reasonable request to the corresponding author.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

[1] WHO. Infertility. https://www.who.int/news-room/fact-sheets/detail/infertility; 2020.
[2] Atlas. European Atlas of Fertility Treatment Policies (Fertility Europe in conjunction with the European Parliamentary Forum for Sexual and Reproductive rights) 2021 [Available from: https://fertilityeurope.eu/european-atlas-of-fertility-treatment-policies/.
[3] Szoke H. The nanny state or responsible government? J Law Med 2002;9(4):470–82.
[4] Thorpe R, Petersen K, Pitts MK, Baker HW. New assisted reproductive technology laws in Victoria: a genuine overhaul or just cut and paste? J Law Med 2011;18(4):835–50.
[5] Calhaz-Jorge C, De Geyter CH, Kupka MS, Wyns C, Mocanu E, Motrenko T, et al. Survey on ART and IUI: legislation, regulation, funding and registries in European countries: The European IVF-monitoring Consortium (EIM) for the European Society of Human Reproduction and Embryology (ESHRE). Hum Reprod Open 2020;2020(1). hoz044.
[6] MR-v-TR. [2006] IEHC 359. High Court; 2006.
[7] MR&DR-v-t-Ard-Chlaraitheoir. M.R. and D.R. (suing by their father and next friend O.R.) & ors -v- An t-Ard-Chlaraitheoir & ors [2014] IESC 60. Supreme Court; 2014.
[8] Roche-v-Roche. [2009] IESC 82. Supreme Court; 2009.
[9] Benagiano G, Gianaroli L. The Italian Constitutional Court modifies Italian legislation on assisted reproduction technology. Reprod Biomed Online 2010;20(3):398–402.
[10] Gordts S, Campo R, Puttemans P, Brosens I, Valkenburg M, Norre J, et al. Belgian legislation and the effect of elective single embryo transfer on IVF outcome. Reprod Biomed Online 2005;10(4):436–41.
[11] Leopoldina. Reproductive medicine in Germany – towards an updated legal framework. . German National Academy of Sciences Leopoldina and Union of the German Academies of Sciences; 2019.
[12] Molinelli A, Bonsignore A, Darretta V, Anserini P. Results and unsolved problems following the amendment to the Italian Law on assisted reproduction brought about by the Constitutional Court. Eur J Obstet Gynecol Reprod Biol 2012;163(1):1–4.
[13] Ombelet W, De Sutter P, Van der Elst J, Martens G. Multiple gestation and infertility treatment: registration, reflection and reaction–the Belgian project. Hum Reprod Update 2005;11(1):3–14.
[14] Brett J, Staniszewska S, Mockford C, Herron-Marx S, Hughes J, Tysall C, et al. Mapping the impact of patient and public involvement on health and social care research: a systematic review. Health Expect. 2014;17(5):637-50.
[15] JCoEAC. Report of the Joint Committee on the Eighth Amendment of the Constitution 2017 [Available from: https://2016-2018.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Joint-Oireachtas-Committee-on-the-Eighth-Amendment-of-the-Constitution-/Report-of-the-Joint-Committee-on-the-Eighth-Amendment-of-the-Constitution-.pdf.
[16] Walsh DJ, Sills ES, Collins GS, Hawrylyshyn CA, Sokol P, Walsh AP. Irish public opinion on assisted human reproduction services: Contemporary assessments from a national sample. Clin Exp Reprod Med 2013;40(4):169–73.
[17] Schaler LGA, Glover LE, Wingfield M. Assisted Human Reproduction Legislation: listening to the voice of Health Care Professionals. European. J Obstet Gynaecol 2022.
[18] Agrawal R, Burt E, Homburg R. Time-Line in HFEA Developments and Regulatory Challenges: 20 Years of Overseeing Fertility Practices and Research in the UK. J Obstet Gynaecol India 2013;63(6):363–9.
[19] Allison J. Enduring politics: the culture of obstacles in legislating for assisted reproduction technologies in Ireland. Reprod Biomed Soc Online 2016;3:134–41.
[20] JCoH. Report on Pre-Legislative Scrutiny of the General Scheme of the Assisted Human Reproduction Bill Joint Committee on Health; 2019.
[21] HCCP. The Parentage/Surrogacy Project: Hague Conference on Private International Law. https://www.hcch.net/en/projects/legislative-projects/parentage-surrogacy; 2019.
[22] JCIS. Final Report of the Joint Committee on International Surrogacy 2022 [Available from: https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_international_surrogacy/reports/2022/2022-07-06_final-report-of-the-joint-committee-on-international-surrogacy_en.pdf.
[23] Rutherford AJ. Should the HFEA be regulating the add-on treatments for IVF/ICSI in the UK?: FOR: Regulation of the fertility add-on treatments for IVF. BJOG 2017;124(12):1848.
[24] Ledger WL. The HFEA should be regulating add-on treatments for IVF/ICSI. BJOG 2017;124(12):1850.
[25] Wilson TL. Unravelling orders in a borderless Europe? Cross-border reproductive care and the paradoxes of assisted reproductive technology policy in Germany and Poland. Reprod Biomed Soc Online 2016;3:48–59.