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The Law and Assisted Reproduction in the United Kingdom and United States

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THE LAW AND ASSISTED REPRODUCTION IN THE UNITED KINGDOM AND UNITED STATES

ROBERT L. STENGER

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I. INTRODUCTION

The development, publicity and availability of new and assisted methods of human reproduction raise profound ethical, legal and medical concerns. As for any new medical technology, there is a need for research and experimentation. At the same time, because human life is involved, there are calls for ethical and legal evaluations and regulations.

These new technologies have been developed and applied in different countries, each with different cultures and legal traditions. It is instructive to compare how different countries respond legally to such new technologies. A comparison between the United States and United Kingdom is particularly enlightening because both share a common law heritage and because assisted reproduction has significant historical roots in England.

II. FEDERAL LEGISLATION IN THE UNITED STATES

Only in the past few years has the Congress of the United States addressed issues arising from the development of assisted reproductive technologies. The Fertility Clinic Success Rate and Certification Act of 1992\(^2\) arose from concerns over consumer protection and quality control. The Act calls for annual reporting to the Centers for Disease Control of pregnancy success rates achieved by assisted reproductive technology programs\(^3\) and for the development of a model program for certifying embryo laboratories.\(^4\)

In articulating the reason for the legislation, the Senate Committee on Labor and Human Resources noted how "[m]edical advancements in the field of assisted reproductive technologies have significantly improved the likelihood

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3Id. § 263a(1).

4Id. § 263a(2).
of overcoming some infertility problems." The Committee recognized the extent of the problem as infertility was found to affect one in six couples (about 5 million families) who sought infertility services at an expense of over $1 billion in 1990.

"Assisted reproductive technology" was defined to include "all treatments or procedures which include the handling of human oocytes or embryos, including in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer" and whatever other methods the Secretary might include. In vitro techniques (IVFs) involve fertilization of an egg in the laboratory ("in vitro"), while gamete intrafallopian transfer (GIFT) involves fertilization in the fallopian tube.

The following year Congress again addressed infertility issues as part of the National Institutes of Health Revitalization Act of 1993. The Act provided for the creation of research centers with respect to contraception and infertility and for research on the transplantation of fetal tissue. It was noted in Congressional hearings that promising research had been threatened and disrupted by "[u]nreasonable prohibitions" and "unilaterally imposed obstructions" arising from a fear that research might increase the number or acceptability of abortions.

In explaining the Act, the Committee articulated the relationship between contraception and infertility. While nearly half of the pregnancies in the U.S. may be unplanned (many due to contraceptive failure), and while half of the unplanned pregnancies may be terminated by abortion, almost two and one half million couples find their desire for a child dashed by problems with infertility.

While some Congressional action on infertility and the impact of assisted reproduction techniques has taken place recently, the United States is far

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6Id.


8S. REP. No. 452, supra note 5, at 2.


12S. REP. No. 2, 103rd Cong., 1st Sess. 13 (1993), reprinted in 1993 U.S.C.C.A.N. 196, 208-09 (stating that recent administration actions . . . subvert the principle of freedom of scientific inquiry . . . . The peer review system that identifies the most meritorious research proposals has been undermined . . . . The Bush administration ban on fetal tissue transplantation research was unjustified on scientific, ethical, or humane grounds.)."Id. at 214-15.

13Id. at 212.

14Id.
behind many other comparable countries in addressing such issues.\textsuperscript{15} The above mentioned Acts call only for the collection of data and providing recommendations for regulating research and procedures. Many crucial questions remain unaddressed.

The reasons for the failure to address issues of human reproduction at the national level are numerous. One is the volatile issue of abortion. The Reagan and Bush administrations were elected on anti-abortion platforms. Medical procedures that could be deemed pro-abortion were forbidden either via continuing the denial of federal funding for abortion-related procedures or through executive orders prohibiting such activities.\textsuperscript{16}

The major change at the federal level with respect to abortion came in 1973 with the decision in \textit{Roe v. Wade}.\textsuperscript{17} The importance of that decision for issues concerning assisted reproduction was the delineation of time periods marking different governmental interests in the developing fetus.\textsuperscript{18} Because mortality in abortion is less than in normal childbirth up to the end of the first trimester, during that period the state has no compelling reason to regulate pregnancy.\textsuperscript{19} Because viability marks the time when the fetus "presumably has the capability of meaningful life outside the mother's womb," the state has a compelling interest to protect fetal life.\textsuperscript{20} After \textit{Roe} the debate centered around the legal protection to be given to the nonviable fetus, when such protection should begin and how the fetus was to be viewed with respect to the pregnant woman.\textsuperscript{21}

For a time, predictions about the continuing validity of \textit{Roe} appeared in media discussions, as nominees for the Supreme Court were quizzed about their positions on abortion. In 1992 the Court reaffirmed \textit{Roe’s} essential holding that a pregnant woman could choose whether to continue the pregnancy. However, the plurality rejected \textit{Roe’s} trimester analysis and recognized the state’s substantial interest, throughout the pregnancy, in potential life.\textsuperscript{22}

The legal semantics and politics of the abortion decisions over more than twenty years have not altered the volatile nature of the underlying issues. Legal protection for human life has been a significant part of discussions concerning

\begin{itemize}
\item \textsuperscript{17}410 U.S. 113 (1973).
\item \textsuperscript{18}\textit{Id.} at 163-65.
\item \textsuperscript{19}\textit{Id.} at 163.
\item \textsuperscript{20}\textit{Id.}
\item \textsuperscript{21}See Laurence Tribe, \textit{Abortion: The Clash Of Absolutes} (1990).
\item \textsuperscript{22}Planned Parenthood v. Casey, 112 S. Ct. 2791, 2798-99 (1992).
\end{itemize}
assisted reproduction, which may involve fertilization and development outside the mother’s body, termination of fetal life (selective reduction of multiple pregnancies, research on embryos) and life after birth (foregoing life-sustaining treatment for newborns).

As Ronald Dworkin suggested some years ago, consensus is unlikely to be achieved when one side is making arguments of principle while the other side makes arguments of policy. Posed differently, consensus is unlikely when proponents of a result based upon a utilitarian calculus face deontologically-based objections. It is extremely difficult, if not impossible, to reach a consensus while one side attempts to justify or at least tolerate what the other side finds absolutely unacceptable.

A second hurdle to a federal solution to questions arising from assisted reproduction lies in the structure of our constitutional form of government. The articulated powers of the federal government leave many issues to the states, including family law (definitions of marriage, family, parenthood, legitimacy), contract (agreements with health care providers, surrogacy contracts), tort (wrongful birth, wrongful life, prenatal injury), crime (feticide) and regulation of health and medical procedures under the police power. Historically, the federal government has not attempted to impose uniformity among the states on such matters.

Uniformity is imposed, however, when the issue is resolved on the basis of constitutional rights derived from the Federal Constitution, which was the avenue taken in *Roe v. Wade*. One major source of disagreement within the *Roe v. Wade* decision was the Supreme Court’s interpretation of the Constitution so as to preclude any state options for different solutions. In recent years more and more of family law has been constitutionalized in decisions based upon rights. Family relationships, however, do not lend themselves to resolution in terms of dichotomous assertions of rights: parent-child, mother-fetus, father-mother-child. So also at the state level, efforts to resolve the issues by discovering rights in state constitutional language would remove the matter from legislative action. Yet the recent history of civil rights efforts, whether on the basis of race, gender, sexual orientation, abilities, or age lends credibility to claims of rights and motivates those promoting a claim based on rights.

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23 Ronald Dworkin, *Taking Rights Seriously* 82-83 (1977) [hereinafter *Taking Rights Seriously*]. Later, he would distinguish further between derivative claims (that the fetus already has rights from conception) and detached claims (that from conception a fetus embodies a form of human life which is sacred). Ronald Dworkin, *Life’s Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* 11-13, 19-22 (1993) [hereinafter *Life’s Dominion*].

24 This is consistent with the mandate that “the powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the States respectively or to the people.” U.S. Const. amend. X.

25 See 410 U.S. at 147.

26 *Id.* at 152-53.
The abortion controversies have also revealed the limitations of claims based on rights. The convoluted controversies over constitutional interpretation show that disagreements on basic issues are not resolved on the basis of textual exegesis or historical practice or philosophical analysis. Such arguments simply add another dimension to the breadth and intensity of the disagreements. For now the two sides differ not only over the underlying substantive issue but also over methodological principles for resolving the issue. The absence of a basic moral consensus becomes more apparent. The United States once took pride in being a melting pot (*e pluribus unum*) with a centripetal moral-religious outlook. That underlying and unifying consensus has itself come under recent attack in the name of pluralism, diversity and recognition of difference.

III. LEGISLATION IN THE UNITED KINGDOM

It proves enlightening to compare the experience of legislation of assisted reproductive technology in the United States with that in the United Kingdom. There are significant differences both at the level of method (how decisions are arrived at) and in the content of the decisions (what is decided). Obviously the two are related for how one makes a decision will shape the outcome.

The experience in the United Kingdom is especially helpful because one can exactly date the eruption of public discussions. That date is July 25, 1978, when Louise Brown was delivered by Caesarian section in the Oldham and General District hospital in Lancashire.\(^{27}\) Research and experimentation had been taking place for some time, but the birth of the first baby whose conception had been assisted artificially focused attention on what was no longer science fiction or dream but a lovely 5 lb. 12 oz. baby girl.\(^{28}\) Yet even as the participants rejoiced in the success of their efforts, questions were raised which would dominate future debate.

Louise Brown was her parents' daughter in every sense of the word. She developed from her father's sperm, her mother's egg, and within her mother's body, from which she was born.\(^{29}\) Her mother and father were married and


Robert Edwards, Professor of Human Reproduction at Cambridge, along with gynecologist Patrick Steptoe, assisted in the conception of Louise. Not only does the author describe the years of effort which went into the birth of the first "test-tube baby," he also states a basic thesis of scientists and physicians working in the area of assisted reproduction (in response to a claim that they are "creating life" or "playing God"): Nobody can create human life artificially, not in a test-tube, a Petri dish, or anywhere else. Such claims are ridiculous, pathetically arrogant. Life is uniquely *there*, bursting out everywhere, a wonderful part of our universe. The most that any of us can do is to help make life possible, and to make it healthy and good.

*Id.*

\(^{28}\) *Id.*

\(^{29}\) See *id.* at 1-2.
their intention to have a child motivated their participation in a program with those who provided expertise in assisted reproduction. At the same time, it was apparent that different persons could function as gestational parent: sperm donor, egg donor, or embryo donor; gestational parent: the woman who carries and gives birth to a child; and intending parent(s): those who hope to raise the child. Some or none of these individuals may be legally married to one another and one or more could be married to a non-participant. The possibility and probability of stimulated ovulation producing many eggs whose fertilization in vitro could produce several embryos raised further questions. Possibilities became even more numerous with the use of cryopreservation to freeze sperm and embryos for future use. Publicized success in one case increases demand from others such as infertile persons seeking to become parents, from physicians treating infertility, and scientists wishing to do research to produce further successes.

The birth of Louise Brown was the first of many from assisted reproduction. Edwards and Steptoe opened their own clinic, Bourn Hall, which had five test-tube babies and sixty pregnancies by 1981. The first child born in Australia through such technology was born in 1980. Similar technology was successfully employed in Europe, the United States, China, the Middle East, Africa and South America.

The growth and success of the new technologies prompted calls for investigation and regulation. While some remembered Mary Wollstonecraft Shelley, Aldous Huxley, George Orwell and the excesses of so-called eugenic experimentation by Nazi doctors, others were anxious about the intrusion of medical technology into the most intimate recesses of human life and human relationships.

Committees to study the ethical, legal, social and political dimensions of the new reproductive technologies were set up by churches, medical societies, and activist groups either supporting or opposing the use of the new technologies. In July, 1982, the Government's Secretary of State for Social Services announced the establishment of a sixteen member committee of inquiry, composed of theologians, social workers, attorneys, and scientists,

30 Edwards, supra note 27, at 1-2.


33 Richard McCormick, How Brave a New World?: Dilemmas in Bioethics, ch. 16 (1985)

34 See, e.g., for example, the Church of Englands' report, Personal Origins, and the Roman Catholic document, Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation.
under the chairmanship of the philosopher Dame, now Lady Mary Warnock, Mistress of Girton College, Cambridge.\textsuperscript{35}

The Warnock Report was presented on June 26, 1984, after two years of work by the committee.\textsuperscript{36} Before addressing specific issues, the Committee recognized the problem of relating legislation and morality in such controversial areas as human life.\textsuperscript{37} It was accepted without argument that birth, death, and establishing a family were morally significant issues.\textsuperscript{38} It was also accepted that such issues with respect to embryos and assisted reproduction were not determinable by rules, for none existed about such issues, nor by arguments from utility, for these required prior judgments about the status of the embryo.\textsuperscript{39} With respect to law and morals, the Committee referred to the distinction offered by H.L.A. Hart in \textit{Law, Liberty and Morality} between a primary moral problem or first level (is some action right or wrong) and a critical moral problem or second level (if law were to intervene, would the infringement of liberty be right or wrong).\textsuperscript{40}

The Committee then adopted its basic position with respect to the human embryo. The question was not whether the embryo was alive or human, or whether, if implanted, it might eventually become a full human being.\textsuperscript{41} The Committee stated the following:

We argued that in practical terms a collection of four or sixteen cells was so different from a full human being... that it might quite legitimately be treated differently. Specifically, we argued that unlike a full human being it might legitimately be used as a means to an end that was good for humans, both now and in the future... This is a moral judgment, with focus not on potentiality but on actuality, on what the embryo was at a particular time.\textsuperscript{42}

\textsuperscript{35}\textit{EDWARDS, supra} note 27, at 113. In commenting upon the Warnock Report, Simon Lee reflected: "At its worst the Warnock Report was the product of the wrong people considering the wrong issues in the wrong way. At its best it provides pointers to good medical law, ethics and practice." Simon Lee, \textit{Rereading Warnock, in RIGHTS AND WRONGS IN MEDICINE}, 37... (Peter Byrne, ed. 1986). He noted the absence of physicians and scientists who were \textit{in vitro} researchers and lawyers and ethicists who specialized in reproductive medicine; yet he recognized the need for some permanent body to monitor the area and to issue codes of practice. \textit{Id.}

\textsuperscript{36}MARY WARNOCK, A QUESTION OF LIFE-THE WARNOCK REPORT ON HUMAN FERTILIZATION AND EMBRYOLOGY (1985).

\textsuperscript{37}\textit{Id.} at xii-xvii.

\textsuperscript{38}\textit{Id.} at viii.

\textsuperscript{39}\textit{Id.} at ix-x.

\textsuperscript{40}WARNOCK, \textit{supra} note 36, at xi.

\textsuperscript{41}\textit{Id.} at xii.

\textsuperscript{42}\textit{Id.} at xiv-xv. In its conclusion, the Committee returned to these issues, noting that matters of life and death, birth and family are central to morality, where persons have a right to make judgments for themselves (such is the Protestant tradition which runs
The Committee recognized that the public strongly supported the value of the absolute sanctity of human life from the earliest stage of development. It also recognized that the public strongly supported advancements in scientific and medical knowledge for the treatment of infertility and the creation and application of knowledge for prenatal diagnosis and treatment.

The Committee made a second moral judgment in determining eligibility for assisted reproduction. It concluded that heterosexual couples living together in a stable relationship should be eligible for treatment. The Committee did consider single parents, but concluded that it was generally better for children to be born into a two-parent family with both a mother and a father. It was less important that the couple be married to one another.

This judgment was based in part upon the European Convention on Human Rights which provides in Article 8: "Everyone has the right to respect for his private and family life" and in Article 12: "Men and women of marriageable age have the right to marry and to found a family."

The Committee made specific recommendations about the different technologies. The Warnock Report's recommendations proved to be quite influential when subsequent discussions and legislation incorporated them. This is especially true of the basic structure of a licensing authority to authorize and regulate personnel and clinics offering assisted reproduction.

Artificial insemination (using semen either from the woman's husband or from a donor) was found to have become morally acceptable within society. The recommendation was that it be licensed with the following restrictions: the couple should be counselled and give their consent in writing, the semen donor should have no parental rights or duties with respect to the child, any third party donor's identity should be unknown to the couple although at age eighteen a child should have access to the donor's ethnic, genetic and health information, and no more than ten children should be fathered by any one donor's semen. The Committee less strongly recommended that semen not be used after the donor's death, even if the semen was from the mother's husband.

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43 Id. at 99.
44 WARNOCK, supra note 36, at 99.
45 Id. at 10.
46 Id. at 11.
47 Id. at 11-12.
49 WARNOCK, supra note 36, at 82.
50 Id. at 23-27.
Similar approval and restrictions were made concerning egg donation, for it seemed illogical to accept semen donation but not egg donation. However, the woman giving birth should be regarded for all legal purposes as the mother and not the egg donor.\textsuperscript{51} In vitro fertilization should be licensed and available and included within the National Health Service offerings.\textsuperscript{52} Surrogacy, however, was found to be quite unacceptable, for by introducing a third party it attacked the marital relationship and allowing payment for giving up a child disturbs the mother and child relationship.\textsuperscript{53} Thus, the Committee recommended that commercial surrogacy not only be outlawed but be made a crime.\textsuperscript{54} Non-commercial surrogacy for convenience alone (where the woman is physically capable of bearing a child) is totally unacceptable. The risk of exploitation of the mother outweighs the potential benefits in almost all other cases. If non-commercial surrogacy takes place, however, the carrying woman is the mother and perhaps the adoption laws should be made more flexible to allow the genetic mother to adopt.\textsuperscript{55}

The Committee recommended that freezing semen or embryos was acceptable and should be licensed. As it was not yet practicable to freeze eggs, that procedure was not be done until research proved it could be performed without harm to the fetus.\textsuperscript{56} There should be regular five-year reviews of frozen semen and embryos and a maximum of ten years of frozen storage.\textsuperscript{57} Where one of a couple dies, the right to use or dispose passes to the survivor, although a widow should be discouraged from using semen after the donor’s death.\textsuperscript{58} Where the donor cannot be found or where both donors die, the decision passes to the storage authority which should bear in mind the donor’s previously expressed wishes.\textsuperscript{59} The donors have no legal rights or duties to children born from donated gametes.\textsuperscript{60} A child who was not \textit{in utero} at its father’s death should be disregarded for all purposes of inheritance and succession.\textsuperscript{61} Among multiple births, the first-born is the oldest and for primogeniture, the time of birth, not of fertilization, should be determinative.\textsuperscript{62}

\textsuperscript{51}Id. at 35-37.
\textsuperscript{52}Id. at 32.
\textsuperscript{53}WARNOCK, supra note 36, at 44-45.
\textsuperscript{54}Id. at 46.
\textsuperscript{55}Id. at 42-47.
\textsuperscript{56}Id. at 81.
\textsuperscript{57}WARNOCK, supra note 36, at 53-55.
\textsuperscript{58}Id. at 55.
\textsuperscript{59}Id. 56-57.
\textsuperscript{60}Id. at 25.
\textsuperscript{61}WARNOCK, supra note 36, at 55.
\textsuperscript{62}Id. at 53-57.
The Committee was created not only to make recommendations concerning the provision of treatment for the infertile via artificial insemination, in vitro fertilization, egg donation and embryo transfer, but also to study research. Research goals included better understanding of fetal development, improved methods of contraception and alleviation of infertility, and prenatal care and therapy. The Committee summarized current biological evidence concerning human development from fertilization through cell divisions to implantation. It determined that the time to be adopted for purposes of regulating research on embryos was the appearance of the primitive streak at about 14 or 15 days. Because this was regarded as the beginning of individual development, no research should be allowed beyond this time. The Committee acknowledged: "Although questions of when life or personhood begin appear to be questions of fact susceptible to straightforward answers, we hold that the answers to such questions in fact are complex amalgams of factual and moral ingredients."66

Commentators noted that the Committee had stated conclusions without providing supporting argumentation concerning the origins of human life. "Ultimately, however, as in the context of abortion, the status of the embryo would remain an elusive concept, secreted in the interstices of the legal regime, but not declared."68

R. M. Hare claimed that the Warnock Committee failed to present reasons regarding both sides of the debate, or to determine which reasons were sufficient and why. Hare contends that these failures occurred because it was easier for the Committee to agree upon recommendations than upon reasons therefor and because Mary Warnock philosophically accepted the position that reactions of people (including obviously members of her Committee) are data upon which one can base moral conceptions.69 Criticism aside, Hare recognized Warnock’s contribution by stating that he would have awarded her a "place in the philosophical Hall of Fame" for getting into a public document the notion that the issue was normative.70

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63 Id. at 58-62.
64 Id. at 58-59.
65 WARNOCK, supra note 36, at 59.
66 Id. at 60.
68 Id. at 75.
69 R. M. Hare, Public Policy in a Pluralist Society, in EMBRYO EXPERIMENTATION, supra note 15, at 183, 188-89.
Instead of trying to answer these questions [of when life or personhood begin] directly we have therefore gone straight to the question of how it is right to treat the human embryo. We have considered what status ought to be accorded to the human embryo, and the answer we give must necessarily be in terms of ethical or moral principles.\(^7\)

It is difficult to point to a specific moment of origin, for, as Stephen Buckle notes, we use the same terminology for what can be an event or a process (e.g. fertilization, conception, implantation) depending upon one's time perspective within the continuum of human embryonic development.\(^7\) There remains, however, the necessity of selecting marker events to designate morally different parts of the continuum.\(^7\)

The Warnock Report's call for legislation was not answered until 1990. In the meantime, further reports and studies were presented, including the Church of England's report on assisted reproduction, Personal Origins (1985), the Government's consultation document, Legislation on Human Fertility Services and Embryo Research (1986), and the White Paper Human Fertilization and Embryology: A Framework for Legislation (1987). At the same time, members of Parliament introduced private members' bills and the Unborn Children (Protection) Bill, which would have the effect of limiting the creation, storage and use of embryos to bringing forth a specific child.\(^7\)

In November, 1990, the Human Fertilization and Embryology Act 1990 [HFEA] was enacted.\(^7\) The Act created the statutory licensing authority recommended by so many voices, the Human Fertilization and Embryology Authority.\(^7\) It is crucial to note from the outset that the HFEA is a beginning and not the last word on assisted reproduction. It represents "a marshalling of arguments after nearly two decades of scientific research and ethical and philosophical debate," "just the starting point," and "a transitory marker in continued moral reflection."\(^7\)

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\(^7\)Warlock, supra note 36, at 66.


\(^7\)Id. at 198-99.

\(^7\)See Surpris Bill, 15 Fam. L. 145 (1985); see also Embryo Concerns, 17 Fam. L. 112 (1987).

\(^7\)Human Fertilization and Embryology Act, 1990, ch. 37 (Eng.) [hereinafter HFEA]. The lengthy act has 49 sections and runs fifty pages with its four schedules. The administrative arrangements for the HFEA and §36 concerning surrogacy were brought into force on 7 November 1990 by the Human Fertilization and Embryology Act (Commencement No. 1) Order (SI No. 2165/1990). Gillian Douglas, Human Fertilization and Embryology Act 1990 21 Fam. L. 110 (1991). 1 August 1991 was the date all other provisions of the HFEA 1990 not already in force, became effective, except §30 (parental orders), which came into force on 14 October 1991. Id. 350.

\(^7\)HFEA at § 50.

The HFEA is to provide structure and direction to the persons and places involved in providing and utilizing assisted reproduction technologies. The Authority shall annually submit a report on its activities to the Secretary of State, who shall lay it before each House of Parliament. The Authority shall also gather information about embryos and treatment services which it shall provide to the government and to persons licensed or seeking treatment.

The major effect of the HFEA is the licensing of persons and premises involved with reproductive technologies covered by the Act. Licenses may be granted for providing treatment services, for storage of gametes and embryos, and for research thereon. The license committee, to be established by the Authority, shall determine that each applicant is a "suitable person to hold a license" and has the "character, qualifications and experience" to provide treatment and to assure that provisions of the HFEA are satisfied. Before granting a license the premises shall be inspected and reinspections shall take place annually. A license may also be refused or revoked. Finally, the Authority shall maintain a Code of Practice concerning activities carried on under the license.

The area of assisted reproductive technology covered by the HFEA is thus brought under continuing public scrutiny and evaluation. The Act guarantees that the government and the Parliament will have regular and current information on what is being done, where and by whom, and on the results achieved. Public representation is assured as more than half the members of the Authority shall not be physicians, persons keeping or using gametes or embryos, or persons directly concerned with research thereon. Members of those three groups are also excluded from holding the positions of chairman or deputy chairman. Membership shall also include the views of both men and women.

In determining what activities should be included under the HFEA and what limitations should be placed upon the power of the Authority to grant licenses, "Believing that such fundamental moral and legal issues can be 'solved' betrays a misunderstanding of what moral disagreement is about, as much as it does about the political process of legislating life or regulating reproduction." Id. at 1.

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78HFEA §§ 6-7.
79Id. at § 8(a)-(c).
80Id. at § 11.
81HFEA § 16.
82Id. at § 9(7)-(11).
83Id. at §§ 18-19.
84HFEA § 25.
85HFEA sched. 1 § 4(2)-(4).
86Id. at sched. 1 § 4(3).
87Id. at sched. 1 § 4(2).
Parliament gave expression to the social limits which would circumscribe current practices in assisted reproductive technologies. The HFEA established not only the structure of regulation but also the content by defining the technologies to be licensed, the legal status of children produced thereby, and boundaries beyond which treatment and research must not venture.

The HFEA sets limits first by defining 'embryo' to mean "a live human embryo where fertilization is complete" and references to any embryo include "an egg in the process of fertilization." The Act includes only embryos created outside the human body or kept and used outside the human body.

Expressly forbidden are efforts to create hybrids or to engage in trans-species fertilization by placing in a woman any live embryo other than a human embryo or any live gametes other than human gametes or by placing an embryo [human] in an animal. Cloning is also forbidden ("replacing a nucleus of a cell of an embryo with a nucleus taken from a cell of any person, embryo . . .”).

The influence of the Warnock Report is evident in the prohibition of keeping or using an embryo after the appearance of the primitive streak, which is statutorily presumed to have appeared "not later than the end of the period of 14 days beginning with the day when the gametes are mixed, not counting time during which the embryo is stored." Around the 14th day after fertilization, if the cells have met no other unfavorable conditions in the uterus the inner cell mass which has differentiated initially into a two layered disc composed of endoderm and ectoderm, produces a third layer (the mesoderm). This third layer has become interposed between the ectoderm and the endoderm by a process of invagination from the ectoderm. The site of the invagination can be seen as a line called the primitive streak on the ectodermal surface of the bilaminar disc. It is the development of this groove on which the Warnock Report fixed as the crucial transformation when the rubicon is crossed between molecular matter and potential human being. To this molecular matter scientists later gave the appellation 'pre-embryo.'

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88 Id. § 1(1)(a)-(b). Fertilization is not considered complete "until the appearance of a two cell zygote." HFEA § 1(1)(b).
89 HFEA § 1(2)-(3).
90 Id. at § 3(2)(a)-(b), 3(b).
91 Id. at § 3(3)(d).
92 Id. § 3(3)(a), (4).
93 BLACKSTONE'S GUIDE, supra note 77, at 68. "[U]ntil the 14th day cells are pluripotential and until the appearance of the primitive streak it is not known whether they will develop into an hydatiform mole, into twins, into one embryo, or degenerate into nothing. It is on this basis that the 14th day is said to be important." Id. at 71. The 14 day time limit had also been adopted by the Parliamentary Assembly of the Council of Europe in Recommendation 1046 "[o]n the use of human embryos and foetuses for
The significance of the 14-day point was highlighted in Parliament by John Hapgood, the Archbishop of York:

What is happening embryologically is the creation of persons through a process, which although it begins with genetic union, is not simply about a union of genes but also depends on a certain cellular identity which only becomes apparent at the time of the appearance of the primitive streak. 94

As a biologist himself, Hapgood noted how scientists work with gradualism and study incremental changes both at the level of evolution and of individual development. 95 He found such a view compatible with the theological view that God continuously calls personal being into existence (continuous creation rather than infusion of a human soul at a specific moment). 96 He proposed that we use a neutral term to describe the result of fertilization up to implantation: 'conceptus' is "an organism of human origin which given the right conditions has the potential to develop and may become a full human person." 97

Parliament, in adopting the HFEA, selected another point in the process of development as legally significant when it modified the Abortion Act 1967 to provide that abortion is allowed when "the pregnancy has not exceeded its twenty-fourth week." 98 The twenty-fourth week would be substituted for the 28th week, which the Infant Life (Preservation) Act 1929 had established as the statutory presumption for the time when a child was "capable of being born alive". 99

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Scientists disagree about exactly when the biological life of any animal begins, but it seems undeniable that a human embryo is an identifiable living organism at least by the time it is implanted in a womb, which is approximately fourteen days after its conception. LIFES DOMINION, supra note 23 at 21. For a critique of the 14 day rule, which he calls "entirely arbitrary, no stronger ethically or medically than any other," see EDWARDS, supra note 27, at 171-73.


96 Id. at 37-6 - 37-7.

97 Id. at 37-7 - 37-8.

98 HFEA § 37(1)(a).

99 See BLACKSTONE'S GUIDE, supra note 77, at 40-55 for a discussion of the complex interrelationships of the Act of 1803, Lord Ellenborough's Act, which criminalized abortion of a quick fetus (about 16-18 weeks), the Offenses Against the Person Act 1861 which allowed abortion only to save the mother's life, the Infant Life (Preservation) Act 1929, R v. Bourne, 1 KB 687 (1939), the Abortion Act 1967, and two recent cases in which the court attempted to define "capable of being born alive": C v. S, 1 All ER 1230 (1987) and Rance v. Mid Downs Health Authority, 140 NLJ 325 (1990). See also James E. S.
In addition to limiting the scope of the HFEA by defining time limits, coverage is also restricted with respect to procedures and persons who receive them. The Act covers only the creation of an embryo outside the human body. It also includes only donated sperm and/or eggs. Because providing treatment services with the use of donated sperm or eggs is to be done only by one with a license therefore and "treatment services" are provided to the public, the Act does not cover a woman who attempts do-it-yourself artificial insemination or who seeks to become pregnant with the help of a man recruited for that purpose. It also does not cover artificial insemination of a woman with the sperm of her husband or partner. At the present time it does not appear possible for nonprofessionals to retrieve and make use of donated eggs.

There was debate about the inclusion of GIFT (gamete intrafallopian transfer) when it involved the use of donated gametes. The Act adopted a compromise, whereby placing sperm or eggs into a woman may be subject to regulations with further guidance to be given by the Code of Practice. Morgan and Lee suggest that the Government succumbed to pressure from the medical community in excluding GIFT, which they believe should be included because it is similar to various covered procedures, including retrieval of eggs, creation and manipulation of an embryo and multiple pregnancies. Moreover, similar risks exist to the woman and fetus in each procedure.

The Act adopted another compromise concerning the persons who may receive treatments. As a condition to a license granted under the Act,

[a] woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born


HFEA § 1(2).

Id. § 4.

Id. §§ 4(1)(a), (b).

HFEA § 2(1).

BLACKSTONE'S GUIDE, supra note 77, at 118.

HFEA §§ 4(3), (4).

Id. § 25(3).

BLACKSTONE'S GUIDE, supra note 77, at 124-34. They indicate that the GIFT procedure is covered by common law doctrines of informed consent and negligence. It was also suggested that GIFT was excluded because the Government wanted to avoid regulating the superovulatory drugs themselves. Derek Morgan, Assisted Conception and Clinical Practice: Whose Freedom Is It? 1990 NEW L. J. 600, (1990).
as a result of the treatment (including the need of that child for a father),
and of any other child who may be affected by the birth.\textsuperscript{108}

Treatment services were not forbidden to single women; however, the provider
must evaluate the impact upon the child of being raised by a single parent.
There is also reference to the child’s need for a father, which suggests a
heterosexual couple. The couple’s being married to one another is not made a
condition for service. Account must not only be taken of the welfare of the child
to be conceived but also how such child may affect other children. The most
obvious reference would be to siblings or half siblings.

Morgan and Lee once again traced the impact of the Warnock Report, which
had taken a similar position:

\textit{[m]any believe that the interests of the child dictate that it should be
born into a home where there is a loving, stable, heterosexual
relationship and that, therefore, the deliberate creation of a child for a
woman who is not a partner in such a relationship is morally wrong . . . we believe that as a general rule it is better for children to be born
into a two-parent family, with both father and mother, although we
recognise [sic] that it is impossible to predict with any certainty how
lasting such a relationship will be.}\textsuperscript{109}

They note the statement by Lord Mackay, the Lord Chancellor, that the Act was
consistent with the Government’s stress upon "family values,"\textsuperscript{110} and concluded that the Act was premised upon "a profamilist ideology" under
which treatment services would be provided "for the married, mortgaged
middle-classes" and was consistent with the current practice of not providing
infertility services under the National Health Service.\textsuperscript{111} Those seeking
treatment services would be evaluated for their "fitness to parent" and the Act
provided in its "conscience clause" that anyone with "a conscientious objection
to participating in any activity governed
by this Act" was under no duty to do
so.\textsuperscript{112} Morgan and Lee indicated that there is very little evidence that would
support negative conclusions concerning single or lesbian couple [or homosexual couple] parenting, or even about children in "fatherless families"
if one factors in poverty and welfare policies.\textsuperscript{113}

\textsuperscript{108}\textsc{HFEA} § 13(5). The Authority is directed to maintain a Code of Practice which "shall
include guidance for those providing treatment services about the account to be taken
of the welfare of children who may be born as a result of treatment services (including
a child’s need for a father), and of other children who may be affected by such births."\textit{Id.} at § 25(2).

\textsuperscript{109}\textsc{Blackstone’s Guide, supra} note 77, at 141 (citing Warnock Report para. 2.11).

\textsuperscript{110}\textit{Id.} at 143.

\textsuperscript{111}\textit{Id.} at 143, 146.

\textsuperscript{112}\textsc{HFEA} § 38(1).

\textsuperscript{113}\textsc{Blackstone’s Guide, supra} note 77, at 147-48.
Furthermore, the Act contains detailed requirements concerning consent, counselling and information to be provided. It is made a condition for a license that no woman shall be provided treatment involving the use of donated gametes without the donor's consent, or the use of an embryo taken from a woman (by lavage) without such woman's consent "unless the woman being treated and, where she is being treated together with a man, the man have been given a suitable opportunity to receive proper counselling about the implications of taking the proposed steps, and have been provided with such relevant information as is proper."  

Schedule 3 of HFEA includes detailed requirements for consent, and conditions the provision of treatment services upon prior consent. Thus, donated gametes may not be used to treat others without the effective consent of the donor. Furthermore, donated gametes may not be used to create an embryo in vitro without consent of the donors to the use of the embryo for the donors, for others, or for research. Finally, gametes and embryos may not be stored without the consent of the donors, and such consent shall also provide what should happen if the one giving consent dies or becomes incompetent. Consent must be obtained in writing and may be revoked or varied up to the time the embryo is used for treatment services or research.

In order for the consent to be legally effective, the one giving consent must have adequate knowledge (informed consent). As in consent for other medical procedures, the information must include the risks and benefits of various treatment options (e.g. some treatment options may involve several embryos with the risks associated with higher order pregnancies), their likelihood of success (especially after one or more treatments have not been successful), and the alternatives to treatment (with respect to parenting, e.g., adoption, foster-parenting). Counselling is required both before treatment in recognition that the experience of infertility may produce guilt, bewilderment, anger and dysfunction in personal and marital relationships, and during treatment, as people experience the financial and emotional burdens of continuing treatments after repeated failures.

Another area about which persons asked to consent must be informed is the disclosure of information that an individual born via assisted reproduction

114 HFEA § 13(6).
115 HFEA sched. 3 § 2.
116 Id.
117 Id.
118 HFEA sched. 3 para. 1. Such revocation or variation can occur up to the time the embryo is used for treatment services or research. Id.
119 BLACKSTONE'S GUIDE, supra note 77, at 128-29, 131-32.
120 Id. at 16-17, 150-51.
services can receive. Licensees for treatment services, storage or research must maintain a register of who receives services, what services were provided, whose gametes were kept or used, the children who appear to have been born as a result of treatment, and any mixing of egg and sperm or taking of an embryo from a woman. An individual, upon reaching the age of eighteen, may require the Authority to comply with a request for information if the register shows such applicant "was or may have been... born in consequence of treatment services." The applicant may request to know whether a person other than a parent would or might be a parent of the applicant and whether the applicant and one whom the applicant intends to marry are related. Information concerning potential marriage partners may be received even by an applicant who is not eighteen. The applicant is not to receive information about "the identity of a person whose gametes have been used or from whom an embryo has been taken" provided such information could not then have been required from the Authority. Commentators note that the protection of donor anonymity is limited to statutory requirements, which of course could be amended at any time (and where there is no information about children born after treatment services, HFEA section 24(1) requires the information to be retained for fifty years).

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121 HFEA sched. 3, 3(1(b)). Person giving consent must be provided "relevant information" which would include the donor's identity and expectations of anonymity.

122 Id. §§ 13(2)(a)-(e).

123 Id. at § 31(3)(a).

124 Id. at § 31(4).

125 HFEA § 31(6). The reason for providing information about the relationship of an individual and a proposed marriage partner is obviously to avoid the possibility of incestuous marriages. To reduce the number of possibly incestuous marriages (as well as for genetic concerns) the Warnock Report would limit the number of births from one semen donor to ten. The HFEA did not limit the number of births from one donor, although the Authority could provide such guidance in its Code of Practice. It would be in the interest of children to be born as a result of treatment services not to have too many half siblings which could increase the risk of biologically incestuous marriages.

126 HFEA § 31(5).

127 BLACKSTONE'S GUIDE, supra note 77, at 162. Morgan and Lee suggest that Gaskin v. United Kingdom, 1 FLR 167 (1990), may be significant. In that case the European Court of Human Rights held that art. 8 of the European Convention (respect for private and family life) required that certain information about an individual's treatment while in care under § 1 of the Children Act 1948 be made available to an adult. It cited the Commission to the effect that "respect for private life... requires that 'everyone should be able to establish details of their identity as individual human beings'" but also noted that confidentiality was necessary to protect third persons, especially when pledges of confidentiality had been given. Thus an independent authority should decide which information should be released. Id. at 180. However, in In Re G (A Minor)(Blood Test), 1 FLR 495 (1994), the Family Court while recognizing that human relationships are best founded upon the truth and that it is in the child's interests to resolve doubt and to "deal with it now," also found that judicial discretion was necessary to determine whether
In addition to establishing the Authority that would conduct the licensing system, define what treatment services, storage and research could be licensed, and define who should receive the services, HFEA also defined the legal status of participants in treatment.128 The development of assisted reproductive technologies has made possible the involvement of many individuals. Potentially included persons include the sperm donor, the egg or embryo donor, the woman in whose womb fetal development took place and who gave birth to the child, the person or persons who initiated the process, and persons wishing to adopt. With the development of technology came questions about legal parentage, legitimacy, rights and responsibilities with respect to the child, and rights of the child to demand care or property. As a result, Parliament, in HFEA, defined who would be the legal mother and father of children born through assisted reproduction technology.

The backdrop to determinations of parentage through technology was the legal notion of legitimacy. At common law, a child was legitimate if born or conceived when the parents were validly married to each other.129 The originally harsh doctrine of the legal disabilities of bastards was modified by allowing subsequent marriages to legitimize children.130 To protect the legitimacy of the children, the law presumed that the husband was the father of any child born to his wife during the marriage, or within a human gestation period thereafter.131 Such presumption was once rebuttable only upon a showing that the husband's paternity was impossible,132 but section 26 of the Family Reform Act of 1969 made the presumption rebuttable upon the balance seeking the truth via a blood test and making the information available, would be in the interests of the child. Id. at 501-02.

Morgan and Lee note than an amendment requiring the recording of data about non-identifying information (physical characteristics, family background, education, skills, health history) was defeated in parliament and that there are authorities who believe that the desire to know one's genetic parentage is socially constructed. BLACKSTONE'S GUIDE, supra note 77, at 163-65. Whatever the decision about anonymity may be, it is important for gamete and embryo donors and others to know whether a child resulting from their contributions will be able to identify them. Similarly, it is important for persons seeking treatment services to know whether children they may have would have access to information about their origins. See Katherine O'Donovan, What Shall We Tell the Children: Reflections on Children's Perspectives and the Reproductive Revolution, in BIRTHRIGHTS: LAW AND ETHICS AT THE BEGINNINGS OF LIFE 96 (Robert Lee & Derek Morgan, eds. 1989).

128HFEA § 27-30.
130Id. at 565. Subsequent marriage legitimates children whether it was intended to do so or not; "in order to" makes the statement appear to mean that legitimation occurs only if that is the intended purpose when the parties marry.
131Id. at 570.
132Id.
of probability. Under this Act, a mother is the woman who gave birth to the child, and proof of maternity was regarded as a question of fact to be proven by witnesses attending the childbirth. HFEA assigns the legal status of mother to "[t]he woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs." It makes no difference whether the embryo or sperm and eggs were placed in the woman while she was in the United Kingdom or elsewhere. Although if placed in her outside the United Kingdom, rules regarding conflicts of law could result in different persons being regarded as the mother.

If the woman was married when the embryo or sperm and eggs were placed in her, or she was inseminated and the sperm was not that of her husband, then the husband is to be treated as the father unless it is shown that he did not consent to the placing in his wife of the embryo or sperm and eggs or her artificial insemination with the donor's sperm. If the treatment services were provided to a woman and a man treated together, then he is to be treated as father. The male partner of a de facto couple is treated like the husband of a couple who are legally married for purposes of determining the paternity of a child born to the woman during the relationship. The male partner demonstrates consent by accompanying his partner to the treatments, while the husband may not accompany his wife. Moreover, HFEA does not restrict treatment services for wives to those who prove their husbands have consented. It is up to the nonconsenting husband to prove he did not consent if he does not wish to be treated as the father. "Parties to a marriage" for this purpose, excludes married persons who are judicially separated, but does include parties to a void marriage if either or both of them reasonably believed the marriage was valid. Unless the contrary is proved, it shall be presumed one of them so believed.

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133CRETNEY, supra note 129, at 570.
135HFEA § 27(1).
136Id. at § 27(3).
137Id. at § 27(3).
138Id. at § 28(2).
139HFEA at § 28(3).
140Id. This provision applies when unmarried woman and man come together for treatment.
141HFEA § 27(7).
142Id. at 28(7).
143Id. at § 28(f)(b).
By use of the husband’s or partner’s consent, such man is presumed the father. If the man does not consent, HFEA, section 28(5)(a), preserves the common law presumption that the mother’s husband is the father of her child. Thus, the husband who succeeds in proving that he did not consent to the placing in his wife of an embryo or eggs and sperm, or to her insemination by donor’s sperm, must also rebut the common law presumption by proving he could not be the father. That burden may be met today by scientific testing of blood and DNA. The donor of the sperm may not be treated as the father if his sperm was used with his consent and in accordance with his consent. If the mother’s husband is not the father and the sperm donor is not the father, then the child is fatherless.

A child may also be fatherless under HFEA section 28(6)(b), if "the sperm of a man, or any embryo the creation of which was brought about with his sperm, was used after his death." This provision is consistent with the suggestion in the Warnock Report that posthumous parenting should be strongly discouraged. The Government determined not to prohibit it, but to discourage it by forbidding inheritance by the posthumous child. The HFEA consent provisions require the person consenting to the storage of gametes or any embryo to "state what is be done with the gametes or embryo if the person who gave the consent dies." Thus, a husband could consent to his wife’s using his frozen sperm after he dies, but if she does so, he would not be the father of the resulting child. If the couple were in a void marriage, but at least one of them reasonably believed that it was valid when the child was conceived, that is, when the embryo was formed, such child would remain legitimate even if the embryo were frozen and the child were born more than ten months after the man’s death. Thus, while the HFEA attempts to resolve some issues of paternity, it creates other problems and inconsistencies.

144 Id. at § 28(f).
145 HFEA § 28(6)(a), sched. 3, 5(1).
146 HFEA § 28(6)(b) and sched. 3, para. 5 § 1.
148 HFEA § 28(6)(b).
149 DOUGLAS, supra note 75, at 111. Because the HFEA limits storage of gametes to 10 years, fears of indefinite delays in probate or impossible perpetuities violations would be minimized. HFEA § 14(3).
150 Id. at sched. 3 para. 2, § 2(b).
151 Id. at § 28(6)(b).
153 One problem which was foreseen and circumvented was the devolution of titles of honor and property accompanying such titles. Determinations of maternity and paternity under HFEA § 27 and § 28 do not affect succession to titles, which would
HFEA did not adopt such explicit provisions concerning who is the mother and father of a child born to a surrogate. In the Surrogacy Arrangements Act of 1985, Parliament prohibited negotiating or initiating commercial surrogacy contracts. That Act was amended by HFEA, section 36(1), which provided that surrogacy arrangements would not be enforceable.\(^{154}\)

Surrogacy continued, however, to provoke continuing debates about the new forms of parenting.\(^{155}\) One commentator has argued that a "[r]eproductive technology has become the bureau de change of the moral economy" and that surrogacy represents a challenge to the way in which societies respond to the re-evaluation of the currency of personhood which technology has forced upon it."\(^ {156}\) Commentators wondered whether legal recognition of parental responsibilities were based upon the welfare of the child or the benefits to the parent(s), and whether recognition of only one person of each sex as a parent was consistent with the contemporary experience of parenting.\(^{157}\)

The HFEA created the possibility of a court's issuing an order declaring that a child be treated as the child of the parties to a marriage if (1) the child was carried by a woman other than the wife as the result of the placing in her of an embryo or sperm and eggs or of artificial insemination by a donor and the gametes of husband or wife or both were used, (2) both husband and wife apply for the order within six months of the child's birth, (3) at the time of the application the child is living with them and either or both of them are domiciled in the United Kingdom, (4) both husband and wife have attained the age of 18, (5) the father of the child, where he is not the husband, and the woman who carried the child freely and with full understanding unconditionally agree to the order (unless such person cannot be found), and (7) the court finds that no money has changed hands in exchange for handing

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continue to follow blood (genetic) lines. HFEA § 29(4). Laws regarding incest and prohibited degrees of marriage would also follow legal, rather than genetic parentage. BLACKSTONE'S GUIDE, supra note 77, at 160-61, DOUGLAS, supra note 75, at 112. Because of the ten year limit imposed by HFEA section 14(3) an unforeseen problem was freezing sperm of a young man likely to become infertile. However, the Human Fertilization and Embryology (Statutory Storage Period) Regulations 1991 (SI 1991/1540) extend the ten year period for up to 39 years if the man is aged 16 or under and up to 11 years if he is aged 44. DOUGLAS, supra note 75, at 350.

\(^{154}\) HFEA § 36(1).

\(^{155}\) HFEA §§ 30(1)-(7).

\(^{156}\) Derek Morgan, Who Is to Be or Not to Be: The Surrogacy Story, 49 MOD. L. REV. 358, 368 (1986). He noted elsewhere that surrogacy has become "the eye of the storm surrounding assisted reproduction" and "the whipping post for the moral backlash against what is seen as the brave new world of technological rationality and scientific finality." Derek Morgan, Surrogacy: Giving it an Understood Name, 1988 J. OF SOC. WELFARE 216. See also Jonathan Montgomery, Constructing a Family After a Surrogate Birth, 49 MOD. L. REV. 635 (1986) (using a genetic-gestational or functional definition of family.

over the child or making the order. These orders, known as Section 30 orders, would allow a married couple who were raising a child handed over to them by the woman who carried and gave birth to it, to be recognized as parents of the child who was related genetically to at least one of them.

In its Draft Circular to Local Authorities of February 18, 1994, the Department of Health outlined how Section 30 orders could work. Under the rules of the Family Proceedings Courts, the court would appoint a guardian ad litem for the child. The guardian could receive information from the licensed treatment center to determine whether there had been a placing of an embryo or sperm and eggs or artificial insemination by the donor and whether gametes of the husband or wife had been used. The Human Fertilization and Embryology (Disclosure of Information) Act of 1992 had amended HFEA Section 33(6) to provide explicitly that such information could be made available to a court in an application for a Section 30 order. The guardian would also determine whether the other Section 30 orders were met and whether issuance of the Section 30 order would be in the child's welfare, which always must be the court's paramount consideration in determining any issue concerning a child's upbringing. Some investigation should already have taken place as treatment services are not to be provided until the licensed treatment center determines that assisted reproduction would be for the welfare of any child born from the services and any other child who may be affected. The guardian would also determine that the woman who carried and gave birth to the child knowingly and voluntarily agreed to turn over the child to the couple. The carrying woman can not give valid consent for such a transfer until six weeks after the birth of the child.

While Parliament provided some answers to questions that had arisen concerning who should receive treatment services and the legal relationships of various participants, significant policy choices remained undetermined. No limits were placed upon the number of children who might be born from a single donor's sperm or eggs. No limits were placed upon the use of relatives, including close relatives, as gamete donors or surrogate mothers. Moreover, no limits were placed upon the number of fertilized eggs or embryos which could be placed within a woman, nor was there any mention of selective reduction of multiple pregnancies. Finally, no decisions were made concerning provision of treatment services to the indigent.

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158 HFEA § 30(1)-(7).
159 HFEA § 13(5).
160 Children Act 1989 § 1(1).
161 HFEA § 13(5).
162 Department of Health, DRAFT CIRCULAR TO LOCAL AUTHORITIES § 30 (Feb. 18, 1994) (as provided to author).
163 Jennifer Gunning & Veronica English, REPORT FROM THE INTERIM VOLUNTARY LICENSING AUTHORITY, DARTMOUTH GOWER 69 (1993). The Voluntary Licensing Authority existed from 1985 until the HFEA went into force in 1991; it provided guidance and direction.
These and other particular issues remain within the broader ethical, social, political and religious context. Athena Liu applauds HFEA for its recognition of the need for social regulation of modern reproductive technologies, while also recognizing the social and psychological experience of infertility and the limited utility of the language of rights to provide adequate answers. The right of a woman to reproductive freedom and control is related to issues of population size and density, compulsory sterilization, bearing or adopting or parenting a child, and the need to involve others in the exercise of one's rights.

IV. CONCLUSION

Decisions concerning parenting are not simply personal or private decisions but also public and political decisions. Who can effectively exercise reproductive choice depends upon the availability of wages, child care, decent housing, and services required for successful child raising. At the same time, as the development of technology is accompanied by increasing governmental control and regulation, the state becomes ever more implicated in the intimate contours of marriage and family life.

While medical and technological developments continue to change our understanding of human reproductive processes, which in turn affects our understanding of parenting and parenthood, it remains a challenge to express experience and change in the law. In the United States, model acts have been proposed. As was indicated at the beginning, however, federal legislation is quite limited in scope, and is of recent origin. In addition, state legislative efforts have been few and recent.

while the Government was developing the HFEA.


165 Id. at 24-25.

166 Vivien Seal, Whose Choice? Working Class Women and the Control of Fertility (1990). As Derek Morgan has indicated in his discussion of surrogacy, the development of new reproductive technologies has forced reconsideration not only of the relationship of the personal and the political (one of the major contributions of feminist jurisprudence) but also of the way in which society assigns and values women's work. Derek Morgan, Who To Be or Not To Be: The Surrogacy Story, 49 Mod. L. Rev. 367-68 (1986).

167 Blackstone's Guide, supra note 77, at 2-3. The authors caution that the ideological dimensions of technological change are "concealed behind cloaks of scientific objectivity and moral neutrality." Id. at 2.


Several features of the Human Fertilization and Embryology Act of 1990 offer guidance to states attempting to formulate laws. Legislative resolution appears preferable to having judges make decisions as to when issues arise in divorce, property, probate, contract, support and parentage.

In the United Kingdom, the initial efforts were studies, such as the Warnock Report discussed above, as well as reports from religious, medical, social and advocacy groups. From such studies, Parliament adopted the fourteen-day time limit for embryo research and implantation. The choice of the fourteen-day marker was rooted in biological processes of development. There was no attempt to divide the continuum of development into discrete moments (e.g. "moment of conception," "moment of fertilization," "implantation"), when in fact each of these events occurs over time.\(^{170}\)

It was also determined, in the United Kingdom, that research on fertilization and on embryos must complement treatment services for infertility. The development of new reproductive technologies came about through the typical process of change in medicine which involves both research and patient care. Both dimensions of the process must be present for the result to be human and humane. The individual experiencing infertility, the intending parents, the gamete donors, and the resulting child(ren) must be recognized in their fully human reality, not only in their biological reality. One step in that direction is the recognition in HFEA of who is defined as mother and father to the child. Participants know from the outset which legal relationships will be established.

Finally, the establishment of one Authority to set up licensing of practitioners and clinics, to promulgate a code of practice and regulations, and to compile data on procedures and results, brings unity to widespread efforts by many individuals who became involved in assisted reproduction. While extra legal efforts will continue to take place, the benefits offered to those who operate within the licensing framework will attract more and more practitioners into conformity with the law. The gathering of data to be presented to the

\(^{170}\)The 14-day limit for research on embryos was recently proposed in the United States by the NIH Human Embryo Research Panel, a 19-member advisory commission appointed by Health and Human Services Secretary Donna Shalala. Dr. Harold Varmus, Director of the National Institutes of Health, will draw up final guidelines. Natalie Angier, Rules Due On Disputed Embryo Research, \textit{New York Times}, Sept. 6, 1994 at B4. The Secretary was authorized to appoint the panel by the NIH Revitalization Act of 1993. \textit{Supra} note 7. Prior regulations had prohibited embryo research unless reviewed by an Ethical Advisory Board (which had never been appointed). Under the new law the Secretary may not withhold funds because of ethical considerations until receipt of a recommendation from an ethics advisory board. A challenge to the Panel's making recommendations was rejected on grounds that the petitioners lacked standing. Doe v. Shalala, 862 F. Supp. 1421 (D. Md. 1994). See OPRR Reports Number 94-03, \textit{In Vitro Fertilization of Human Ova}, NATIONAL INSTITUTES OF HEALTH, July 22, 1994, 45 C.F.R. § 45 (1994).
government and to Parliament will provide an ongoing opportunity to evaluate and, if necessary, redirect the developing technology.171

What the United Kingdom might discover from the experience in the United States is that surrogacy need not be the exploitative procedure which might be found in media presentations. In *In re Baby M*,172 the court denied enforcement of a surrogacy contract when the genetic and gestational mother refused to terminate her parental rights. The matter was resolved under the usual "best interests of the child" criteria and the genetic father (by artificial insemination—donor) was awarded physical custody.173 California, in the first surrogacy case to reach its appellate court, upheld a surrogacy contract after both parties had performed. The surrogate, who was also the genetic mother, gave birth and delivered the child to the intending parents, and then attempted to change her mind eight months after signing her consent to the adoption by the genetic father's wife.174

Surrogacy situations do continue to present awkward statutory construction problems. For example, California resolved a conflict between genetic parents and the gestational mother by finding that although both women were "mothers" under California law (which recognized giving birth and blood tests as proof of maternity), the "best interests of the child" would be recognition of the genetic parents as the legal parents.175

In a similar situation, New York determined that the genetic father could establish paternity via blood tests while the genetic mother would have to

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171 In its Third Annual Report (covering November 1992 through October 1993) the Human Fertilization and Embryology Authority listed three social and ethical issues which had been considered: (1) embryo freezing for treatment and research, (2) use of donated ovarian tissue in embryo research and treatment (see Human Fertilization and Embryology Authority, *Donated Ovarian Tissue in Embryo Research and Assisted Conception Report*, (1994)), and (3) oncology patients, especially young men. Human Fertilization and Embryology Authority, Third Annual Report at § 3.1 (1994). For the coming year issues to be considered include: (1) oocyte freezing, (2) improved methods of ongoing inspection of licensed centers for treatment, storage and research, (3) payment for sperm and egg donors, (4) academic follow-up studies on children born from assisted reproduction, and (5) dealing with low success rates and comparative success rates at various licensed centers. *Id.* at § 8.1.

172 537 A.2d 1227 (N.J. 1988).

173 *Id.* at 1277. *See In re Marriage of Moschetta*, 30 Cal. Rptr.2d 893 (Cal. Ct. App. 1994) where in a similar situation recognition of the genetic father and the surrogate genetic mother as the legal parents did not appear to be in the child's best interests.


175 Johnson v. Calvert, 19 Cal. Rptr.2d 494 *cert. denied*, 114 S. Ct. 206 (1993). In a situation hypothesized in *Johnson* of a true egg donor, where the wife was the gestational mother of a child whose genetic father was her husband and the genetic mother was an anonymous egg donor, New York held that the husband in a divorce action could not deny his wife's parenthood of the child. McDonald v. McDonald, 608 N.Y.S.2d 477 (App. Div. 1994).
adopt the child who was presumed the child of the gestational mother. In Virginia, a decision terminating the rights of the gestational mother in favor of the genetic father and mother was reversed upon request of the appointed guardian ad litem who wanted more time to protect the infant's constitutional rights.

In the end, there remain the inextricably intertwined issues of law, medicine and ethics. Reproductive technologies raise questions at the beginning of individual human lives:

If the desire to bear a child is biological, is it unnatural to oppose it?

If the desire [to bear a child] is social, is opposition to artificial means to realize it an interference with liberty?

If the desire [to bear a child] is a reflection of God's purpose, should we use even unnatural methods to advance it?

Or did that God intend that we should accept ourselves for what we are?

As was indicated by the Archbishop of York in the Parliamentary debates on HFEA, in discussing what happens within society as these issues are debated and resolved, the continuing and underlying issue is "what are we doing to ourselves and to our own respect for human life if we fail to be sensitive to something so intimately bound up with our personal origins?"