Brief on Draft Code of Practice on the Reproductive Technology and Embryo Research

Purpose

1. This briefing paper highlights the major areas covered in the draft Code of Practice on the Reproductive Technology and Embryo Research.

Background

2. According to clause 7 of the Human Reproductive Technology Bill, the Council shall prepare and maintain a code of practice giving guidance about the proper conduct of any relevant activity.

3. The Provisional Council on Reproductive Technology has prepared a draft Code of Practice on the Reproductive Technology and Embryo Research (COP). It is planned to issue the draft COP to service providers and relevant organisations for consultation in February 1999.

Highlights of the Draft COP

4. As shown in the content page, the draft COP has 15 chapters covering various aspects of the practice of reproductive technology (RT) procedures and relevant activities.

1

5. Chapter 2 highlights the legal provisions of licensee and person responsible. This Chapter also describes the qualification and experience required for other staff. RT procedure should be administered and/or supervised by a registered medical practitioner. The overall clinical responsibility for RT procedure should be a medical practitioner with relevant specialist registration.

6. The general standards and minimum requirement of the facilities and equipment in the RT centres for different services are outlined in Chapter 3.

7. Detailed guidelines on the assessment of clients and donors are provided in Chapter 4. The assessment would take into consideration of the welfare of the child and various psycho-social and medical factors of the clients and donors.

8. Chapter 5 describes the guidelines on the necessary information that should be provided to the clients and donors which include information about treatment procedure, legal status of the child and various parties, submission of information to the Council and the child's right to access to non-identifying information about the donor on reaching 16 years old.

9. Chapter 6 outlines the guidelines in obtaining consent from various parties which include the husband of a woman who received donor insemination. Eleven sample consent forms are listed in Annex I.

10. Guidelines on the information to be covered during counselling are listed in Chapter 7.

11. Chapter 8 mentions the general standard of the treatment methods. This Chapter also highlights the importance of the prevention of high multiple pregnancies. In case embryonic / fetal reduction is needed, such procedure should be authorised by court.

12. Chapter 9 describes the principles on the collection and use of gametes and embryos. Only banked semen should be used for donor insemination whereas fresh or banked semen can be used for artificial insemination of husband. This Chapter also provides guidelines regarding importation and exportation of gametes and embryos. Gametes or embryos from any single donor should not be used to produce more than 3 pregnancies.

13. Chapter 10 provides guidelines and principles on the proper storage and disposal of gametes and embryos and the storage period. In general, the maximum storage period of gametes or embryos should not exceed 10 years. For cancer or other patients, the gametes may be stored until 55 years old. Stored sperm or embryo should not be used to bring about a post-humous child.

14. The legislative provisions regarding embryo research and the use of fetal ovarian or testicular tissue are reiterated in Chapter 11. Besides, this Chapter also provides additional guidelines on the conduct of research on gametes and embryos. There should be Ethic Committee within the RT centre to scrutinise research proposal before it is submitted

to the Council for approval.

15. Chapter 12 provides guidelines about surrogacy. Factors including marital status, history of pregnancy, and physical and mental fitness to carry a baby should be taken into consideration in assessing the suitability of a woman to be a surrogate mother. A woman who is at a higher risk of suffering complications of pregnancy should not be a surrogate mother. Cases of surrogacy should be reported to the Council within 3 months after completion of procedure of each treatment cycle.

16. Guidelines on gender selection are laid out in Chapter 13. Besides mentioning the relevant legal provisions, information needs to be discussed with patients / clients about severe sex-linked genetic disease are also highlighted in this Chapter. A list of examples of sex-linked genetic diseases is attached in Appendix 4. Cases of sex selection achieved through RT and cases which resort to sex-selective abortion should only be conducted in accordance to the law and these cases should be reported to the Council within 3 months.

17. Chapter 14 provides guidelines on proper record keeping and information management. Information needs to be submitted to the Council are listed in this Chapter.

18. Chapter 15 provides guidelines on the handling of complaints and the subsequent channels that the complaints may be referred.