

Beyond consanguinity risk: developing donor birth limits that consider psychosocial risk factors

To the Editor:

In the August 2008 issue of *Fertility and Sterility*, Sawyer and McDonald provide a useful and insightful review of mathematical models used to determine sperm donor birth limits (1). The review is timely, given recent policy deliberations around gamete donation.

Worldwide, advocacy groups, governments, and gamete donation programs strive to identify and implement policies that promote the best interests of the recipients, donors, and donor-conceived people. As discussed, donor limits are typically determined by attempts to minimize the risk that donor-linked individuals will have children together. We agree that mathematical modeling is useful to determine these limits in cases when donors are anonymous and parents do not disclose their children's donor origins. However, when families are more open and/or when single women and lesbian couples represent the majority of donor insemination (DI) recipients (e.g., in the U.S.), additional consideration needs be given to the phenomenon of contact among individuals and families who share the same donor (2). Meeting a few or even ten donor-linked families can be joyous and incredibly positive; the impact of meeting 25–50 families may be more challenging and even negative. We suggest that birth limits may be better determined by psychologic factors primarily, and then secondarily informed by modeling based on consanguinity risk.

Following this, we suggest that with open-identity donation (e.g., in Victoria, Australia), psychologic factors should be the primary determinant. In this case, the limit should be the number of individuals with whom a donor can have meaningful interactions. Indeed, the goal of open-identity donation is to meet the needs of donor-conceived adults by providing access to genetic and medical information and addressing questions of origins and ancestry. No doubt this will result in lower birth limits per donor than one determined by consanguinity risk alone.

Finally, because Sawyer and McDonald's review will likely provide material for limit-setting deliberations, we note that some of the limits have changed, likely owing to the rapidly changing environment of assisted reproduction. For example, in the U.K., donor limits are specified by families (ten per donor), not by births (3). In the U.S., the limits actually differ from the U.K. and are recommended, not regulated, to be 25 births per donor per population of 800,000 (4). Thus, many programs in the United States will have higher numbers of individuals born per donor than the ten nationwide listed in this article. Knowing that these numbers vary widely and how they may affect the people and families created through gamete donation should provide us with impetus to more closely consider how DI is practiced.

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