

ASSISTED HUMAN REPRODUCTION:

**SOCIAL ETHICAL
AND
LEGAL FACTORS**



*A one day
Private Conference
Organised by the*

**COMMISSION ON
ASSISTED HUMAN
REPRODUCTION**

**September 2001
The Coach House, Dublin Castle**

Private Conference

Commission on Assisted Human Reproduction

September 2001

The Coach House, Dublin Castle

Conference Proceedings

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Introduction

Seven topics were presented at the conference, four at the morning and three at the afternoon session. This report contains papers supplied by the speakers. Due to time constraints in some cases the full papers may not have been delivered at the conference. The open discussions are reconstructed from simultaneous, long-hand notes.

ATTENDANCE

Ms. Helen Browne	Dr. Teresa Iglesias
Ms. Esther Casey	Prof. Maureen Junker Kenny
Dr. Alpha Connelly	Dr. Carol Barry Kinsella
Ms. Mary Cooke	Ms. Geraldine Luddy
Prof. Dervilla Donnelly	Prof. Marina Lynch
Dr. Dolores Dooley	Dr. Deirdre Madden
Ms. Lynn Dowling	Dr. Evelyn Mahon
Ms. Veronica English	Dr. Miriam McCarthy
Ms. Geraldine Fitzpatrick	Dr. Paul McCarthy
Ms. Nora Geary	Prof. David McConnell
Prof. Susan Golombok	Dr. Enda McDonagh
Prof. Sigrid Graumann	Dr. Orla McDonnell
Prof. Andrew Green	Prof. Anne McKenna
Dr. Reinhard Grunwald	Mr. Tom Mooney
Mr. Peter Hanrahan	Prof. Derek Morgan
Ms. Caroline Harrison	Dr. Aonghus Nolan
Ms. Noirin Hayes	Mr. Séamus Ó hUallacháin
Prof. Bernard Hedon	Dr. Tony Ryan
Ms. Benny Hennelly	Rev. Paul Tighe
Dr. Tom Higgins	Mr. Hugh Whittall
Prof. Jim Houghton	Mr. Gerry Whyte

SESSION 1

Chair

Professor Reinhard Grunwald,

**Secretary General,
Deutsche Forschungsgemeinschaft
(DFG).**

Topic 1: HFEA Regulations in a European Context.

Presenter: Mr. Hugh Whittall, Deputy Chief Executive, HFEA, UK.

First I ask myself, what is regulation? What does it seek to do?

One might say the object of regulation is to set and maintain the acceptable limits of what is being regulated. To set the minimum standard that is compatible with the social and ethical norms, as interpreted by the competent authority which could be at local, national or international level, depending on the source of its legitimacy. This process is a constantly evolving one, involving the identification of minimum standards and optimum practices.

A second objective of regulation is surely to provide public reassurance, which means that society must be able to observe the process of regulation and be persuaded that that it is subject to ongoing surveillance. This must involve the monitoring, recording and reviewing of optimum practices to feed back into the regulatory scheme.

Regulation seeks to achieve these objectives by using a structured approach, identifying key principles and practices – building pillars of regulation. *Essentially there are two stages: (i) establishing principles, and (ii) establishing the structures and mechanisms appropriate to these principles.*

Across Europe many attempts have been made to establish some form of regulation at both national and international level.

What we have seen, what we have come to know, is that the identification of common beliefs and standards regarding AHR is difficult at national level, let alone in the international arena. However, those involved in this dialogue would certainly say that the effort and the discussion is worthwhile in itself.

We have many key reference points in Europe from which we have learned and which have helped our thinking:

- Warnock Report in the 1984

- the French Bioethics laws of 1994
- the Council of Europe's efforts throughout the 90's including a major symposium in 1996 and the Bioethics Convention in 1997
- the Health Council of the Netherlands' excellent reports including the 1998 report on Assisted Human Reproduction
- similar reports from Denmark and Norway in the 1990's

to mention but a few.

In some countries we have seen internal tensions that have meant that agreement on regulation, whilst desired and desirable, is particularly difficult to achieve – I tentatively mention Italy, Belgium, Germany.

On one hand one might say that regulation is easier to establish where there is a clear social/political consensus. On the other hand, we see the example of Italy, where there seems to be some difficulty in establishing a regulatory framework precisely because the dominant thinking from Rome, while representing a certain consensus, is unable to give legitimacy to techniques by giving them a regulated framework.

Nevertheless, significant landmarks have been achieved at an International level:

- The Declaration of Helsinki, while not directly relevant, is notable
- The Bioethics Convention of the Council of Europe provides more of a regulatory document, though on the embryo (Article 18) it is scant
- UNESCO declaration on the Human Genome provides a measure of agreement at a fundamental level on notions of respect and integrity, but is little more than exhortation.

In UK we established regulatory system in 1990 built on Warnock report of 1984. The underlying principles of respect for human life, the welfare of the child and autonomy/consent guide the HFEA in its operation of an essentially permissive system with a strong flexible framework. The membership of the HFEA is mixed reflecting all interested parties. Among other things it is the task of the HFEA to regulate and inspect service providers, license new procedures where appropriate. The main test that the Authority must apply in considering a new technique is whether

it is "necessary or desirable".

In taking up this role, the Authority has itself set out a number of principles from which it has been guided. These are stated in the introduction to the Authority's Code of Practice:

- NS
- The respect which is due to human life at all stages in its development;
 - The right of people who are or may be infertile to the proper consideration of their request for treatment;
 - A concern for the welfare of children, which cannot always be adequately protected by concern for the interests of the adults involved; and
 - A recognition of the benefits, both to individuals and to society which can flow from the responsible pursuit of medical and scientific knowledge.

In looking at these ideals as the basis for regulation we can find common ground. (For interesting discussion of this, see Gunning 2001)

However, is this - setting out common basic principles - all that regulation needs? I suggest not.

We each will recognise underlying principles but each have particular social and cultural history that means that we will find different expressions of these principles.

We find different systems with different limitations. This can, and has, resulted in reproductive tourism. Is this a problem? Not necessarily as long as we respect the requirements of legality in the home country and standards of ethics being applied in the treating country. The Convention on Human Rights, and the European principles concerning the free of movement of people, goods and services may mean that we must accept that people can seek elsewhere that which we might consider inappropriate at home. e.g. We do see import and export of embryos, and people travelling for egg donation from countries that do not allow it.

The UK is often quoted as a model that has achieved a degree of success. Not for me

to say. It works but it has never been easy, we are always working at the limits. The regulatory scheme exists to manage precisely those questions that we find difficult to answer - we would not exist otherwise.

Ireland can benefit from the experience of others but its own unique historical mores and emerging social values will determine the recommendations that this Commission will make to government. In any regulatory body of this kind there is sure to be some kind of ongoing negotiation between historical principles, current social consensus, and the technological possibilities. In this context a developmental approach would seem to be a wise course of action.

Is there a lesson that we have learned? There are several.

- Work in the public eye - need to be clear and consistent
- Consent and welfare of the child as key underlying strengths
- Flexibility in instruments of regulation – not all should be fixed firmly in law
- Consultation is important, and this must include patients and have a clear interdisciplinary flavour
- The dialogue must be continuous
- There should be a never-ending review of standards and practices

**Topic 2: Bioethics of Assisted Human Reproduction.
A Personal Approach.**

**Presenter: Professor David McConnell,
Department of Genetics, Trinity College, Dublin.**

Ethical questions concerning human reproduction can best be resolved if we enquire about and decide how we show respect for life. It follows that such questions cannot be addressed in the absence of a sound knowledge of the nature of life and living systems, that is, of the science of life, which is biology. Living systems are distinguished from non-living systems because they reproduce. Certain biological characteristics are passed on from generation to generation by genes. As Darwin knew, but did not correctly explain, it is important to take into special account the mechanism of heredity, that is, to take account of genetics.

There is a general principle of biology that is perhaps quite surprising. This is the principle that life is a continuum, and it is a continuum in many different senses – in this paper I concentrate on four.

First, life is a continuum in the fundamental sense that all living organisms on earth are related to each other. Although the details are not known and never will be, it is clear that life emerged gradually on the earth about 4 billion years ago, from within a prebiotic chemical “soup”, through a process akin to natural selection. Life, as we know it today, came into being, once the first replicating “cells” clearly emerged, and this was surely in itself a slow and gradual process. All organisms on earth today have evolved, from those primordial cells, due to a combination of mutation, recombination, Darwinian selection and genetic drift. Thus, all organisms are related to each other by descent, and their ancestry in every case is traceable in principle to one or a very few primordial cells. This primordial cell (or cells) is in theory traceable to a small group of replicating molecules in the primordial soup.

Man may not resemble an oak tree or a seaweed or a yeast but these are his relatives, and we can see that most clearly by examining the chemical structures of the genes in any man, oak tree or seaweed. All genes are made of the same chemical, DNA (or RNA), and some of the genes in very different organisms are nearly identical. The biological world

emerged through a tortuous, slow process, of evolution from a pre-existing non-biological world – the living world is a continuum and has no beginning. This is the single greatest finding of modern science - all other ideas of science must encompass the fact of evolution.

Second, life is a continuum in the sense that one generation gives rise to another, in a process which has no beginning. The relationship between one generation and the next is however more complex than commonly assumed. In particular, the transition from one generation to another, in sexually reproducing species, actually requires the alternation of two generations where we commonly think of only one. In the case of man, the sperm and the egg comprise one of these “generations” and people comprise the other. Sperms and eggs are human and alive. Which came first, the chicken or the egg? is a question which has no answer.

Third, life as observed in a growing embryo is a continuum. The sperm and egg, which are alive, combine to produce a fertilised egg, which is also of course alive. This egg, composed of countless trillions of biochemicals, undergoes countless trillions of chemical reactions as it prepares to divide into two cells. The reactions continue in a highly ordered process controlled by the genetic information and the cell divides. Then the first two daughter cells divide, and so the process continues. As many cell divisions occur, the embryo gradually takes shape, the result of a continual process, comprising an unimaginable number of biochemical reactions and interactions. There is no beginning to this process.

Fourth, the complex “higher” biological qualities of a human being, which I call personhood, depend on the higher neurological functions, which are centred in the brain. We know very little about how the brain works but it is clear that it is a wonderful electrochemical machine of enormous chemical and physical complexity, comprising more than one billion interconnecting cells. It is also clear that the physical structure of the brain develops gradually during embryogenesis. So the qualities of personhood, which cannot exist without the brain, emerge gradually. It is impossible to say that there is a time during embryogenesis before which personhood does not exist and after which it does. A person, defined by the qualities of personhood, has no beginning.

The fact of the continuum of the biological world, in these four senses, should have profound implications for all of us, in all our thoughts about humanity and our place and our responsibilities in the natural world. It should play a greater role in ethical discussions. In the first place it should cause us to respect the whole of the living world. However, as we face ethical dilemmas, it quickly becomes plain, that we will have to find ways of justifying why it is that we give different degrees of respect to different parts of the living world. In the words of Hubert Markl we need to inquire "Why there is more to Life Science than just Biology".

The continuum of life poses enormous ethical difficulties, especially in the matter of human reproduction, which cannot be solved fairly and beneficially by simple biological formulae. Paradoxically, our knowledge of biology shows that we cannot yet use that knowledge on its own or in a simple way as the basis of ethics or laws. It is not logical to found ethics or laws on biological "events" or "moments" within a biological continuum, unless these ethics or laws seem reasonable, for reasons other than biological ones, to a very wide spectrum of society.

For example it is quite literally *incredible* to accord or deny human rights on the basis of fertilisation or implantation. The genes of a sperm or of an egg should not be defined in law as part of a person just because they are fortunate enough, among their millions upon millions of fellow sperm and eggs, to take part in a more or less random biological collision, and to find themselves by dint of good fortune as part of a zygote or by further good fortune as part of an implanted embryo. We must instead seek other ways of deciding how to develop ethical and legal codes for human reproduction.

In summary, my overall conclusion will be as follows: (i) Knowledge of biology and genetics shows that many questions concerning the ethics of human reproduction are so difficult and so complex that good and caring people will differ in their answers; (ii) Therefore, *a priori*, the State should be reluctant to legislate the answers for such questions; (iii) Apparently opposite or different ethical decisions can be equally good, because they refer to situations which although superficially similar are in fact different, notably because they affect different people, and the problems are in fact different; (iv) Many of these questions will not be resolved unless we take a liberal

view and emphasise the primacy of the rights of the individual over the rights of the State in deciding on those perplexing and difficult matters that are essentially private and on which good people hold different opinions; (v) In particular the State should show great respect for the opinions of mothers and rely on the natural capacity of mothers to think caringly about their children; (vi) When the Oireachtas decides to legislate, it should do so in such a way that the individuals who are directly involved, especially the mothers, are helped to arrive at thoughtful, caring, private decisions; (vii) In the end the State should leave the final decisions in most cases to the individuals who are most directly affected by the decisions. I agree with the Nobel laureate James Watson, who would like to see "genetic decisions put in the hands of the users, which governments aren't"

The record shows that in the past Irish governments and Irish institutions, acting with good intentions, have nevertheless done substantial harm by denying Irish people the rights to decide on whether or not they will conceive offspring, how they will do so, whether they will be sterilised, whether they may be provided with genetic counselling, whether they will have abortions, whether they will marry, whether they will stay married, and what will be the relationship and even the sex of their partners. Irish law and practice seem to have been especially prone to measures that have penalised people who have wanted to conduct their personal, intimate and family relationships in ways outside the norm.

Whereas law is supposed to protect people, some Irish law has in fact damaged the health and welfare of parents and children and caused quite unjustifiable suffering. Some Irish law and Irish institutions have been (and in many respects they continue to be) open to the charge that they have been intolerant, inflexible, overbearing, even that they have been uncaring and merciless, in their treatment of people who want or do not want to have children in particular situations. Some Irish law and social practices still constrain certain forms of birth control, including early abortions, make it difficult for parents who need special treatment if they are to have children, prevent parents from avoiding the conception or birth of children with severe genetic or congenital disorders, or from having abortions of severely affected foetuses, or from having abortions in cases of rape or incest, and inhibit Irish doctors and scientists from carrying out valuable studies on

human biology.

It is clear that we have made progress. We now accept that many questions concerning human reproduction are in essence private matters and that the Oireachtas should *a priori* be reluctant to legislate for them. We no longer make it illegal for people to use “artificial methods for the prevention of conception” as contraceptives were legally defined when we disgraced ourselves “again”. We no longer outlaw divorce or homosexual relationships. In 1995 the Fine Gael Labour coalition Government decided that all methods of contraception, some of which had been either illegal or nearly unobtainable until the early 1990s, would be provided free to all holders of medical cards.

A survey in 1996 discovered that 87% and 74% of urban and rural women are in favour of the availability of male and female sterilisation (Women and Health Care in Ireland. ESRI).

So Ireland has increasingly taken a liberal view and in many new respects we now emphasise the primacy of the rights of the individual over the rights of the State in some of those perplexing and difficult matters that satisfy two criteria: they are essentially private *and* they cause great differences of opinion between otherwise thoughtful and responsible citizens. The State actually accepts in practice that many ethical dilemmas are so complex that good people, coming from different or even similar cultural backgrounds, will differ in what they consider to be the correct course of action – apparently opposite or different ethical decisions can be equally good, essentially because they refer to situations which although superficially similar are in fact different, notably because they affect different people at different times and in different places, and the problems are in fact different.

However we still have quite a long way to go on a number of issues and all of them relate to one question. What is the moral status of the embryo?

We can make a much better attempt at dealing with the remaining issues if we extend the principles that have allowed us to improve so many of our laws concerning personal relationships and the regulation of reproduction. If we are to do this we must be prepared to make these principles explicit, and far from hiding them or apologising for them we

must describe them, explain them and advocate them as appropriate in a modern, educated, multicultural and sophisticated society. We have got to move from reluctant acceptance of diversity to wholehearted celebration of the differences within our society, without becoming unprincipled, we must become liberal without becoming libertarian. We should accept the dictum of William Bateson "Treasure your exceptions." In particular, in considering matters affecting the integrity of the family, including the status of the embryo, we should accord great respect for the opinions of mothers and rely on the natural capacity of mothers to think caringly about their children. When the Oireachtas decides to legislate on the matters that I have in mind, all of which turn on the question of the moral status of the embryo, it should do so in such a way that the individuals who are directly involved, especially the mothers, are helped to arrive at thoughtful, caring, private decisions.

The State may want to take note that Article 41.1 could be interpreted so that the authority of the Family extends to cover decisions about the future of a pregnancy, and that a Family, which need to be newly defined, has an "inalienable and imprescriptible right" to make such decisions.

The reforms of the relevant laws, and related professional and institutional codes, will fail if they are not properly informed by knowledge of biology, especially the concepts of the oneness and continuum of life, and the gradualness in the emergence of personhood during human embryonic development. Personhood is that galaxy of qualities that distinguishes human beings from all other forms of life and entitles them to the highest possible degree of respect and protection within society. Biology shows us that the embryo develops slowly and continuously, and imperceptibly acquires the qualities of personhood, and the moral status of a person.

The State should accept that the acts of fertilisation and implantation have no moral significance that is generally accepted by thoughtful people; it is literally incredible to many people to make the claim that the early embryo has a significant elements of personhood. If some people choose to believe that the fertilised egg or the implanted embryo is a person or should have a status equivalent to that of a person, they are entitled to have such beliefs and of course may act accordingly as private individuals. But they

are not entitled to expect the State to incorporate these beliefs, which are essentially religious and narrowly so, within law, which is essentially secular. The reform of the laws should be based on the principle that the embryo does not have the moral status of a person until it is both capable of being born *and* capable, with care, of ordinary life after birth, leading in normal circumstances to the fullest possible expression of its personhood.

The State should therefore strengthen its commitment to a liberal society. It should espouse a broad ethical framework for new laws regulating the way in which respect and protection is accorded to embryos. The ethics must be secular, free of the language of any religion, and capable of attracting the support of the great majority of thoughtful citizens, regardless of their religious affiliations. The State should accept that the ethical dilemmas with which we are concerned should be resolved through case by case assessment of how to do good rather than harm, and that the mother, with the advice of the father, should have a very great degree of discretion in deciding on the future of an embryo. The laws should allow a mother, with the advice of the father, to have absolute discretion about her embryo up to the end of the first trimester, and absolute discretion after taking professional advice, up to the end of the second trimester. The State should have laws and should provide support for parents and their professional advisors to ensure insofar as possible that all involved are able to reach ethical decisions which take account of the rights and responsibilities of all of those most intimately concerned, the embryo, the parents and family, and the carers, and which in sum lead to “the greater good for the people”. The largest role for the State is in the field of ethical and civic education, that is, in the formation of the moral capital of our people, and in the provision of informed and sympathetic medical and social services. Mothers and fathers who face extraordinary ethical dilemmas, which do not bear easy resolution, need to be cared for sympathetically, rather than criticised or even criminalized, as they struggle to come to terms with their situation.

Topic 3: Moral Status of the Embryo.

**Presenter: Professor Maureen Junker Kenny,
School of Hebrew, Biblical & Theological Studies,
Trinity College, Dublin.**

I. Ethical issues in Assisted Reproduction

Techniques of human assisted reproduction try to overcome the suffering of childlessness that up to a fifth of couples experience. There are ethical questions relating to this suffering: How much of it is aggravated by society, by images of familial bliss that exclude childless couples and singles? To what extent is it prolonged by the lack of resources and inflexibility of the process of adoption? And how much of this suffering from an unfulfilled wish for children is caused by treacherous hopes and false promises that fail to point out the continually low success rate of methods of assisted reproduction - with a carry-home baby rate of at most 20 % (which includes twins and triplets)? More than 80 % of couples seeking medical assistance will remain childless after treatment.

Apart from these ethical issues relating to the suffering of couples, and besides the moral status of the embryo which is my theme, there are important other ethical questions in human assisted reproduction, such as the rights and obligations of parents and the rights of children. Is there a right for adults to have a child of their own? And if there was, would a right of children correspond to it to have identifiable parents of their own? These questions will come up again later today when we deal with surrogacy and with regulations concerning egg or sperm donation. Depending on one's answer concerning a right of children to identifiable singular parents, one will be happy or unsatisfied with the prohibition of surrogacy that exists in most European countries, and different laws on donor registration. Should donors, i.e. genetic parents, be contactable by their children, as is the case in Austria, or should they be allowed to remain anonymous, as is still the case in Britain?

While these questions of children's and parents' rights alone could fill a conference programme, it is **the moral status of the embryo** that is at the core of ethical, legal, and political divisions on practices between different countries: It is decisive in

debates on whether to allow

- "surplus" embryos to be created beyond the ones that are going to be implanted
- the freezing of embryos instead of "pronuclear" freezing
- embryo-wasting research
- embryonic as opposed to adult stemcell research,
- sex selection
- pre-implantation diagnosis as opposed to prenatal diagnosis
- embryo splitting as one form of non-reproductive cloning
- "therapeutic" cloning with the Dolly method of using an enucleated egg, ...

Whether these practices can be justified, depends on one's position regarding the moral status of the embryo.

Yet before I go into the different argumentations on the moral status of the embryo, I want to clarify the status of Ethics.

Personal opinions arising from individual experience as those outlined by David McConnell, or "considered convictions", to speak with the political philosopher John Rawls, may be the **starting point** for Ethics. But Ethics understands itself not as a forum of **opinions** but as the science or the discipline of argumentation. One has to be able to show the validity of the **reasons** behind one's opinion. To quote the theological ethicist D. Mieth:

"That is your opinion, respect mine", this is an option against debate about coherent justification and for the mere juxtaposition of moral standpoints, which puts an end to ethics even before it has started. As if the different argumentations were just matters of opinion, and as if scientific rationality was not itself always preliminary!"¹

Which philosophical argumentation is more convincing in its interpretation of the biological, scientific observations of human development? This is the major ethical question in what follows. The other decisive question (for which there is professional

¹Mieth, in: Das Parlament, 5.

expertise within your committee) is, what parameters does the Irish Constitution set for the definition of human personhood that enjoys the protection of the law?²

There are two different theories on whether the embryo or foetus can be ascribed any moral status of its own: the "process argument" and the "continuity argument", to follow the distinctions used by the Christian ethicist Ken Kearon (Medical Ethics. An Introduction). The "process argument" bases different grades of personhood and protection on relevant thresholds in the development of the fertilized egg or embryo which we will have a look at in a minute.³

The opposing view claims that the different stages and steps of development cannot negate the underlying continuity of the human developmental process from the zygote onwards, i.e. the fertilized egg after the fusion of the nuclei of egg and sperm and before cell division. In this view, it is arbitrary to turn thresholds into cut-off points and impose dividing lines before which the embryo is considered human tissue with no right to life, and after which it is attributed person status and the protection that goes with it.

II. The moral status of the embryo

1. The hermeneutical circle inherent in definitions of human personhood

How can we determine when human life, individuality, personhood begins? We first need to understand the hermeneutical and practical character inherent in all definitions of human life and personhood before we analyze the two opposing positions, "process" versus "continuity". Hermeneutics (which receives its name from the messenger God Hermes) is the art, the reflected technique, the methodology of understanding. "Hermeneutical circle" denotes the insight that as humans we have no absolute standpoint from which to assess things. We come with a pre-understanding and with the knowledge of the practical consequences of our position to the scientific

² It is likely that the Irish Constitution with its deontological Natural Law basis is closer to the Kantian deontology of the German Constitution and its protection of human dignity which finds expression also in the Embryo Protection Act (1990), than utilitarian traditions of ethics that fail to acknowledge justified rights of the individual over against the interests of the majority.

³ Such "thresholds" could be e.g., implantation around days 6-10 after fertilization; day 14 after which twinning is unlikely and which is taken to be the earliest date for "individuation". It coincides with the woman becoming aware that she is pregnant, through a missed period and a positive pregnancy test. A few days later, day 17, the development of the primitive streak as the first beginnings of neural system; brain activity at around week 12; birth.

data. Any definition of the beginning and the end of human personhood is caught in this hermeneutical circle. "We define its starting (and end) point because we want to act in a certain way, and we act according to how we have defined it."⁴ E.g., the shift in many countries to the definition of death as brain death which is prior to the full death of the human person happened because we wanted to act in a certain way: We wanted to be able to retrieve organs from the brain-dead person for transplantation, with the prior consent of the now dead person or her relatives. Practical matters come into the definition of the end and the beginning of human life. Each definition includes a practical intent: Once we ascribe human life and personhood to an entity, we want to protect it. If one wants to give maximum protection, one has to use a minimal definition, such as the new genetic unity created by egg and sperm. A maximal definition of human life, such as the ability to communicate, or to act independently, offers minimal protection to the stages prior to these competencies and after they have been lost.

The practical intent, however, has to be justified by reference to the biological data which need to be interpreted. Interdisciplinary ethics means that scientific findings form part of the process of reaching moral judgments.

Which stages in the process of human development have been identified and taken as significant bases for the attribution of personhood?

Let's look at the process of development and what it is interpreted to mean.

⁴ Here, I am following the argumentation of Dietmar Mieth, Geburtenregelung. Ein Konflikt in der katholischen Kirche (Mainz: Grünewald, 1990), 78-82. 95-96. A similar evaluation can be found in the French philosopher Paul Ricoeur's discussion of "respect for persons at the 'beginning of life.'" In Kant's "bipolar opposition of persons and things, the distinction between mode of beings remained inseparable from practice, that is, from the manner of treating persons and things . . . To be sure, the identification of thresholds and degrees marking the appearance of properties of being is dependent on science alone. But the ontological tenor assigned to the predicate 'potential' in the expression 'potential human person' is perhaps not separable from the manner of 'treating' beings corresponding to these various stages. Manner of being and manner of treating would seem to be mutually determined in the formation of prudential judgments occasioned by each advance in the power that technology confers today on 'humankind over life in its beginnings.'" Ricoeur speaks of the "complex play between science and wisdom" and rightly analyzes any definition as a prudential judgment which has to be all the more cautious in the context of scientific manipulation of embryos." (Oneself as Another (Chicago: Univ. of Chicago Press, 1992), 270, 272-73)

Beginning of fertilization

A sperm enters the egg cell

Pro-nuclear stage

After 16-18 hours the genetic inheritance of egg and sperm are ready to fuse

Fusion of the genetic inheritance = Zygote

Fertilization is complete, the embryo is ready for cell division

2-cell-stage

Each cell is still "totipotent" and can result in another person (twin) by division

8-cell-stage

Here the totipotency of the cells is likely to end

16-cell-stage

Pluripotent cells

Implantation

Primitive streak

Brain activity (week 12)

Birth

2. The "process" position

Relevant thresholds for attributing personhood rights:

- implantation in the uterus (6-10 days after fertilization)
- end of twinning possibility -- "individuation" (day 14)
- primitive streak (from day 17) -- neural system
- brain activity (week 12)
- birth -- independent breathing, ability to communicate

3. The "continuity" position

Offers a different answer to the question, when is the human being a human being?

When is she the bearer of inextinguishable values, i.e., an end in itself, which cannot be instrumentalized totally? It takes the only relevant line to be drawn to be

- conception (from hour 0-1 of fertilization), or more specifically,

Progress Report on the Commission on Assisted Human Reproduction

May to December 2001.

1. Administration

1.1 Offices

The Commission moved into its new offices at 31-35 Bow Street, Dublin 7, in July 2001. This has helped the Commission by providing a permanent venue for meetings and a fixed point of contact for the members with the Commission's administrative staff.

1.2 Working Methods

The practice of the Work Groups and the Commission holding meetings in the morning and afternoon of the same day has been continued. Work Groups hold additional meetings if they consider it necessary.

The Chairperson of each Work Group makes a report to the Commission meeting in order to keep it fully informed of progress by each group.

Decisions are reserved to the Commission.

The table below shows the number of meetings held in the period in question.

Structure	Number of meetings
Commission	4
Work Group 1	5
Work Group 2	7
Work Group 3	5

2. Conference

The Commission organised a one-day conference for Commission members and an invited audience of about thirty, in Dublin Castle on 14 September 2001. The conference dealt with the social, ethical and legal factors inherent in assisted human reproduction. It provided an opportunity for an exchange of views between experts in the various fields from Ireland, the UK, France and

Germany. A report has been prepared on the conference by the secretariat which is being sent to you for your information.

3. Information Gathering Activities of the Commission

3.1 Survey of AHR services provided in specialized clinics

A survey instrument was drafted by the Commission with a view to establishing the extent of the provision of AHR services in Ireland. It is being administered by the members of the secretariat and returns are already complete from the recognized AHR centres in the country. It is expected to be able to make an interim report to the Commission at its next meeting (17 January 2002).

3.2 Survey of GPs

A member of the Commission has conducted a survey on his own behalf of the involvement in AHR services of GPs in his Health Board area. It has been decided to conduct a similar survey on behalf of the Commission of a sample of GPs in the country as a whole.

3.3 Survey of Maternity Hospitals and maternity units of General Hospitals

A draft of a survey of the level of involvement in AHR services of maternity hospitals and the maternity units of general hospitals will be considered by the Commission at its next meeting.

3.4 Published Information

The Commission has access to international data in printed and electronic form. It takes note of published studies, such as those of the International Federation of Fertility Societies.

4. Work Groups

4.1 Work Group 1

The topics which have been assigned to this Work Group are:

Gametes/Embryos. It has met on five occasions in the period in question. The Work Group has adopted definitions of the terms gametes and embryos. The recent meetings of the group have been devoted to a discussion of the ethical, social, legal and equality issues that arise in relation in particular to the embryo.

The ethical issues that arise in relation to gametes arise in relation to the methods of collecting and storing them than to the gametes themselves. The ethical issues that arise in relation to *in vitro* embryos have been the subject of extended discussion in the group, with particular reference to the ethical significance of conception and implantation. Arguments for different ethical positions have been made and reported to the Commission. An argument has also been made that separate consideration should be given to the views of women on matters of human reproduction.

The group has also considered the possible implications of the Protection of Human Life in Pregnancy Act 2001 for the legal status of the “unborn” in Ireland. The group feels that it is now in a position to prepare a Working Document summarising its discussions and to begin an examination of the options for regulation.

4.2 Work Group 2

The topics that have been assigned to this group, which has met on seven occasions in the period in question, are Donor Programmes and Surrogacy.

The group has given lengthy consideration to the legal issues that arise for children born through donor programmes and through surrogacy and for their parents and other siblings. Research papers have been written and/or commissioned by members of the group dealing with the current position

under Irish law of such children and their parents and their current legal status in a number of other jurisdictions.

The group has also given much attention to the social implications of donor programmes and surrogacy, while noting that Ireland has no recorded cases of children born through surrogacy. The relevance of current Irish adoption law to any children born through surrogacy is being examined.

The medical and clinical conditions likely to facilitate the success of donor programmes have also been considered as well as such issues as the selection, remuneration and identification of donors.

4.3 Work Group 3

The topics that have been assigned to this group are Infertility Treatments/Infertility Services and Information. The group has met on five occasions in the period in question. So far it has concentrated on the first two parts of its brief, namely Infertility Treatments and Services. At the Work Group's suggestion the Commission agreed to adopt the definition of infertility used by the World Health Organisation i.e. "failure to conceive following one year of unprotected sex".

The group has considered the most common causes of male and female infertility and the risks attendant upon a decision to undergo fertility treatment. It has also considered the possibility of commercialization of human reproduction inherent in some of the most recent reproductive technologies.

It has examined AHR service delivery models in other jurisdictions and has taken special note of the service provision model recommended by an expert advisory group on the provision of infertility services in Scotland (EAGISS). It has given special consideration to the most recent survey of assisted reproductive technologies, carried out on behalf of the International Federation of Fertility Societies, showing the latest position in relation to the regulation, provision and research of AHR services in 43 jurisdictions, including Ireland.

The surveys initiated by the Commission (see section 3 above) are of special interest to Work Group 3 in that they will enable the group to give a full description of AHR services at GP, maternity hospital and specialist clinic levels in Ireland and to indicate how the level and extent of provision here compares with other countries.

5. Conclusions

The Commission as a whole is making satisfactory progress. The Work Group structure facilitates close attention to a relatively limited range of topics by a highly specialized group. It also facilitates the detailed exploration of a range of ethical and social implications that arise from assisted human reproduction. All group discussions are presented in summary to the full Commission and further comment is invited. Decisions are reserved to the Commission.

Descriptions of the current state of assisted reproductive technologies in Ireland in scientific and medical terms are also complete. The implications of assisted human reproduction for the legal status of the parents and children involved are being thoroughly explored.

It seems to me that the Commission reflects society at large in holding a range of views on the ethical and social implications of assisted human reproduction. I am happy that divergent views are being expressed and heard in a spirit of mutual respect and enquiry. In conclusion I am confident that the Commission has the commitment and the capacity to fulfil its terms of reference.

- syngamy (from hours 18) after the fusion of the nuclei of sperm and egg --
autoreproductive (=self-dividing) unit, male or female, with unique genetic make-
up

-- personhood due to existing potential for "capability to be moral" (Kant).

From the zygote stage onwards, this position attributes human rights to life and the inviolability of its (his or her) body. The reason for anticipating the future autonomous, self-governed person in the embryo are its continuity and individuality in being already male or female.⁵

The continuity position insists that there is one process of development; in principle, all the emergent features are founded on the basic autoreproductive unit of the zygote, and it would be arbitrary to say any particular stage introduces such a qualitative difference that only from then onwards there would be a sufficient basis for personhood. It is one human being that has all the dispositions for later realizations within itself: It is a potential marked by identity on a genetic basis, and by continuity both temporally and substantially.

However, to attribute human personhood to the zygote does not imply that in ethical dilemmas it is always the embryo who "wins." It allows one to set up the dilemma and ask whether the right of the embryo to survive is equal, superior or subordinated to the mother's rights to life and self-determination.

The comparison of the "process" or "thresholds" position and the "continuity" position shows that the same scientific data are interpreted in totally opposite ways. For the first approach, they represent quite separate stages, each of which entails a vastly different status. Its maximal definition of personhood is mainly interested in signs of cognitive development: primitive streak, brain activity. Here, personhood is based on actual consciousness, and its pre-stages. It is in the consequence of this emphasis on intelligent behaviour that Peter Singer comes to place the right to life of whales, dolphins and chimpanzees, intelligent as they are, above that of human newborns who are mentally handicapped.

⁵ This is a minimal definition of the beginning of personal human life that offers maximal protection. Calling this unit "pre-embryo" presupposes the decision that no moral status can be ascribed to the product of conception in the first 14 days of its existence, and this decision is clothed in the language of science. To call the zygote "pre-embryo", makes one of many stages in its development, namely implantation, definitive for attributing basic rights to it.

The second approach is interested in rationality only insofar as it relates to the "capacity to be moral," which is the foundation of human dignity for Kant. The potential for freedom as the capacity to be moral comes with being human. It does not have to be, nor can it be, proven in actual performance.

The gulf between the two positions amounts to the difference between an empirical concept of dignity - you have as much dignity as you display in your behaviour -, and a transcendental one: Human dignity is inexhaustible, never directly realizable, it is the condition of our actions. The attribution of personhood is embedded in an anthropology of anticipation.

Between these two views, no mediation or compromise is possible. How does one proceed in this situation of moral pluralism?

While striving for consensus, "overlapping" (J. Rawls) or otherwise, is a value, it is not an end in itself. If agreement were to be bought at the expense of the most vulnerable human beings, then a culture of dissent, of resisting superficial harmonization, can be more productive than compromise. Ireland's and Germany's withholding their signatures from the Council of Europe's "Convention on Human Rights and Biomedicine" because of the uncertain degree of protection for embryos and for people incapable of consent against non-therapeutic research on them, their refusal to endorse it, can be seen as a sign of prophetic protest against a downward spiral towards the lowest common denominator. Pluralism as the respect for otherness cannot mean that everyone settles for the lowest level. "The ethical paradox" is "that if you take pluralism as the *norma normans* (the crucial highest norm that shapes all other norms), you need no more ethics because all argumentation can be stopped by the norm of pluralism. And if there are no limits to pluralism, then the so-called position (reclaiming pluralism) is nothing other than a kind of fundamentalism" that does not allow for argumentation (D. Mieth, in Haker/Beyleveltdt, 10).

2. Consequences for reproductive technologies

1. Embryo freezing

The medical advantages to embryo freezing are

- the woman has to undergo ovarian stimulation and egg harvesting only once,
- the chances of the second and third cycles being successful are slightly higher,
- only one or two embryos would need to be replaced, thus reducing the complications of multiple pregnancies.

The ethical problem, however, is that, depending on one's answer to the question of the beginning of human personhood, freezing of embryos at the four-cell-stage could mean to have "human beings in waiting" and most of them waiting to be discarded after a fixed period, or to be kept indefinitely, even after the lifetime of their parents. This last way out, however, is not an option, if one insists, as the body of Protestant, Anglican and Orthodox Churches in Europe does in a Position paper of the "European Ecumenical Commission for Church and Society" that the biological and relational aspects should not be separated and that the "parental or marital context" needs to be ensured.⁶

A balance between the interests of the couples and the dignity of the embryo would be achieved with "pronuclear" freezing. The fertilized egg is frozen before syngamy, i.e. before the genetic material from both gametes combines to form the new and unique genetic individuality which is autoreproductive and able to divide. This freezing of the pre-zygote is practiced e.g. in Germany to fulfill the demands of the German Embryo Protection Act. Freezing at the pronuclear stage, however, comes at the scientific disadvantage of not being able to single out the "healthy-looking" embryos, and thus slightly reduces the success rate.

2. Experimentation

The Position Paper of the "European Ecumenical Commission for Church and Society" submitted to the Council of Europe summarizes the different positions of the

⁶ EECCS Bioethics Working Group, "Drawing the Line - The Ethics of Biotechnology." Occasional Paper No. 521 (Brussels, 1997), 57. Further page references in the text.

member churches on the status of the embryo - from regarding it as human tissue to seeing it as a person - and states its disapproval of creating spare embryos for research: "Christian anthropology does not allow a separation of biological or relational aspects . . . Speaking about a human embryo as a child should take place . . . in the "parental or marital context". . . So-called 'spare embryos'. . . are artificially placed outside the parental context. As such, they are still human embryos, but at least in practice, no future children or persons to be." (57) With regard to research on them, e.g. to help people with Parkinson's disease, they conclude: "We want to make it clear that what has been developed to help childless couples should not be used as a key to open up other research areas." As a general rule, they endorse "in dubiis, abstinere" ("if in doubt, refrain"). For some of them this means that "non-therapeutic embryo research should be prohibited." (58) For others it means that it should only be allowed in a "case-by-case approach where the researcher has to give sufficient reasons." (cf. 58). If research is going to be permitted, they call for a "broadly based (!) licensing body to monitor and control the research."

3. Cloning

What the "European Ecumenical Commission for Church and Society" demands, not to use a technology developed to help childless couples for the medical aims of other people, has a direct bearing on the specific use of cloning which has now been permitted through a significant change of language, the "distinction of the year" 1997, according to D. Mieth: "reproductive versus non-reproductive cloning." What is prohibited is reproductive cloning but this term, "reproductive", no longer denotes sperm, egg, and all embryos - as in an earlier Declaration of the Council of Ministers in the European Union - but now means only those embryos which are going to be implanted. This restriction of the meaning of "reproductive" which in effect, declares the cloning of embryos for research legal, is an example of language policy that veils the real intentions. It promotes what also the Protestant Churches in Europe do not want to be allowed, namely using the IVF technique outside of the context which justifies its origin, namely of helping infertile couples to have children. Cloning embryos to be used for tissue development for organ donation is not within these boundaries.

One point that needs to be clarified, however, is, if ever a cloned baby was to be born: Not the cloned person is morally wrong, but the action and intention of cloning is wrong. Once a clone was conceived and born, we would have to respect her human dignity like anybody else's.

IV. Conclusions

1. Every embryo created in Assisted Human Reproduction is a potential child for his/her parents. (Margot v. Renesse, SPD, Chairperson of Enquete Commission on Genetics and Human Reproduction of the German Parliament)

This principle excludes the creation of surplus embryos, embryo freezing (as opposed to pronuclear freezing), any kind of experimentation, and genetic testing prior to implantation.

2. Possible secondary consequences of each decision have to be acknowledged and debated now, not postponed. (D. Mieth)

"Supernumerary embryos, selective early diagnosis outside the mother's womb (pre-implantation early diagnosis), or the storage of pluripotent stem cells which originate from destroyed embryos - once they are there the next step seems only logical.

Of course, some people hold that with the introduction of IVF itself the Rubicon was passed, among them the Vatican who rules out IVF even in the case of married couples who cannot have children because of the woman's blocked tubes. While I take issue with their claim that it is against the dignity of the child to be conceived in a Petri dish, I agree that the possibilities that arise from the embryo being exposed to human manipulation by its in vitro situation, can indeed violate its human dignity: freezing instead of implantation, sex selection, genetic testing, being appointed either to become research material or a future child. The original equality of the child with the parents is severely endangered by the possibilities for manipulation and instrumentalization that the laboratory situation offers. Therefore, the legislation of an embryo protection act is required.

One conclusion drawn in the newspapers from the American President's decision only to use already existing embryonic stemcell lines for stemcell research was that it confirms the German position that one has to draw the line at the very beginning.

3. The State has to take responsibility for the legal regulations that protect all its members from the violation of their rights and their dignity. (H. Haker)

It cannot delegate its responsibility to professional bodies such as the doctors.

- On a practical level, the guidelines of the Medical Council only affect medical doctors, not microbiologists, geneticists, etc. The fact that they are being breached now by the practice of the Rotunda Hospital to freeze embryos shows that even for doctors, guidelines do not have the necessary legal force.

- On a principal level, it is the State that has to guarantee fundamental human rights such as the right to life also against economic systems in times of globalization (Lutz-Bachmann, 19). The people's representatives have to debate to whom this right extends and what it includes.

Civil society, that is private citizens, institutions in civil society like the churches, voluntary agencies, have to express in solidaric actions that in our society all members are welcome.

Since my theme was the embryo, most of my considerations were located at the level of Normative Ethics: duties we owe each other and rights we can claim. Had I been focussing on the patients, I would have had been able to include the perspective of an ethics of desire, of striving, of people's vision of their identities and the lifeworld and society they would like to live in. Then I would have pointed out some contradictions inherent in some uses of Assisted Reproduction that endanger the very aim of the flourishing life one hopes to attain:

Contradictions in assisted reproduction

- Couples aim for a child biologically their own -- and then one of them settles for sperm donation, egg donation, surrogacy.

- or: they do not just aim for a child genetically their own, but for a quality-controlled

child with or without certain features, endowed with "the best of you", as the film *Gattica* suggests. Does the right to be assisted to have a child of one's own extend to the right to have a healthy or even an "enhanced" child? Here, conflicts may also arise as to whether IVF means an empowerment of parents, or their loss of power and control to fertility experts. What if the scientists want to introduce quality control and refuse to implant an embryo who is genetically impaired? Who defines what is normal?

- The unconditionality of the parent-child relationship is lost when we move from given features to chosen ones (O. O'Neill). Yet, if I am not good enough for my parents, are my parents good enough for me?

Techniques of assisted reproduction can only be welcomed as long as they respect the radical equality between parents and children. Natural hazard protects human dignity. Human manipulation of the embryo in vitro through testing, sex selection, etc. sets up a relationship of domination - less than what parents wish for, which is unconditional mutual acceptance.

Topic 4: Medical Ethics of Assisted Human Reproduction.

**Presenter: Ms. Veronica English, Deputy Head of Medical Ethics,
British Medical Association.**

The BMA has policy and guidance on a wide range of issues around assisted reproduction including:

- Embryo research;
- Surrogacy;
- Payment for gamete donors;
- Sex selection; and
- Access to treatment

Access to treatment

This paper considers whether there should be limits on who should be able to receive fertility treatment, for example an upper age limit, or restricting treatment to married couples or those who have passed some form of assessment for “good parenting” – whatever that means. The BMA’s starting point when considering these issues is the welfare of the child. The BMA has, in the past, criticised the HFEA for stating that the rights of all parties need to be considered and that no single interest takes precedence over the others. In the BMA’s view, being the most vulnerable party, the child’s welfare should be the paramount consideration.

Arguments that it will always be in a child’s interest to be born because any life is better than no life are unhelpful because it is not possible, in any meaningful sense, to compare existence to non existence. And while many individuals experiencing pain, abuse, neglect or other substantial disadvantages are nevertheless glad to have been born, it would be wrong for a health professional to help someone to conceive a child in the knowledge that that child would be born to a life of suffering.

But the idea that people seeking assistance to conceive should be subject to assessments about the welfare of the potential child has been challenged as discriminating against the infertile. Those who can have children without assistance are not subject to any checks of their suitability for parenthood so why should the infertile be held up to greater scrutiny?

The BMA believes that there is a fundamental difference between those who conceive naturally and where health professionals assist a person to conceive. Where health professionals are involved they have a special responsibility to ensure that the child will not be foreseeably disadvantaged. For example, if it is known that a couple's existing children have been physically and psychologically abused and taken into care, would it be right for a health professional to knowingly help that couple to have more children, when there is a strong chance that they too will be abused? This may seem a purely theoretical question but in fact the BMA does receive enquiries from doctors about the scope of their responsibilities when one partner of a couple seeking treatment has a history of violence and criminality.

There is a major difference here between negative and positive rights. While the couple have a negative right not to be prevented from having children, by forcible sterilisation, for example, they do not have a positive right to be given assistance to have children. This point was reinforced by the UK courts recently when a prisoner, Gavin Mellor, challenged the Home Secretary's decision not to allow him to use artificial insemination to have a child with his wife whilst he was serving a life sentence for murder. There were no medical indications for treatment and the only apparent impediment to his wife becoming pregnant was Mr Mellor's imprisonment. Mr Mellor argued that the refusal to allow him access to treatment services breached his human rights. This argument was rejected and it was made clear that the Human Rights Act does not give a positive right to assistance to conceive.

But what about someone who is not in prison, but has been in prison in the past, or someone who has a history of alcoholism or of mild psychiatric problems? What about those who have an unusual lifestyle, live in a caravan or in a commune or whose existing children "look dirty"? There is clearly a risk here that individual views and prejudices about appropriate and inappropriate lifestyles and family make-up could unfairly influence these judgements. While we think it is right that health professionals should take account of the welfare of the resulting child before offering fertility treatment, such assessments must be carried out fairly and objectively. Such assessments should seek to weed out those cases where a future child is at clear risk of harm rather than seeking only to permit the optimal utopian family. They should not

be used to restrict treatment to the minority of the population who fulfill the idealised image of a “happy family”.

Post-menopausal women

One of the areas where the welfare of the child arguments are often used against providing fertility treatment is when the treatment involves older postmenopausal women. There have been reports of women in their late fifties and even in their early sixties using eggs donated by younger women in order to have children. In fact, the number of women over 50 having treatment in the UK is very small but, of course, these are the type of cases that hit the headlines. Most people would consider that treatment using donated eggs is acceptable for women who have suffered from a premature menopause at the age of 25 or 30 but many are unhappy about older women, say those over 50, having treatment.

So what are the main arguments against the treatment of older women?

- **It is simply wrong**

Some people have an instinctive, ‘gut’ feeling, which they can't explain, that it is not right for older women to use eggs from younger donors, in order to have children.

While these feelings should not simply be ignored, neither should they be assumed to be morally correct in the absence of clear moral reasoning.

- **It is unnatural**

There is a feeling among many people that the menopause is nature's way of telling us that we have reached the end of our reproductive life and that we should not use medical technology to defy this. But it is also unnatural to have any infertility treatment or medical intervention. If it is acceptable to cross some natural boundaries why is it not acceptable on this issue?

- **Dangerous to mother's health**

There is evidence to suggest that the risks of pregnancy increase with age. In addition to the strain of pregnancy and childbirth, the physical strain of rearing a child needs to be considered. But pregnancies in older women can be safely and successfully carried to term if the woman is medically and psychologically fit. So, from a health

perspective, suitability should be assessed on medical criteria rather than on age alone. A woman in her fifties may, in some circumstances be healthier and more able to cope with childbirth than a woman in her thirties.

- **If people miss the opportunity to have children when they are young it is their own fault**

This argument is based on the stereotype image of a woman who has done everything else with her life, had a successful career and then decides, later in life, that she wants to have a child. These arguments are often presented in terms of the woman seeking a child for her own satisfaction rather than for the benefit of the child, although it is not clear that younger women's motivations for having children are necessarily any different. There are many different reasons why a woman might decide to delay having children, and it should not be assumed that these people's motives are necessarily irresponsible. They may, to the contrary, be very responsible – wishing to have a stable home life and a secure financial background before embarking on parenthood.

- **Trauma for children of losing one or both parents at an early age**

It is argued that children have a right to expect to be cared for and to have their physical and emotional needs met throughout their childhood and with older parents the chances of one or both parents dying when the child is young are increased. While, undoubtedly it is a tragedy for a child to lose one or both parents at a young age, our society does not appear to disapprove of older fathers. If a clinic was asked to provide fertility treatment for a 35 year old woman and her 54 year old husband, one wonders whether the same arguments would be made.

- **"Children should reasonably expect parents to be young and fit enough to play football in the park"**

This argument is frequently found in editorials, letters to newspapers and radio phone-ins but is this expecting older women to satisfy criteria that one would never ask of a younger woman? Would it be acceptable on the same grounds, for example, to refuse treatment to someone who was disabled on the grounds that they could not play football or do other physical activities that children might enjoy?

These type of factors are not unimportant but they need to be assessed on an individual basis. A woman of 52 may be in a far better position to care for and satisfy the needs of a child than a woman of 35. It depends on the individual woman and her circumstances. Age is one factor but not the only, or perhaps even the most important, factor that needs to be considered. The BMA does not want to see the boundaries being constantly pushed back so that older and older women are having babies, but neither does it wish to see blanket rules which deny the very different circumstances of individuals.

This example illustrates the reasoning behind the BMA's general policy on the question of access to treatment. The BMA has firmly rejected the notion of establishing hard and fast rules on eligibility for fertility treatment as part of a general refusal to classify individual patients into groups. It believes that nobody should be automatically denied access to fertility treatment on the basis of blanket rules on factors such as age or marital status. Instead, judgements about whether or not a woman should be offered fertility treatment should be based on a full assessment of her particular clinical situation and all other relevant factors.

Assessing the welfare of the child

The Human Fertilisation and Embryology Act states that:

“a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of treatment (including the need of that child for a father) and of any other child who may be affected by the birth”

HFE Act section 13(5)

During the passage of the legislation, attempts to prohibit the provision of treatment to single women, lesbian couples or unmarried couples were unsuccessful although, in the House of Lords, an amendment to restrict treatment to married couples was defeated by just one vote. The reasons given for seeking such a restriction were that: children of single women would be disadvantaged by only having one parent; children born to lesbian couples would lack a suitable male role model; and if heterosexual couples were unwilling to marry, this usually meant that one partner wanted to be free

to break up the relationship and so the child would end up with only one parent. In the House of Commons an attempt to restrict treatment to women being treated with a male partner was defeated but the requirement to take account of the child's need for a father was carried. Although not prohibiting single women and lesbian couples from receiving treatment, it makes treating such women more difficult to justify.

The HFEA has interpreted this statement about the welfare of the child as not excluding any group of patients from being considered for treatment, but places the obligation to make assessments in individual cases firmly at the door of the licensed clinic. The HFEA's code of practice advises that all people seeking treatment are entitled to a fair and unprejudiced assessment of their situation and needs. In fulfilling their legal obligation, the code of practice says that clinics should undertake assessments of those seeking treatment, bearing in mind:

- their commitment to having and bringing up a child or children;
- their ability to provide a stable and supportive environment for any child produced as a result of treatment;
- their medical histories and the medical histories of their families;
- their health and consequent future ability to look after or provide for a child's need;
- their ages and likely future ability to look after or provide for a child's needs;
- their ability to meet the needs of any child or children who may be born as a result of treatment, including the implications of any possible multiple births;
- any risk of harm to the child or children who may be born, including the risk of inherited disorders or transmissible diseases, problems during pregnancy and of neglect or abuse; and
- the effect of a new baby or babies upon any existing child of the family.

Additional factors to take into account are listed for cases involving the use of donated gametes, where the child will have no legal father and in cases of surrogacy.

Although the responsibility for making individual assessments rests with the clinic,

these decisions are overseen by the HFEA. Either through its data collection, or the inspection process, the HFEA may pick up on any case and ask the clinic to justify its decision to provide treatment. Where treatment was provided for a lesbian couple or single woman, for example, specific enquiries can be made about the checks that were made to assess the welfare of the child, including the need of that child for a father. The clinic might, for example, satisfy this requirement by making enquiries about male friends and family members who would be involved in the child's upbringing and who would provide a male role-model for the child.

The BMA supports the way the HFEA has interpreted and implemented this requirement of the legislation. In our view this form of individual assessment is a much better, fairer and more appropriate way of making decisions about access to treatment than setting firm boundaries excluding whole categories of people.

It is not clear how many people have actually been refused treatment because of concerns about the welfare of the child. There have been a small number of high profile cases, including one before the legislation was enacted, where a former prostitute challenged the decision not to allow her access to fertility treatment. In that case, the court held that the decision of the clinic was not unreasonable. The BMA receives a number of calls from general practitioners who have been asked by clinics if they have anything to contribute to the assessment of the welfare of the child and from these discussions, it is clear that they take this responsibility very seriously. But doctors also often feel that they are being unfairly judged by society. If they provide treatment on a non-discriminatory basis, they are sometimes seen as being only interested in the money. The decisions they are being asked to make are not medical decisions but social ones and doctors are not, on the whole, well-equipped to make these social judgements. Society is usually happy to push this responsibility onto doctors but is quick to criticise when things go wrong. Doctors fear being scape-goats if they withhold treatment on grounds that are considered discriminatory by society but also if they give treatment and, with hindsight, "unsuitable" people have been helped to have children.

Assessing the welfare of the child before offering fertility treatment is an important

task but it is by no means an easy one. Given that medial intervention is being requested to assist with conception, and the need to assess the individual circumstances in preference to blanket rules, it probably is appropriate for doctors to be the ones making these assessments. But, clear guidance and support needs to be available for those doctors who are expected to make these judgements.

Discussion

A number of ethical questions were raised in the discussion that followed the four morning presentations.

When does life begin/Status of the embryo

It was suggested that it is up to society to decide whether life begins at conception or at some other point. One speaker pointed out that Warnock's 14-day limit was regarded as having an element of arbitrariness about it since the developmental streak is of little interest except in a biological sense. Another speaker said that while we certainly have a continuum there are certain pivotal points which determine whether a pregnancy can continue or not. One speaker said that there are radically opposed opinions on the beginning of life – the absolutist view and the gradualist view and the debate has not been resolved. A degree of protection is necessary and we must arbitrarily decide when this protection comes into effect. Abortion is legal in certain circumstances in the UK and therefore they have decided that the foetus can be aborted. The function of regulation is to support good decision making. Another speaker said that if you set up protection from the zygote stage it doesn't mean that the embryo always wins – you set up the dilemma and turn it into a moral decision.

It was also pointed out that most modern contraceptives have a back-up abortifacient action and we should either ban them or abandon our 0-8 hours position. The main drawback of the IUD, it was suggested, is that it can lead to infertility.

Legislation / Regulation

The Chairperson said that this is a most pressing question for the Commission and there is a need for legislation. Legislation needs consensus.

One speaker asked if there is need for legislation pointing out that the written Constitution defines the unborn. Another speaker noted that there are procedures being carried out in Ireland and this demonstrates that there is a need for regulation. We must take account of how things are as well as how we might like things to be. Two speakers pointed to the need to consider individual cases on their own merits.

The question was asked as to what kind of social process is necessary so that regulation if it emerges will enjoy lasting public support and the related question as to whether regulation should be by way of national legislation or by way of self-regulation by the clinics within nationally prescribed guidelines. The point was made that our search for suitable models should not be confined to the UK. It was noted, for example, that whereas the UK tends to be adult centred, Germany and Ireland are child centred.

The role of the law in this area was also raised – to what extent do we regulate? What limits on freedom of choice should the law impose?

An element in the discussion was the role of the general public in establishing the broad parameters of regulation. A huge amount of public debate intervened between the Warnock report and the HFE Act. Hindsight suggests that the time for reflection was crucially important since legislation can play a protective as well as a restrictive role. It was pointed out that we must recognize the position we are starting from – we must be honest about what is already going on. We should consider the impact of legislation – it could prevent things that are already happening or enable things that are not permitted. Legislation must try and respond to broad social and cultural change in the society it aims to serve. It would be useful to have a forum where professional and social attitudes can come together.

One speaker argued that the Irish State is too restrictive and over involved in ethical issues. He pointed out that Irish parents have no power to decide not to continue with a pregnancy. He went on to say that the State has an important role in encouraging public discussion in order to enable people to take moral positions.

Another point that emerged was that reproductive cloning seems to have little public or professional support although it was suggested that a cloned human being would merit respect on the basis of its humanity and individuality.

One speaker expressed the view that the age of parents doesn't matter as long as they are identifiable. It was also suggested that the fact that abortion is legal in certain circumstances in certain jurisdictions implies a gradualist rather than an absolutist view of the status of the foetus in those jurisdictions. One speaker asked if identifiability is a major issue or is it a luxury? He said that it is different with an adopted child – he/she would wonder about the romance between the parents, have I got siblings, is my mother interested in how I am getting on? It is different with assisted reproduction.

Summing up the Chairperson for the Session said that we need a moral position and we need to discuss these issues since there are no clearcut borderlines because knowledge develops.

SESSION 2

Chair

Professor Bernard Hedon,

Secretary General

International Federation of Fertility Services

Topic 5: Embryonic Stem Research.

**Presenter: Professor Sigrid Graumann,
Centre for Scientific Ethics, Tubingen University, Germany.**

My task here is — as I understand it — to give an overview of the discussion of embryonic stem cell research. In doing this, I will mention the German situation, but I will not focus on it exclusively. The German discussion is currently concerned with the question of whether the DFG (German Science Foundation) should fund ES-Cell research, and if so, under what conditions. The DFG has published a statement on ES-Cell research, ES-cell import and the creation of ES-cells which has caused heated public debates. Reinhard Grundwald from the DFG (the German Science Foundation) is here and can answer your questions about their point of view later in the discussion.

1. What is embryonic stem cell research?

Stem cell research is not very new. It began in the 1960s. The current discussion, however, started in the end of 1998, when the creation and cultivation of two pluripotent cell lines derived from human embryonic cells in the US was reported.

a) EG-cells: The group of John Gearhart at the John Hopkins University in Baltimore developed embryonic stem cells derived from embryos from abortions in the 5th-9th week of pregnancy. They used primordial germ cells of these embryos. These are precursors of egg- and sperm cells which are still diploid. Following this procedure, Gearhart created a pluripotent and potentially immortal stem cell line.

The current debate, however, is concerned with another procedure, (namely)

b) EC-cells: The group of James Thomson from Madison/Wisconsin (USA) is working with spare embryos from IVF-treatments. At approximately the 6th day after *in vitro* fertilisation, they took the interior cells of the blastocytes — the part of the blastocyte which is destined to develop into the embryo, whereas the external cell will instead build the foetal part of the placenta, etc. — and cultivated them on a so-called feeder layer which consists of mouse embryonic cells. Under these conditions, the

embryonic cells did not produce the different cell types of a developing organism. In this way, Thomson also achieved a potentially immortal and pluripotent cell line.

Instead of spare embryos from IVF-cycles, it is also possible to use embryos specially created for research by using donor germ cells — that is what was done at the Jones Institute in Virginia. Another possibility is to use cloned embryos to gain stem cells. With this procedure, nuclei of somatic cells are injected into donated and denucleated egg cells. The cloned embryos are grown for about 6 days, then the interior cells are taken out and cultivated. That is what we call **therapeutic cloning**. The company “Advanced Cell Technology” in Massachusetts, for example, was performing such research in order to investigate the use of this technique for creating embryonic stem cell lines. (I assume they have now had to stop it in the US.)

Meanwhile, more stem cell lines than just the two reported in 1998 were created by researchers from Israel, Australia, Singapore and the US.

Cultivated embryonic stem cells are designated as immortal — that means, theoretically they can be cultivated infinitely in the laboratory — and pluripotent — theoretically they can differentiate to every one of the 270 cell types of the human body. Thus, they represent an unending source of material for *pharmaceutical research* and, in the future, perhaps for *transplantation medicine* as well. Particularly the second application dominates the current debate. It is hoped, for example, that it may prove possible to produce neuronal cells for patients from Parkinson’s and Alzheimer’s disease, to gain cardiac muscle cells to restore heart function, or cells which will produce insulin for sufferers from Type I diabetes.

c) adult stem cells: The alternative to embryonic stem cell research is the research with adult stem cells. Adult stem cells can potentially be derived from every kind of tissue, from blood, for example, from bone marrow or from the pancreas. The function of these stem cells in the organism is tissue regeneration. As they occur in the body, they can build one or some but not all different cell types of the organism. Nevertheless, there is promising research on reprogramming adult stem cells to make

them pluripotent again. If this could be done, then, theoretically, they could be used in the same way as embryonic stem cells. They could differentiate into all 270 cell types. That means, embryonic and adult stem cells can be regarded as comparable alternatives.

2 Situation in different countries

In the UK before December last year, embryo research within 14 days after fertilisation was restricted to the field of *in vitro* fertilisation. In December 2000, the house of commons decided that the creation of ES cells by using *in vitro* embryos and cloned embryos (therapeutic cloning) was also allowed. Research projects will be licensed, case by case, by the HEFA, and research can be publicly funded.

In Germany, on the other hand, any research which leads to the destruction of human embryos or to the cloning of human embryos is treated as a criminal offence due to the Embryo Protection Act from 1990. Accordingly, therapeutic cloning and the creation of embryonic stem cells is not legally possible. Legally possible, however, is research with adult stem cells and the import of embryonic stem cells from other countries. The political conflict we have in this field relates to the question of public funding. The DFG — responsible for the major part of public research funding — intends to fund a research project with imported embryonic stem cells. At the present time, however, they have not yet agreed to the proposal because of a very controversial public discussion.

Until recently, the US had no legal restrictions on IVF and embryo research. After 1995, the National Institutes of Health were not permitted to fund embryo research. But the private sector didn't have any restrictions. Recently, two political decisions have changed the situation. First, reproductive and therapeutic cloning was declared to be a criminal offence. Second, the NIH was permitted to fund embryonic stem cell research with already existing embryonic stem cell lines.

In all three countries the process of political decision making was accompanied by heated public discussions.

3. Expected medical and commercial benefits

In my view, one of the weakest points in the current ethical discussion concerning human embryonic stem cell research is the over-estimation of the medical and commercial benefits expected from it. The empirical basis of this research consists mainly of knowledge about the ES cells of mice, and there are indications that human ES cells are rather different in important respects. With regard to expected therapeutic use, what works in non-humans does not necessarily work in humans, as we should have learned from somatic gene therapy research. We don't know how tissue cells derived from ES-cell-lines will integrate, interact with other cells or function in the human body. Everybody who has ever worked with cell cultures knows how unpredictable they are due to chromosomal stability. It is possible, for example, that tissue cells derived by forced differentiation from embryonic cells may cause cancer. And it is possible that they contain animal viruses due to the feeder layer cell (embryonic mouse cells) they are grown on. Like the potential therapeutic benefits, such health risks for the patients can be no more than speculations. I don't want to say that research on ES cells has no future therapeutic potential at all. I just wonder if we are not allowing ourselves to be influenced too much by the "normative force of fiction" in the current ethical debates. For a good ethical evaluation of ES cell research, we need more than just ideas about future benefits and risks. Instead, we would need an empirically based benefit and risk assessment for embryonic stem cells as well as for adult stem cells. And this is not even available in animal research today.

Stem cell research is still at the very beginning. A lot of basic research has to be done for years before we can think about therapeutic options on a realistic basis. From a scientific point of view, I think, there is no hurry to pass over from animal models to the human system.

But if this is true, where is the pressure on political decision-making coming from?

4. Patenting and competition in the field of stem cell research

Regardless of whether it was politically intended or not, worldwide patenting practice has led to a situation in which biopatents are structuring the field of the future market of biotechnical and biomedical procedures and products very early in basic research.

Another relevant background development is the increasing interweaving of university or publicly funded scientific research and the involvement of private companies. This means that we have an increasing influence of economic competition in the field of basic research. Competition is not new in scientific research. The academic competition between researchers was rather productive in the past. But it was productive under the condition of the rules of good scientific practice such as the collective possession of knowledge, mandatory publication, intersubjective examination of results, fairness, and so on. These rules could or should guarantee good science. Some of these rules are clear contradictions of the rules of the field of economics. The result can be bad science — this only as an aside.

Thomson holds the patent for ES-cell creation. This means that if a German group, for example, is developing a medical treatment with his ES-cells or with ES-cells which are created by the same procedure, they will only get a dependent patent — they will have to share their economic benefits with Thomson. Thus, it is quite understandable that, in order to be independent, the German group will want to investigate a new procedure to make their own cell line. And, understandably, they will lobby in order to reach that goal.

It follows, I think, that the driving force behind the current pressure on political decision-making is biopatenting and economic thinking. The pressure is not scientifically motivated. This is not objectionable as such, but it should be pointed out clearly.

5. Ethical questions

Up to this point, I have not mentioned the ethical questions raised by embryonic stem cell research directly, rather, I have mentioned scientific and economical aspects which can lead to ethical problems, such as the safety of the patent in clinical trials, the allocation of funding resources in medical research, etc. The main problem in the public discourse is seen to be the moral status of the human embryo. This concerns first of all not the research with stem cells but the creation of embryonic stem cell lines. Personally, I believe that we should treat human embryos with respect, which means that we should regard them as “future children of future parents” and not as raw material to produce children or any other biomedical product. I say that without

labelling my position as a strict pro-life position. Nevertheless, I don't want to point this out here, first, because this is the topic of Maureen's talk, and second, because I don't think it would bring the discussion forward.

It has not been possible to resolve the controversies about the moral status of human embryos in many years of ethical debate concerning abortion and IVF, and I really don't believe that we will be able to solve the problem in the ethical discussion of stem cell research either. This is true for countries with more restrictive legislation like Germany as well as for countries with more liberal legislation like the U.K. — to say nothing of the situation in the U.S. Instead of putting new efforts into this as persons involved in the ethical debates, I think we should just face the problem that by allowing ES cell research in one way or the other, the deep moral convictions of certain people will be violated. Our aim should be to find ways to deal with the political conflicts which result. Here I'm thinking about questions like how high the estimated benefits and risks of stem cell research have to be in order to balance out the political price that society will have to pay for it. And I think we need some more years of animal research and public discussion before this question can be answered.

6. Import of embryonic stem cells

Another question is whether this concerns only the creation of embryonic stem cell lines, or also the work with imported embryonic stem cells — as is being discussed in Germany — or the work with already existing embryonic stem cell lines — as in the U.S. As far as we know, ES cells can not develop into an entire organism.¹ There is one German researcher in the field of developmental biology who thinks that ES cells alone can develop into entire organisms, which would mean that they are embryos. He wants to demonstrate this with monkey stem cells. I think that the DFG should fund his project — which they currently don't do — to see if he is right. If he is not right, ES cells are not very different from any other (e.g. adult) stem cells and therefore their moral status is not our main problem.

Nevertheless, in the public discussion the use imported Embryonic Stem Cell Lines or in the private sector already existing ones is often seen as a "moral free rider" problem. In my view this points to a strong moral intuition which cannot easily be

¹ It can only develop into an entire organism after being aggregated with trophoblasts (in the mouse model). have the p. I have is with the "moral status" of ES cells. Siggi? Verstehe ich nicht...

philosophically reconstructed. A technology or empirical knowledge as such is not morally bad, nor is it bad because bad means were used in its development or attainment. Thus, the "moral free rider" problem is not so much a question of moral inconsistency as a problem of finding political compromises which the public is willing to accept.

7. Impact on medical practice and resource allocation

I would like, very briefly, to mention one more aspect of creating embryonic stem cell lines, which is rarely discussed. To gain spare embryos, women have to undergo IVF-treatments. This means that with embryonic stem cell research, the interests of third parties will gain influence in reproductive medicine — especially in Germany where egg cell and embryo donation is strictly prohibited. I think that this is risky because of the vulnerability of women undergoing IVF, in particular if we speak about therapeutic cloning. To produce one embryonic stem cell line by using cloned embryos, hundreds of donated egg cells are needed. The idea of therapeutic cloning is to produce individually tailored tissues for single patients. I wonder where all these egg cells are going to come from. Gaining egg cells is a burdensome and risky procedure for the woman. Personally, I think this is only legitimate in order to fulfil her desire for a baby. But people who say that egg cell donation is legitimate so long as the woman gives her free and informed consent, should also mention that the need for so many egg cells will lead to a dynamics which will endanger the respect of her rights. But that is not the only reason why I do not find the idea of therapeutic cloning very appealing. To put it bluntly, women will be degraded to deliverers of raw materials for medical purposes.

I would like to end with this point. I know that I have raised more open questions than answers concerning stem cell research. Nevertheless, I hope I have been able to give at least some impulses to the discussion in your Ethics Commission, and I'm eager to hear your questions and critique.

Discussion

The Chair initiated a discussion on stem cell research by asking is it worth it if we have to use embryonic stem cells? Will it be possible to use adult stem cells? He raised the economics question and asked if we should allow the US research to

continue and then have to buy patents in years to come. Foetal stem cells, which it was pointed out are, as things stand, better than adult cells, are widely available in France. Forbidding stem cell research can inhibit the economic development of a country. The 60 stem cell lines available to the US will not sustain us in the future. It was suggested from the floor that stem cell therapies have not delivered huge benefits and the question was asked as to why somatic gene therapy had provoked such opposition. One suggested reason was that it was designed to correct human genes.

Another speaker referred to underinvestment by governments in scientific infrastructure, and said that we have lost control over embryo research. He added that, if it is not funded publicly, it will be funded by private agencies which will want a return on their investment.

Topic 6: Parents and Children of the Reproductive Revolution.

**Presenter: Professor Susan Golombok,
Family and Child Research Centre,
School of Social and Human Sciences, University of London.**

What I would like to do today is to review the research that has been carried out on parenting and child development in families created by assisted reproduction.

In spite of the changes that have taken place to the structure of the family in recent years, the traditional nuclear family is still generally considered to be the best environment in which to raise children – the “gold standard” against which other families are compared.

Families created by AR differ from the traditional family in a number of important ways.

What I would like to do is to outline some of these differences.

- and examine some of the concerns that arise from these differences with respect to the psychological well-being of children and their parents.

I would then like to look at the empirical evidence to establish whether or not these families are experiencing problems.

And finally, I would like to draw some conclusions with respect to current knowledge about assisted reproduction families, and outline some questions that still need to be addressed.

Categories of ART Families

For the purpose of this talk, I am going to group the various types of assisted reproduction family into 4 broad categories:

- 1) Those involving “high-tech” procedures such as IVF and ICSI
- 2) Those involving gamete donation such as DI, egg donation and embryo donation
- 3) Those resulting in non-nuclear families such as single parent and lesbian mother families

4) Those involving surrogate mothers

Although the 4 categories are not mutually exclusive, I have organised them in this way as each raises a specific set of concerns.

In Vitro Fertilisation

I'd like to begin with high-tech families, starting with IVF.

In the early days of IVF it was feared that children would be born with physical abnormalities. Although these fears proved to be unfounded, there remained a number of concerns about potentially adverse consequences for children's psychological development and for parenting.

It has been argued, for example, that IVF parents may be over-protective of their children, or may have unrealistic expectations of them, or of themselves as parents, which may result in negative outcomes for the child.

There is now a substantial body of research on parenting in IVF families. I don't have time to discuss these individually.

In summarising the findings I have drawn on separate studies from Australia; France; the Netherlands; Belgium; Italy; Spain; Sweden; Israel; Taiwan, the US and the UK.

In Vitro Fertilisation – Research on parenting

These studies have generally found IVF parents to be well adjusted and to have good relationships with their children.

During infancy and the pre-school years, no differences between IVF and natural conception families have been identified for a wide range of measures of maternal feelings, attitudes and interaction with the child.

The few differences that have been found between IVF and natural conception parents have tended to reflect higher levels of anxiety about parenting by IVF mothers, and a tendency to be more protective of their child. And some studies have reported more

positive results for IVF mothers of infants and pre-school children in terms of affection and involvement with their child.

As IVF children enter the early school years, it seems that positive relationships prevail. IVF parents have been found to be more affectionate towards their children, and more involved with them on a day-to-day basis, than natural conception parents

The European Study of Assisted Reproduction Families has now followed 100 IVF children up to early adolescence in Italy, Spain, the Netherlands and the UK. These families were characterised by stable and satisfying marriages, psychologically healthy parents, and a high level of warmth between parents and their children accompanied by an appropriate level of discipline and control.

In Vitro Fertilisation – Research on children

With respect to the children themselves, there is no evidence from any of the studies conducted so far to suggest that singleton IVF children born at full-term are at risk for cognitive impairment.

These studies have used a variety of standardized assessments of psychomotor and intellectual ability with children of different ages.

The social and emotional development of IVF children also appears to be within the normal range. Only one study has reported a higher incidence of psychological problems among children conceived by IVF.

ICSI Concerns

A number of specific concerns have been raised in relation to ICSI, including the use of abnormal sperm, and the potential for damage to the egg or embryo.

These factors may produce changes in genetic material and may thus have implications for children's psychological development, particularly in relation to cognitive functioning.

ICSI – Research on Children

Standardised assessments of children's cognitive functioning in Belgium (Bonduelle et al, 1998) and in the UK (Sutcliffe et al, 1999; 2001) have found no evidence of delayed mental development.

In contrast, however, significantly lower scores were found for ICSI children in an Australian study (Bowen et al, 1998). Seventeen percent of the ICSI children experienced mildly or significantly delayed development compared with 2% of IVF and 1% of natural conception children.

The findings regarding the cognitive development of ICSI children remain inconclusive, and only very young children have been studied so far, although studies of older children are currently underway.

No investigations have been conducted of the quality of parenting or of the socioemotional development of children in ICSI families.

Donor Insemination - Concerns

I would now like to talk about the second category of families, families with a child conceived by gamete donation, beginning with donor insemination.

In addition to the concerns raised by "high-tech" treatments, there are other concerns that are specific to children conceived by donor insemination.

For example, parents may feel or behave less positively towards a non-genetic than a genetic child, and may not fully accept the child as their own.

Fathers, in particular, might be expected to be more distant or hostile towards their child.

A further issue is that the majority of children and adults conceived in this way remain unaware that the person they know of as their father is not their genetic parent.

In recent years there has been growing unease about the secrecy that surrounds families created by donor insemination.

It has been argued that secrecy will have an insidious and damaging effect on family relationships and, consequently, on the child.

The belief that secrecy is bad for children comes from two major sources – research on adoption which shows that adopted children benefit from knowledge about their biological parents – and family therapy where secrets are believed to be detrimental to family functioning because they create boundaries between those who know (the parents) and those who do not (the child).

Donor Insemination – Research on parenting

Fewer studies have been carried out of parenting in families created by donor insemination than of parenting in IVF families.

The European Study of Assisted Reproduction Families looked at this issue and found DI parents to have good relationships with their children at age 6 and again at age 12, which suggests that genetic ties are less important than a strong desire for parenthood. The absence of a genetic link between the father and the child did not interfere with the development of a positive relationship between them.

But in a review of studies of parents' disclosure of donor insemination, Brewaeyts found that fewer than 10% of parents intended to tell their child about their genetic origins.

Interestingly, the proportion of parents who intended to be open with their child was no higher in the more recent studies suggesting that parental attitudes to secrecy have not changed over the years.

Even in Sweden, where legislation gives individuals the right to obtain information about the donor and his identity, a recent survey by Lindblad (2000) found that only 11% of parents had informed their child about the donor insemination.

The European Study of Assisted Reproduction Families identified a number of reasons why parents decide not to tell:

1) Parents are concerned that telling would distress the child, and would interfere with the relationship between the father and the child.

2) They also wish to protect the father from the stigma associated with infertility

3) They don't know what or when to tell the child – and when an anonymous sperm donor is used they have little information to give the child about the non-genetic parent

Parents were worried that they would be unable to answer the child's inevitable question: "Well, if you're not my biological father then who is?"

In addition, some felt they had left it too late.

And others simply felt that there was no need to tell – often emphasising social rather than biological aspects of parenting.

It is noteworthy that in spite of their decision to opt for secrecy, almost half of the parents in Brewaeys' review had told at least one other person that they had conceived by donor insemination, thus creating a risk that the child would find out through someone else.

Donor Insemination – Research on children

Studies of the cognitive development of DI children suggest that these children may be performing above average. These findings have not been supported by large-scale controlled studies but could conceivably result from the use of high ability donors.

With respect to social and emotional development, there is no evidence of raised levels of psychological disorder in children conceived by donor insemination.

In spite of the parents' decision not to tell, the children do not seem to be experiencing negative consequences arising from the absence of a genetic link with their father, or from the secrecy surrounding the circumstances of their birth - but the consequences of non-disclosure for later life remain unknown.

As yet, no studies exist of children who are aware of their conception by donor insemination, apart from interviews by Robert Snowden with a small number of adolescents who reported good relationships with their parents.

Anecdotal evidence suggests that some people who find out about their donor conception in adulthood feel hostile towards their parents and mistrustful of them. However, these adults are not representative of people conceived by donor insemination in general and so we cannot draw conclusions from their experiences

Systematic studies that compare children who have been told with those who have not are necessary to establish the effects of openness about donor insemination

Important factors in a person's response to finding out about donor insemination may be his or her age, and the circumstances under which he or she is told.

The consequences of disclosure by parents in the early years are likely to be more positive than those of discovering about donor insemination by accident in adult life.

Egg Donation - Concerns

The concerns that have been expressed about egg donation are similar to those raised by donor insemination.

The absence of a genetic link with the mother raises the possibility that the mother may not fully accept the child as her own

And again there is concern about the effects of secrecy about the child's conception.

But unlike donor insemination where the donor is usually anonymous, egg donors are more often relatives or friends of the parents and may remain in contact with the family as the child grows up.

Contact with the genetic mother has been viewed by some as a positive experience for children in that they have the opportunity to develop a clearer understanding of their origins.

But it is not known what the impact of two mothers will be on a child's social, emotional and identity development through childhood and into adult life.

Egg Donation – Research on parenting

The few studies that have been carried out of parenting in egg donation families indicate that the quality of parenting is not adversely affected by having a child in this way.

The absence of a genetic link with the child does not seem to affect the mother's warmth, responsiveness or sensitivity to the child.

Although a higher proportion of egg donation than donor insemination parents intend to tell their child about their genetic origins, the majority do not plan to disclose this information to the child.

Most of the parents studied to date conceived their child using the egg of an anonymous donor.

So little is known about the consequences of egg donation when the donor is a relative or friend.

One study, conducted by Soderstrom-Anttila et al in Finland, included 8 known donors (sisters or friends) who saw the child regularly.

There were no reported difficulties in the relationship between the mother and the egg donor.

Egg Donation – Research on children

With respect to the children, the limited data available do not indicate adverse psychological effects arising from the method of their conception.

But it is too early to draw conclusions from the few existing studies.

Only 1 small investigation has been conducted of the cognitive development of egg donation children, reporting no evidence of developmental delay.

And there have been two published studies of the socio-emotional development of egg donation children, again reporting no evidence of emotional or behavioural problems.

Embryo Donation

Children born through embryo donation (sometimes described as prenatal adoption), not only lack a genetic bond with one parent like children conceived by egg or sperm donation

- but also lack the information about genetic parents that is usually available to adopted children.

No empirical investigations of embryo donation families have yet been carried out although a study is ongoing in the UK.

Lesbian mother families - concerns

The third category of assisted reproduction families – non-nuclear families – includes lesbian mother families and single mother families with a child conceived by donor insemination.

In lesbian mother families, the child does not have a social father, the genetic father is an anonymous sperm donor, and the child is often raised by two mothers.

There have been two main concerns:

First, that the children will be teased and ostracised by peers, and will develop emotional and behavioural problems as a result,

Second, that they will show atypical gender development, i.e. that boys will be less masculine in their identity and behaviour, and girls less feminine, than their counterparts from heterosexual homes.

It has also been argued that lesbian mothers will be less committed to parenting than heterosexual mothers.

Lesbian mother families – research on parenting

The first wave of studies of lesbian mother families focused on mothers who had their children while married and then moved into a lesbian family

In recent years, studies have been published of lesbian families created by DI where the child has been raised in a lesbian family right from birth.

What these studies show is that lesbian mothers are just as warm and responsive to their children, and just as involved with them on a day-to-day basis, as heterosexual mothers.

And, in fact, co-mothers in lesbian families are more involved in parenting than are fathers in heterosexual homes.

Lesbian mothers are also much more likely than heterosexual parents to tell their children that they were conceived by donor insemination.

Lesbian mother families – research on children

There is now a large body of research on the development of children in lesbian mother families, and the findings are strikingly consistent

Children in lesbian families are no more likely than their counterparts from heterosexual families to experience psychological disorder

Boys no less masculine, and girls no less feminine, than boys and girls from heterosexual homes

The large majority of young people who grow up in lesbian families identify as heterosexual in adulthood

Single heterosexual mother families

In contrast to lesbian mother families, little is known about the outcomes for children of being born to single heterosexual mothers through donor insemination.

Studies of single mother families in general have found children to be more at risk for psychological problems than children in two-parent families.

But it is important to remember that these children tend to be economically disadvantaged, many have experienced their parents' separation or divorce, and often the mothers lack adequate social support.

It is these factors, rather than the absence of a parent in itself, that have found to be largely responsible for the negative outcomes for the child.

We don't yet know the effects on children of being raised by financially secure single mothers who opt for donor insemination and choose to be single mothers right from the start.

Once again, the child does not have a social father and the genetic father is an anonymous sperm donor.

A study of these families is again currently underway in the UK.

Surrogacy

Even less is known about the 4th category of families – families created through a surrogacy arrangement.

It is not known, for example, how a child will feel about having been given away by the surrogate mother, particularly if the surrogate mother is also the genetic mother of the child.

Or, if the surrogate mother remains in contact with the family, what the impact of 2 mothers will be on the child.

And from the point of view of the commissioning mother, it is not known how the involvement of the surrogate mother will affect her security in her mothering role.

The one study that has investigated the cognitive development of children born through IVF surrogacy by Serafini found no evidence of speech or motor impairment

But no studies have yet been carried out of the consequences of surrogacy for family relationships or the psychological well-being of the child.

It is also worth mentioning that surrogacy has paved the way for a number of new family forms.

It is now possible for a child to have 5 parents – egg donor, sperm donor, surrogate mother who hosts the pregnancy, and the two social parents who bring the child up.

Surrogacy has also made it possible for gay men to become fathers.

And even more complex families have been created such as the French couple who became the focus of media attention last week where a child was born to a brother and sister using a surrogate mother.

Conclusions

So what can be concluded about parenting and child development in assisted reproduction families?

Parents of children conceived by the most widely practiced forms of assisted reproduction (such as IVF, donor insemination and egg donation) appear to have good relationships with their children, even in families where one parent lacks a genetic link with the child.

With respect to the children themselves, there is no evidence of cognitive impairment in children born through assisted reproduction procedures, although the findings regarding ICSI children remain unclear.

And in relation to social and emotional development, assisted reproduction children appear to be functioning well.

So these very wanted children appear to be well-adjusted and much loved by their parents.

Unanswered questions

Although existing knowledge does not give undue cause for concern, there are many unanswered questions.

For example, what are the long-term consequences of assisted reproduction, particularly of secrecy about the child's genetic origins?

What is the effect on children conceived by gamete donation of finding out that one or both parents is genetically unrelated to them?

And for children conceived through egg donation, or surrogacy, what is the effect of ongoing contact with the egg donor or surrogate mother?

These are just some of the questions that need to be looked at more closely.

There is a great deal of speculation about such issues.

Instead of uninformed opinion, what is needed are systematic, controlled studies of representative samples so that the outcomes of assisted reproduction for both parents and children can be fully understood.

Discussion

The Chair pointed out that the insemination of single and lesbian women is forbidden in France.

One speaker said that you cannot tell the effects if any on these children until they are in their 40s and have families of their own. She wondered about an infertile boy born through ICSI asking his father why he went through this process.

Topic 7: The Surrogacy Alternative

**Presenter: Professor Derek Morgan,
Health Care Law and Jurisprudence, Cardiff Law School.**

'Every family has a secret, and the secret is that it's not like other families.'¹

The leading Irish academic legal commentator on assisted conception, Dr Deirdre Madden has observed that

'The law relating to assisted conception in Ireland at the present time [1999] is unclear haphazard and unsatisfactory. There is a clear need to enter the legal minefield that exists to try to address the issues which arise here ...'²

The conclusions of the authors of the leading text on Irish Medical Law in their discussion on surrogacy, David Tomkin and Patrick Hanafin are that:

'Surrogacy is neither regulated nor prohibited in Ireland by specific legislative provisions. At common law it is clear that an agreement for surrogate motherhood is against public policy, since it is the purported contract for the sale and purchase of a child.'

Yet, clearly, this has not and does not prevent surrogacy arrangements being concluded by people living in Ireland. Dr Madden suggests that in the absence of legislation in Ireland dealing specifically with assisted reproduction, it is likely that couples and families will try to facilitate the private pursuance of their rights by using existing procedures to formalise their family structure following on the use of assisted conception, and she notes that

¹ Alan Bennett, *Writing Home* (London, XXXX, 199XXX) at 9

² 'The Quest for Legal Parenthood in Assisted Human Reproduction' (1999) 21 *Dublin University Law Journal* 1 at 39

'In one situation in Ireland a married man successfully applied for a guardianship order in respect of a child born to a surrogate mother on behalf of himself and his wife. The facts of the surrogate arrangement were not made known to the court.'

And a quick and brief internet search last weekend (it had of necessity to be brief as I was 'snipped'; my wife cut through the telephone wire connecting me not only to the internet but also a second line carrying the fax and phone line from my study believing that it was in some way associated with the potentilla that she was also attending), nonetheless disclosed this:

Just starting in Dublin, Ireland

Hi, I'm a 40 year old woman who has just been offered the chance of a gestational surrogacy. My husband and I have tried all other treatments in order to have a family. Unfortunately there are no surrogacy facilities in the country. My sister-in-law who has offered us this chance is an American living in Boston Mass. What we need is information

This seems to me to be a pretty clear example of what Senator Henry recognised in an adjournment debate on her Regulation of Assisted Human Reproduction Bill 1999 in December 1999, when she advised the Senate that while her Bill sought to render surrogacy contracts null and void, yet, 'its impossible to stop surrogacy, no matter what one's views on it, one has to accept that it can happen.'

The recent UK Brazier Review proceeded on the basis that public concern had moved on from Warnock, from regarding surrogacy as being an almost offensive offering on the reproductive menu to being a legitimate service after all other courses have been sampled and found wanting. For Brazier, the fundamental concerns were now with safeguarding the welfare of the child born of the surrogacy arrangement and ensuring protection of the interests of the surrogate. But perhaps pre-eminent was the one that clearly troubles Brazier personally above others; is the payment in surrogacy distinguishable from the buying and selling of children? She has elsewhere publicly declared her view that it is not.

If an infertile couple can buy an egg, and rent a womb, why should they not buy the finished product? It will be argued of course that in purchasing gametes and/or the services of a surrogate, they are *not* buying a baby. I hope to demonstrate that that argument is specious. If, in the UK we wish to sustain objections to trade in babies, payments to surrogates should continue to be outlawed, and continuing payments to gamete donors must be, at least, a cause for concern.’ⁱ

There are those who have argued that it is possible to distinguish between the payment for the reproductive services of a surrogate which we should permit and ‘baby selling’ which we should not, including philosophers such as Dickensonⁱⁱ and lawyers such as Masonⁱⁱⁱ and Freeman,^{iv} who suggests that ‘... Brazier is too readily dismissive of the distinction between payment for the purchase of a child and payment for a potentially risky, time-consuming and uncomfortable service,’ although the reasoning that supports that conclusion is largely of a consequentialist kind.

NB: Cant ban the receipt of information following Open Door Counselling, Dublin Well Woman Centre v Ireland (1993) 15 EHRR 244, because it was not an offence to seek an abortion outside of Ireland, the prohibition upon information was an improper restriction. On extra territoriality see such as the War Crimes Act, the Sexual Offences (Paedophilia) Act?? but whether surrogacy rightly thought of as coming within frame

Tomkin and Hanafin’s conclusion on the current state of Irish law – and while it may undoubtedly be correct, their supporting reason is, I suspect, one of the areas where the most fierce debate is likely to be joined - is that which Senator Henry sought to have enshrined into statute in her Regulation of Assisted Human Reproduction Bill in 1999. Clause 13 of that Bill provided, in apparently simple terms;

‘ 13. A surrogate contract shall be void and of no legal effect.’

I say ‘apparently simple’ advisedly. For while it falls neatly into my Bill Bryson categorisation of desirable shopping traits, it piles it all into a string bag rather than one of those fashionable holders from xxxxxxxxxxxx; most of the important or valuable let alone contestable items are apt to fall straight through.

For example, it is only when something goes wrong that anyone is likely to be concerned about the legality of a surrogacy contract. As Ruth Deech, Chairman of the HFEA has observed, writing in a personal capacity, when surrogacy runs smoothly, there are no objections; but if the arrangement breaks down, the surrogacy is disapproved of by the media and the general public and the disposition of sympathy is dependent almost entirely on the facts of the individual case.³

And, as I have implied, if most of the surrogacy contracts to be made in Ireland are in fact negotiated via the internet with an American lawyer using an American surrogate (or even as Russian surrogate; see www.russiansurrogacy.com/UkrSURR.htm) then making the contract of little immediate effect in the domestic courts in Ireland is a little like Lansdowne Road erupting in indignation at the Welsh being deprived of a penalty try against the English by perverse decision of a Scottish line judge. Incidentally, I doubt given the wording of clause 2 of that Bill (on the prohibition of advertising by unregistered assisted reproduction providers) that surrogacy contracts other than IVF contracts are covered at all.

Surrogacy is not only that place in the 'reproduction revolution' where reasonable people (and reasonable lawyers) may properly disagree, it is also that place where reason and coherence have an unfortunate and uncomfortable habit of going astray. For example, there is no data to support the fear that imperfect babies will be abandoned by both commissioning parents and surrogate mothers (Gostin, 1990, p. 7). In van den Akker's survey of surrogacy in the UK 'no commissioning couple has been known to refuse to adopt a baby following the arrangement' (van den Akker, 1999, p. 264). The recent controversy (early August 2001) involving breach of contract and misrepresentation claim by British surrogate Helen Beasley (a legal secretary), against American couple Charles Wheeler and Martha Berman (both lawyers; although what we might make of that may be a matter of conjecture) in the San Diego Superior Court throws that into relief. Beasley had refused to terminate one of a twin pregnancy when requested by Wheeler and Berman for whom she was carrying the foetuses, despite an apparent contractual provision that allowed the intended parents

³ Ruth Deech, 'Family Law and Genetics', (1998) 61 *Modern Law Review* 697

to request this up to the end of the 12th week; (Beasley claiming that the request was made at the end of the 13th week; so last menstrual period retains a central place in e-production).

The Stiver-Mallahoff case in the United States had earlier received a great deal of publicity: the facts were that after a surrogacy arrangement with the Mallahoffs, Mrs Stiver gave birth to a child who was almost certainly mentally retarded. Initially neither the Stivers nor the Malahoffs wanted the child, who was subsequently discovered to be Mr Stiver's baby, rather than Mr Malahoffs. The Stivers agreed to keep the baby (see further Corea, 1985, p. 215). While undoubtedly regrettable, it is undeniable that handicapped children conceived naturally are sometimes rejected by their parents, and so it is unclear that any general lessons can be learnt from the Malahoff case. John Robertson argues that rejection of a severely disabled child "reflects common attitudes toward handicapped newborns as much as alienation in the surrogate agreement" (Robertson, 1990, p. 162)

There is little evidence to suggest that women regret agreeing to be surrogate mothers (Baker, 1994, p. 608). Lori Andrews' research demonstrated that 1% of surrogates changed their minds about giving up the child (Andrews, 1995, p. 2351) Yet, as Michael Shapiro argues, "in surrogacy the small failure rate gets 'writ large'" (Shapiro, 1994, p. 648)

Thus, as Michael Freeman observes, the Warnock Report, having for the most part eschewed paternalism, grasps it wholeheartedly when surrogacy is considered. And the later Brazier report, as Emily Jackson has reminded, offers the astonishing proposition that the small 'failure rate' needs to be examined in the light of what constitutes 'success' in a surrogacy arrangements. The fact that the child is handed over to the commissioning parents without contest 'may not be a reliable criterion of success.' (Brazier et al, 1998, para 6.2), without then going on to suggest what better or more manageable definition there might be.

The real question has become; what are we seeking to regulate in regulating surrogacy, surrogacy or reproductive freedom and procreative choice? Perhaps far from coming along at the wrong time surrogacy appeared just at the right time; i.e. too

late historically speaking for (m)any people to want to ban or prohibit it outright, but just as over time the language of fundamental rights and procreative freedoms was beginning to be articulated and when in the 15 years since cotton, despite Winston in evidence in Broidy suggesting that the mood was turning away from surrogacy, brazier was suggesting Brazier 1998, across a wide spectrum of opinion, "we judge that the existence of surrogacy is now accepted"⁴.

That surrogacy makes parenthood possible for people who would otherwise be unable to have children is undeniable. In a 1999 Finnish study of 27 IVF surrogacy cycles, where the presenting conditions by the intended social mother were exclusively medical; 5 were congenital absence of uterus and vagina; 4 were hysterectomy because of obstetric complications; 3 hysterectomy for severe uterine disease, 3 for uterine abnormality; 3 uterine abnormality and 1 for sever systemic lupus erythematosus.

In 1989 - 1990 the debate which led to the UK's HFE Act 1990 were about how and in what appropriate way(s) to respond to biological infertility and where, if judged appropriate, to bound the commons of assisted conception. Since then the news has been dominated by postmenopausal women ⁵ and posthumous pregnancies; ⁶

⁴ Brazier et al 1998 para. 4.5

⁵ For a valuable consideration of some of the main issues in this debate see Fleur Fisher and Ann Sommerville, 'To Everything there is a Season? Are there Medical grounds for Refusing Fertility Treatment to Older Women?' and Inez de Beaufort, 'Letter From a Post Menopausal Mother' in John Harris and Soren Holm, eds, The Future of Human Reproduction; Choice & Regulation, (Oxford, Clarendon press, 1998), at 203 and 238, respectively.

A retrospective data analysis of donor IVF and hormone replacement treatment given to 34 post-menopausal women considered the 'success rate' and complication arising from the treatments. the mean age of the women was 53 (50-62 years); the clinical pregnancy rate per transfer was 32.7% with no foetal or maternal mortality but some incidence of maternal morbidity (injury), especially in woman over 50 above an beyond what would be expected in the population group at large. ('Pregnancies in postmenopausal women over 50 years old in an oocyte donation program', (1995) *Fertility & Sterility* 63, 259

⁶ A survey of over 300 fertility clinics in the United States and Canada found that more than a dozen had already 'harvested' sperm from dead men and stored it for possible alter use. Three times as many had been asked to perform such a procedure; *New Scientist* 30 November 1996. The New York task Force on Life & the Law has recommended in its 1998 report Assisted Reproductive Technologies: Analysis and recommendations for Public Policy, that '... in general gametes should not be retrieved without the subject's informed consent.' The case of Diane Blood was raised in the House of Commons by her MP; replying to Joe Ashton Under Secretary of State for Health John Horam reminded the House that the HFE Act 'was passed after substantial public and parliamentary debate and is carefully drawn. It is therefore not an area in which either policy or legislation should be tinkered with on the spur of the moment.' *Hansard*, 30 October 1996, col 584.

surrogate mothers ⁷ and homosexual fathers ⁸; tourism - procreative, ⁹ surrogacy - (very occasionally unintentional) - abortion and sperm ¹⁰; sex selection and genetics; virgin births ¹¹ and multiple births ¹² the appearance of social infertility and, latterly, sheep ¹³ and pigs. ¹⁴

⁷ In varying guises and disguises;

⁸ Sometimes run together; witness

⁹ The season of procreative tourism was publicly inaugurated by the birth to a 59 year old British woman refused treatment services in the UK of twins in an Italian clinic. Health Secretary Virginia Bottomley lamented that 'We cannot stop people going to any country in the world for treatment but maybe we'll renew our efforts to have discussions with other countries as to the examples we set and how they can establish ethical controls over some of the dramatic achievements in modern medicine.' Almost immediately following this the French junior Health Minister Phillipe Douste-Blazy announced its government's intention to introduce legislation to prohibit in vitro fertilisation of post menopausal women (The Guardian 5.1.94 p. 9, although this was followed immediately by protests from various parts of the political spectrum and different interest groups The Guardian 5.1.94 p9) and the Italian Health Minister Mariapia Garavaglia was quoted (The Guardian 6.1.94 p10.) as saying that 'desires are not rights, and babies are not consumer goods' and announced the imminent establishment of a commission to establish 'controls over the treatment of sterile and post menopausal women.' see The Independent 28.12.93 p.1; The Guardian 28.12.93 p.2, reporting an interview on the BBC 'Today' programme 27.12.93. For a careful consideration of some of the possible consequences of treating reproduction and issue as if they *were* items of the consumer market see Margaret Jane Radin, Contested Commodities: The Trouble with Trade in Sex, Children, Body Parts, and Other Things, 1996, Cambridge, Mass., Harvard University Press, 1996.

¹⁰ So called 'transport IVF' - where sperm is collected from a donor in one Centre and transferred for fertilisation use to another - occasionally gives rise to its own problems and might have provided an original and startling reason for train delays on the Great Northern line. A phial of frozen human sperm was dropped by the courier while passing through York station. The leaking liquid nitrogen - in which frozen sperm is stored - caused fire crews to be called and the station cleared for two hours. Attending firemen eventually discovered what they were dealing with by reading the confidential details of the donors in the papers which the courier was carrying, The Sun, 24 October 1991.

¹¹ For an illustrative example of this early furore see (1991) The Lancet 337 at 559-60; commentator Paul Johnson is reported as having called the prospect of lesbian mothers (for that is what this is) a 'nightmare vision of the baby production line.' Cited in (1991) Bulletin of Medical Ethics, March at 7

¹² Mandy Allwood, pregnant with 8 fetuses which all died, paralleled by Zoe Efsthathiou a Cypriot woman pregnant with 11 fetuses after fertility treatment who decided that 7 should be aborted by selective reduction. (Daily Telegraph 20 December 1996)

¹³ 'Viable Offspring derived from Foetal and Adult Mammalian Cells,' Nature, 385, 881: 1997; 'Dolly' the sheep born following a technique which involved nucleus substitution into an egg and not an embryo. Dolly had been preceded at birth by Morag and Megan, but they had been born following the use of an embryonic or fetal cell. All had been preceded by over 270 unsuccessful attempts to perform the technique, see Ian Wilmut, Keith Campbell and Colin Tudge, The Second Creation: The age of Biological Control by the Scientists who Cloned Dolly, (London, Headline, 2000)

¹⁴ Dolly has since gained a number of piglet cousins; the birth of Millie, Christa, Alexis, Carrel & Dotcom was heralded in the British press in March 2000.

Difficult and controversial areas that 'regulators' internationally are now grappling with relate to eligibility for treatment, posthumous use of gametes, dealing with (i.e., disposing of) unclaimed embryos, embryo research and therapeutic cloning, genetic testing of embryos and storage of ovarian tissue, access to information about donation, access to information about donation (where there appears to be a rapid shift even in the medical fraternity, to consider it to be a right for offspring to have access to this information), and surrogacy.

'Sensitive Subjects of Human Endeavour'

Surrogacy is one of those sorts of ethical problem on which everyone appears to have a view, to defend it strongly and indeed passionately, and in which hardly anyone seems neutral. It is at the heartland of the ethical divide in which we also find subjects such as abortion, research and experimentation on human embryos, genetic engineering, and cloning.

Surrogacy Stories

Yet, surrogacy is and remains complex and controversial because it raises not one issue but a cluster of issues, and issues of different sorts at that. 'It is easy to confuse considerations relevant to one of these issues with considerations relevant to another, or to misunderstand the character of a particular claim or a particular objection.'¹⁵ There is no single moral issue called surrogacy; people's moral worries about surrogacy arrangements will vary greatly depending on the type of surrogacy in question, the relationships of the parties involved to one another, and whether it is a commercial transaction. And this moral concern will engage a variety of wider concerns too; not just about the family and parenthood but 'about one's whole attitude to what life brings.' The 'issues of different sorts' will carry different force in different circumstances. Thus, worries about resource implications (which can of course involve ethical concern), are very different sorts of worries from those deep, inarticulate worries about the basic legitimacy of an action or of a general attitude exemplified in an action.

There are questions such as whether it is more desirable that the relationship be established and maintained solely at arms length, with the participants' identities

¹⁵The Elimination of Morality, 1993, London, Routledge. 202.

known only to a third party? Or whether it is preferable, as is sometimes suggested, that if surrogacy is to take place, it should only be between close friends or sisters?¹⁶ Should commercial surrogacy be prohibited or preferred? And in what plane should surrogacy be tolerated, if at all; the vertical or the horizontal? And if vertical, in which direction?

'Surrogacy stories' disclose some of these complexities; they show graphically the moral and legal webs which can be woven with surrogacy.

- a 17-year-old woman in Lancashire England, gave birth to a child for her own mother who had been unable to conceive the child she desired in a new marriage.¹⁷
- Pat Anthony, a 48-year-old woman gave birth in a Johannesburg hospital to triplets. The intended mother of the children was her daughter, who had had her womb removed following the delivery of her first child.¹⁸
- Lori Jasso who was regarded by her three sisters as 'little more than 'a baby making machine' and who had four young children, was asked by her eldest sister, the vice president of a large bank, and one of her four sisters, all of whom were successful professional women without children to carry a child for her. She agreed, despite her own and her husband's misgivings, because it made her feel powerful and important in her family's life. She inseminated herself with sperm from her sister's husband and engulfed by a sense of foreboding, rather hoped that it wouldn't work. 'I did it out of obligation. ...I felt raped by sisterly love.'¹⁹

¹⁶ This suggestion was made by Health Minister Kenneth Clarke in Standing Committee debate in the Surrogacy Arrangements Act 1985; Official Report House of Commons, Standing Committee B, 25 April 1985, col. 7. See also Singer and Wells, *The Reproduction Revolution*, p.124 for details of the Corzier case in France of a woman who carried a baby for her infertile twin sister: *The Guardian*, 29 September 1984, *Times* 23 November 1984, p.11, *Woman* 2 June 1984, p.21 and the BBC Day to Day Programme, 13 January 1987, for comparable English examples. On egg donation between sisters, see *Independent*, 29 September 1987, p.13.

¹⁷ *Star*, 1 October 1987, pp.1-4.

¹⁸ *Mail on Sunday*, 4 October 1987, pp.1, 2.

¹⁹ *Daily Telegraph* 23 February 1994

Eight years later she had not seen the child, Tiana, since her birth, immediately after which the baby was taken away by her sister.²⁰

- a couple who arranged for a surrogate to carry a child for them became the first couple to be granted full parental rights without adoption procedures using the 'parental orders' s30 of the Human Fertilisation & Embryology Act 1990, which was granted by two magistrates sitting in the Family Court in Manchester. Their solicitor, Christine Buchan, was quoted as having said that 'this procedure is much less time consuming than adoption. Adoption also tended to emphasise that a couple *were in some way out of the ordinary*.'²¹
- a baby girl was born from the egg of a woman who had died in a car accident two years earlier;²² the surrogate was the dead woman's husband's married sister. Dr Pasquale Bilotta is quoted as having said to Italian newspapers that 'It was strange and very sweet to see two men suffering as they waited the birth of the same daughter. ... This isn't a case of incest, but of a child adopted by one of its relations. ... The baby is not an orphan, but, if you like, a child with a bigger family than normal.'
- in Johnson v Calvert the surrogacy dispute was complicated somewhat by the conclusion that both women adduced evidence of a mother-child relationship, as contemplated by the relevant legislation.²³ In terms, this provides that maternity may be established either through the fact of giving birth - the equivalent of the mater est quam gestatio demonstrat presumption - or genetic consanguinity, based on evidence derived from blood testing. Lacking Solomon's belief that the best way of winnowing out an acceptable solution to this dilemma was to chop the child in two, the court concluded that there were two ways forward; that it should attempt to discern the 'best interests of the child' or that the intentions of the

²⁰ This example certainly casts a shadow over the opinion expressed by then Health Minister [Kenneth Clarke] at the time of the 1985 Act that surrogacy between sisters was the most acceptable.

²¹ The Guardian, 25 February, 1995 p5

²² The Guardian, 12 January 1995 p11

²³ Johnson v Calvert 851 P. 2d 776, at 787 (1993) (Supreme Court of California) interpreting the Californian Civil Code, s. 7003, subd. (1), 7004, subd. (a), 7015 and Californian Evidence Code, s. 621, 892.

parties as initially expressed in the contract should dispose of the case, whether that amounted to a fully enforceable contract or not.

- another Californian couple arranged to have a child with a surrogate following the death of their unmarried daughter who had left frozen embryos in storage;²⁴
- A Californian couple is seeking a surrogate mother to carry a child for their dead daughter; she survived a brain stem tumour but developed lymphoblastic leukaemia two years later. She underwent fertility treatment, eggs were collected and fertilised by donor sperm and frozen. She died two years later, in late 1996. She had wanted at least one of her frozen embryos to be used to establish a pregnancy and her parents were seeking to oblige (Daily Mail 25 January 1997).
- A British woman - Edith Jones hoped to become the UK's first 'surrogate grandmother - acting as a surrogate for her own daughter who has no womb (Mail on Sunday 6 August 1995). Similar stories are reported from South Dakota, USA (The Times 14 October 1991) and South Africa, Sue Reid, Labour of Love: The Story of the World's First Surrogate Grandmother, London, The Bodley head, 1988)
- One particular case from a Manhattan IVF clinic concerns Donna Fasano and Deborah Rogers who attended clinic on the same day. Mrs Fasano became pregnant, with twins; Mrs Rogers did not. Mrs Fasano later discovered that she had been an unintentional host surrogate to Mrs Rogers' child when she gave birth to the babies; one was white, the other was black. Mrs Fasano is reported to have handed the black child to his biological parents and lawyers have been consulted; Daily Telegraph 31 March 1999.
- '... Video Baby [is] a tape just produced in the States for those who fancy being parents but in the abstract. A pair of delightful infants crawls around, take baths and all the rest of it. But they never have to be changed, and if you get bored, you can always switch them to fast-forward for a while.'²⁵

Thus, a woman has given birth to her sister, to her grandchildren, and to her niece.

²⁴ Sunday Times, 30 November 1997

²⁵ Independent on Sunday 170695 p7

The 'case' of ²⁶ Rathfarnham gay business couple John Macmahon and Gerard Whelan illustrates a number of the further complex modern issues to which surrogacy gives rise, and it parallels the birth in late 1999 of Aspen and Saffron Drewitt-Barlow to their gay fathers Tony Barlow and Barrie Drewitt who had found a surrogate mother in California to carry the pregnancy after an donated egg was fertilised with sperm provided by one of them. On arrival in Britain, the babies were refused entry at Heathrow airport (Guardian 3 January 2000), and an immigration battle appeared imminent before the Home Office relented].

The 'case' of ²⁷ Rathfarnham gay business couple John Macmahon and Gerard Whelan has shown how surrogacy, especially IVF surrogacy,

- has the ability further to melt down previously understood elements of the nuclear family;
- how what we might call 'cyber-reproduction' – or e-production (taking the 'rrrr' out of reproduction) - is now a real presence in the 'reproductive revolution' – with the presence and the promise of the internet;
- can bring the outriders of the reproductive revolution closely into formation and concert with the reproductive rights movement to create a formidable army of new problems marching across the public policy terrain.

Surrogacy, if you'll forgive the pun, has become a global issue. Global in two senses.

²⁶ Lawyers, forgive them, are addicted to speaking in cases. Of course, there is no litigated case. Indeed, the closest involvement of Irish law that I have been able to detect with Mr MacMahon and Mr Whelan is a visit by the Gardai following a tip off about the presence of triplets Max, Tom and Connie in their House. Isabel Hurley's report in the Irish Independent announces that 'the fact that Mr Whelan is the children's natural father and they are named on his passport satisfied the Garda authorities.'

²⁷ Lawyers, forgive them, are addicted to speaking in cases. Of course, there is no litigated case. Indeed, the closest involvement of Irish law that I have been able to detect with Mr MacMahon and Mr Whelan is a visit by the Gardai following a tip off about the presence of triplets Max, Tom and Connie in their House. Isabel Hurley's report in the Irish Independent announces that 'the fact that Mr Whelan is the children's natural father and they are named on his passport satisfied the Garda authorities.'

First, in that many countries of the developed world have had or are having to deal with the high technological manifestations of it, in the form of IVF surrogacy; in the past 12 months alone, Japan, New Zealand and Ireland have for the first time faced public manifestations of IVF surrogacy²⁸ with resulting legislation or proposed legislation. At the same time, Hong King has joined the UK and Israel as being in the minority of jurisdictions *not* to prohibit surrogacy, either in legislation or governmental fiat or professional edict.

Secondly, with the Internet, and the possibilities of e-production.

The internet is in the process of changing much of the surrogacy debate, not just in rendering certain individual state based or jurisdictionally specific approaches less final, but in bringing to life further bundles of legal issues, such as the proper law of the surrogacy contract, where one exists, a whole host of welfare issues that mirror those that we saw reflected in the Kilshaw jamboree earlier this year in England (and recall that Alan Kilshaw is a solicitor), and even more complex and difficult issues of private international law, or what is sometimes called conflicts of law.

One more recent example of this is afforded by the claim in the San Diego Superior Court by Helen Beasley, a British surrogate against intended parents Charles and Martha Berman, whom you may recall last month refused to continue with a surrogacy agreement into which they had engaged Beasley (again following internet contact) when she refused to terminate one of a twin pregnancy. Beasley is suing in the Californian courts for breach of contract and fraud, and seeks unspecified damages for medical costs and emotional suffering. Beasley must also sue in order to gain legal rights over the children, for whereas in the UK she would be regarded as the mother of the children, under Californian law, as we saw in the earlier litigation of

²⁸ In December 2000 a panel of experts recommended to the Japanese Health & Welfare Ministry a ban on surrogacy. In May 2001 an obstetrician in Nagane Prefecture announced that he had helped a woman through surrogacy while in September 2001 a study group of the Health Ministry established in July announced that anti-surrogacy laws that would introduce penalties for doctors and intermediaries involved in surrogate births. New Zealand's first surrogate IVF attempt to result in a pregnancy following 10 previous attempts was announced earlier in 2001, having been approved by the National Ethics Committee on Assisted Human Reproduction, which requires that any IVF surrogacy be carried out on a non commercial altruistic basis, that one of the intended parents is the potential child's genetic parents and that the birth mother is either a family member or a close friend.

Johnson v Calvert, there are two ways of establishing parenthood in that State, either genetically or through the fact of birth, and in resolving that dispute between two women both of whom might lay claim to be recognised as a 'mother' under the Californian statute, the court granted the parental rights to the 'intended' parents based on their 'intention' as evidenced in the contract to be regarded as the parents of the resultant child.

Standard Arguments in Surrogacy

Warnock's arguments against surrogacy are that

- it amounts to third party intrusion into the marital relationship
- the use of a woman's uterus for financial profit is inconsistent with human dignity
- it distorts the relationship between the mother and child and might be psychologically damaging to the child
- no woman should be asked to bear the risks of pregnancy for another person

The arguments in favour of surrogacy were that

- those who regard it as degrading the sanctity of marriage need not take part, but should not restrict the freedoms of others
- it might not be degrading or commodifying, but instead a supremely altruistic act
- the psychological risks are speculative, and already accepted in relation to adoption
- women should be entitled to choose to enter surrogacy arrangements

Michael Freeman contends that "the Warnock case against surrogacy is thin, distorted and unconvincing" (Freeman, 1989, p. 172)

For	Against
<ul style="list-style-type: none"> • it is the only chance for some couples to have a child 	<ul style="list-style-type: none"> • surrogacy is an assault on the marital relationship
<ul style="list-style-type: none"> • carrying a child for another is an act of generosity or virtue 	<ul style="list-style-type: none"> • it is inconsistent with human dignity that a woman should use her uterus for profit
<ul style="list-style-type: none"> • woman can and should decide for themselves how to use their own bodies 	<ul style="list-style-type: none"> • the relationship between mother and child is distorted by surrogacy
<ul style="list-style-type: none"> • true voluntariness excludes exploitation 	<ul style="list-style-type: none"> • surrogacy is potentially damaging to <ul style="list-style-type: none"> • the child; • the mother
<ul style="list-style-type: none"> • those who fell surrogacy compromises the marital relationship should not impose this view on others 	<ul style="list-style-type: none"> • risks of pregnancy should not be run for money
<ul style="list-style-type: none"> • there is no firm evidence to support 'bonding' between mother and child during pregnancy 	<ul style="list-style-type: none"> • a woman should not be forced to part with a child against her will

International Responses to and Regulation of Surrogacy

Regulatory type / Response	Jurisdiction
Loosely regulated market	US
Permissive/regulated market	UK, HK, ACT (Aus); Russia *
Tolerated (/ + medically supervised)	Finland, Netherlands, Canada, NZ,
Disallowed (k void) or Invalid (by reference to Civil Code);	Spain, Germany, France (Code), Portugal (Code), Greece (Code), Japan (1 IVF birth but contrary to JS Obs & Gyn, and prohibitive legislation coming)
Prohibited (in law)	Denmark, Sweden, Norway, Austria, Australia (except ACT),

* Family Law 1995 made surrogacy lawful in Russia. This has led to a number of internet based services out of the United States, such as that run by East Coast Assisted Parenting (run, ironically, from an office at 73 Old Dublin Pike in Doylestown, Pennsylvania)

Working with Regulation: Surrogacy and the HFE Act 1990

The Human Fertilisation and Embryology Act established the HFEA to regulate certain types of infertility treatment and research. It is a statutory requirement for any centre undertaking activities covered by the Act to have a licence from the Authority which specifies the activities covered by the licence, the premises in which the activities may be performed and the name of a "person responsible" under whose supervision the work must be carried out^v. Licensed activities include the creation or use of an embryo outside the body and the use of donated eggs, sperm or embryos. Any medical treatment used as part of a surrogacy arrangement will involve the donation of sperm, eggs or embryos and thus must be carried out in a licensed centre. Under the Act's requirements, details of every treatment carried out must be lodged with the HFEA. Thus, although the Authority does not directly regulate surrogacy,

licensed treatment services provided to establish a surrogate pregnancy will be carried out under its auspices.

HFEA Code of Practice

The Human Fertilisation and Embryology Authority issues licences to centres carrying out certain activities. One aspect of the Authority's supervisory role is the publication of a Code of Practice which provides guidance concerning proper conduct of licensed activities. All centres providing treatment services for the purpose of establishing a surrogate pregnancy must be licensed by the HFEA and abide by the Code of Practice. One of the provisions of the 1990 Act makes it a condition of all treatment licences that "a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born 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"^{vi}.

- Thus all centres providing treatment services as part of a surrogacy arrangement are legally obliged to take account of the welfare of the child. This requirement is complicated by the fact that either the surrogate mother and her partner, if she has one, or the intended parents could take on the role of social parents; the centre is therefore obliged to make enquiries of both parties. The HFEA's Code of Practice advises consideration of the following factors:
- the commitment of the woman, and her husband/partner to having and bringing up a child or children;
- their ages and medical histories and the medical histories of their families;
- the needs of any child or children who may be born as a result of treatment, including the implications of any possible multiple birth and the ability of the prospective parents (or parent) to meet those needs;
- any risk of harm to the child or children who may be born, including the risk of inherited disorders, problems during pregnancy and of neglect or abuse; and
- the effect of a new baby on any existing child of the family.^{vii}

The HFEA also advises in its Code of Practice that all people seeking treatment are entitled to a fair and unprejudiced assessment of their situation and needs, which should be conducted with the skill and sensitivity appropriate to the delicacy of the case and the wishes and feeling of those involved.^{viii}

Enforceability of Surrogacy Arrangements

Those participating in a surrogacy arrangement must reach agreement between themselves as to how the arrangement will proceed. Nevertheless, regardless of whether the agreement is detailed in writing or whether expenses have been paid, section 36 of the Human Fertilisation and Embryology Act renders surrogacy contracts unenforceable.^{ix} This means that if the surrogate mother wishes to keep the child she is entitled to do so. Equally if the intended parents they do not want the child, the surrogate mother, as the legal mother of the child (which we have considered in Chapter 0) is responsible in law for its welfare. In practice, a child

rejected by its birth mother and the intended parents is likely to be placed for fostering or adoption.

Birth Registration

A child born to a surrogate mother must be registered as her child, and if applicable, that of her partner or person treated as the father under the Act. Where a parental order has been granted under section 30 by a court, the Registrar General will make an entry in a separate Parental Order Register registering the child and cross referencing to the entry in the existing Register of Births. There is no public Parental Order Register. It is not possible to "abolish" the original record of birth and at the age of eighteen, a person who was the subject of a parental order may be supplied with information enabling him or her to obtain a certified copy of the original record of their birth. This certificate will include the name of the surrogate mother. Prior to being given access to the information the person is to be advised of counselling services available. This is an exception to the general provisions (which we discuss in Chapter 0) that children born of assisted conception may not discover the identity of the people party to their conception.

The Parental Orders (Human Fertilisation and Embryology) Regulations 1994 (S.I. 1994/2767) (made under the provisions of the Human Fertilisation & Embryology Act 1990, sections 30(9), 45(1) and (3)), are intended to achieve the same effect as an adoption order. The relevant provisions of those regulations are Paragraph 1(1), (2) and Paragraph 2, column 1, Schedule 1, sub-para. 1(b), which adopts (under section 30(9) of the 1990 Act) amended provisions of the Adoption Act 1976, section 12 (1)-(3). As amended, the relevant part of that section reads:

‘(1) A parental order is an order giving parental responsibility for a child to the husband and wife, made on their application by an authorised court.

...

(3) The making of a parental order operates to extinguish -

(a) the parental responsibility which any person has for the child immediately before the making of the order;

(aa) any order under the Children Act 1989;

(b) any duty arising by virtue of an agreement or the order of a court to make payments, so far as the payments are in respect of the child's maintenance or upbringing for any period after the making of the order. ‘

Concerns, however, have arisen with the s30 procedure. ^x Some couples are reported to have believed that s30 will substantially modify the adoption procedure, yet want to ensure that in formalising their relationship with the child, the surrogate mother and any of her parental rights are excluded. This is indeed the case with the adoption procedure, but not with section 30. In England & Wales the terms of the Adoption Act 1976 ss.12 and 39 provide that adoption is the process whereby a court irrevocably extinguishes the legal ties between a child and his or her natural parents and creates analogous ties between the child and the adopters. Section 30 has only the effect that the intending social parents are registered as the child's legal parents; two birth certificates will be issued, one accessible to the public naming the commissioning parents as the child's parents if they have completed the parental orders procedure. A second register, not open to the public, will list the surrogate mother.

The HFE Act does not explicitly extinguish the legal responsibilities of the surrogate mother but gives additional rights to the intending social parents. It is therefore possible that the surrogate mother could apply for access to the child under the Children Act 1989, and for a court to be required to consider whether to admit such a claim.

Regulations made under s30 (9) provide for the court to be satisfied that the welfare of the child is being prioritised throughout the proceedings. Some solicitors have argued that by the time a social worker has been appointed as guardian ad litem (under Children Act 1989 section 41(1)) for these purposes and assuming only a first hearing, the time involved could be as that usually involved in obtaining an adoption order. Section 30(5) further requires the consent of the surrogate mother to the making of the orders, and s30 (6) that that consent is ineffective if given within the first six weeks after the child's birth. Compared with the adoption process, in which any refusal of consent is open to review after consultation with social work staff, including whether any consent is being unreasonably withheld, section 30 has clear and present dangers or limitations.

The limitation of section 30 to married couples caused predictable disappointment to some people, but the limitation has gone further than some could have anticipated. Section 30(1) provides that; 'The Court may make an order providing for a child to be treated in law as the child of the parties to a marriage,' if the further conditions of the section and subsequent regulations are satisfied.

The phrase 'parties to a marriage' has for lawyers, of course, a particular significance. Death is one of the incidents which brings a marriage to an end. In separate cases reported to the surrogacy self-help group COTS within the same week in December 1994, two women who had intended to apply with their respective husbands for parental orders under section 30 died. One woman was killed in a road accident and the other died of natural causes. In both cases their husbands were deprived by the death of, amongst other things, the ability to apply for a section 30 order. In the first case the child had been living with the couple for several years, while in the latter the child was only 12 weeks old. The father would face uncertainty in establishing a good case under the Adoption Act that he is the most fitting person to care for the child, because he has, by definition, little parenting experience.

The Brazier Review

In parallel with the reviews by the BMA have come two major government reviews; first the Warnock Report of 1984 and latterly the Brazier Committee Report of 1998. Just after election in 1997, the Labour administration was galvanised to action by a number of events which came together to push surrogacy back onto and up the public policy agenda. The Brazier Review was commissioned immediately following the publicity in May attracted by Karen Roche and Clemens and Sonja Peters, a Dutch couple for whom Roche had agreed to act as a surrogate mother for payment of 'expenses' of £12,000. ^{xi} The agreement proceeded to unravel before an entirely delighted press corps as accusations about the arrangements grew more rancorous; revelations that Roche had terminated the pregnancy were swiftly followed by retraction and an announcement that she would in fact keep the child herself. This appeared to confirm an impression of the UK as the surrogacy capital of the western Europe. ^{xii} This had been coupled with headlines earlier in 1997 proclaiming that '£35,000 gets you the Perfect Baby,' as newspapers previewed a London seminar by

Bill Handel of the Centre for Surrogate Parenting and Egg Donation in Los Angeles, aimed at intending parents from the United Kingdom.^{xiii}

These were but the most celebrated of a number of 'difficult' cases as the Public Health Minister Tessa Jowell called them. A year previously, *Re Q* [1996] 1 FLR 369, further complicated what understanding there might have been of payments made on a 'commercial basis' within the 1985 Act and was thought by many to demonstrate the benign if not relaxed attitude of a number of judges to the question of expenses properly allowable to a surrogate mother under section 30. In that case *Johnson J* was asked retrospectively to authorise and did authorise receipt by a surrogate mother of over £8000 in respect of a child which she had carried on behalf of intending parents who subsequently applied for a 'parental order' under section 30. This approach reflected that which had been established by *Latey J* in hearing the surrogacy cases to come into the High Court in the 1980s. He initialised the highly pragmatic solutions to cases such as the *Cotton* case, *Re C* [1985] FLR 445, and in *Re An Adoption Application (Surrogacy)* [1987] 2 All ER 826 he held that payments made to a surrogate were to recompense her for her time and inconvenience. Hence, he had said, they were not payments in contravention of section 57(3) of the Adoption Act 1976 which renders it unlawful to make or give any payment or reward in consideration of the adoption of a child.

The announcement of a Committee of Inquiry to review developments in the law of surrogacy enjoyed widespread assent. The terms of reference for the Review required the Committee to consider whether in the caring, compassionate 90s compared with the grasping, greedy 80s, payments should be continue to be allowed^{xiv} and whether there was a case for the 'regulation of surrogacy arrangements through a recognised body or bodies.' The Committee was charged to advise on the scope and operation of any such arrangements that it recommended and in both cases to consider whether reforms of the Surrogacy Arrangements Act 1985 and section 30 of the Human Fertilisation & Embryology Act 1990 were required.

The Committee was chaired by Professor Margaret Brazier, and its Report was published in October 1998.^{xv} The Committee recommended that:

- payments to surrogate mother should cover only genuine expenses associated with pregnancy and that the surrogate should be required to provide documentary evidence of the expenses incurred;
- any additional payments should be prohibited in order to prevent surrogacy arrangements being entered into for financial benefit;
- legislation should define such expenses in terms of broad principle;
- agencies involved in establishing surrogacy pregnancies and supporting participants in the process should be required to register with the Department of Health and conform to a Code of Practice drawn up by the Department, with an interim voluntary Code put in place as an interim measure;

- Health Departments should take the opportunity to establish full record keeping mechanisms to discover the incidence of surrogacy and to facilitate research into the outcomes of surrogacy arrangements.

The Review team recommended that a new Surrogacy Act should replace the 1985 Act and section 30 of the 1990 Act. This new Act (perhaps the Surrogacy Re-Arrangements Act?) should continue to provide for the continuing non-enforceability of surrogacy contracts, a prohibition on advertising and profiting from surrogacy arrangements,^{xvi} and should introduce new provisions to define and limit lawful payments. Other consequential amendments to establish a Code of Practice should be included, as should reform to section 30. Under the Brazier proposals parental orders' applications should henceforth go only to the High Court (and not as now to any court with family jurisdiction), and the guardian ad litem should have power to review records of criminal convictions before an order is issued.

Alan Wertheimer he writes that in trying to protect a woman from coming later to regret her decision 'we are refusing to treat her as an autonomous and responsible person.'^{xvii} Yet, it does not follow that in doing this we are refusing to treat people as less than full citizens, for there may be social benefits to a limited state paternalism or protectionism which serves to benefit the state, as Freeman has said of both the Warnock and the Brazier reports, they are shot through with an ample injection of paternalism when it comes to surrogacy.^{xviii} It might be quite a defensible public policy to seek to prevent as much distress and anguish as possible - real psychic costs - so as to relieve medical treatment and care for others who need it. If the unenforceability of certain types of contract contributes to that goal, then it may be an appropriate one for a State to pursue, even if it looks as though it is treating people less than autonomously.^{xix} It also contributes, as we have suggested, to the symbolic representation of surrogacy as part of a world which we would prefer to live without, an important part of saying who we are and who we do not want to become.

We might be driven to the conclusion that some *form of regulation* is now the only acceptable or viable reform option. Then the question is properly put; regulation of whom or of what, and at what moral and financial cost? Brazier advocates the introduction of a regulatory regime for surrogacy because it '... might reduce the more obvious hazards to the child and the others involved. ... The risks of not having a regulatory framework are greater than any entailed by introducing one.'^{xx}

Hospitals providing IVF surrogacy and IVF (host) surrogacies undertaken there are already subject to HFEA review and licence. The question which then arises concerns the extent to which surrogacy - already metamorphosed from BMA 'no' to BMA 'yes' should become an *exclusively* medical, and highly technology driven one at that, altogether. There might be some in the IVF profession (or business) who would welcome such a move - it would be good for business to have the back-bedroom procreationists out of the surrogacy domain altogether. But I suspect there would be something repellent about moving from the counterpane to the laboratory altogether in this small corner of the reproductive close.

Alternatively, we might say - despite the criticisms that this would evoke about further state regulation of reproduction and motherhood - that surrogacy agencies - if not the arrangements themselves - should be subject (at least) to some form of

scrutiny if not registration and regulation. Yet again, surrogacy arrangements might themselves be required to be registerable. And this is what Brazier concluded.

The questions then become - who should do the regulating? what would be consequences of non-registration? who should think through the administration and adumbration of the principles on which such a scheme might work? and who should pay for it? There is a ready made template upon which some of the answers to these questions could be forged in the model proposed for Ontario by the Ontario Law reform Commission in 1984, and widely thought to be the work of the Commission's Consultant, Bernard Dickens.^{xxi} There are problems with this, freedom of reproductive choice and personal autonomy are sacrificed to the imprimatur of a state body, and as we reviewed in Chapter 0, there are many who would object to this model on that ground.

Rather more mundanely, but we suspect more sensibly, the HFEA could be mandated to establish a system of review and report over the activities of surrogacy arrangements agencies. And that of course raises the thorny issue of costs and subventions; cover for substitutes. And here a fairly stark public policy issues presents; providing public funding for assisted conception services risk positioning the state as pimp, purser, patriarch or protector. The irony here is that while private money is deemed to be the root of the problem - altruistic surrogacy attracts almost universal sympathy and praise rather than criticism and condemnation - we are singularly reluctant to offer public money in finding a way through the moral maze.

Japan

There has been no law prohibiting or approving surrogate motherhood (both genetic-gestational surrogacy and exclusively gestational surrogacy) in Japan. The only regulation is through the notice of observations issued occasionally from the Japan Society of Obstetrics and Gynecology. These observations were drafted by the ethics committee established within the board of directors of the Society, and reported to and approved by the board. The Society took the position that some of these notices in effect prohibit surrogacy.

On the other hand, an Expert Committee on the Assisted Reproductive Technology was established in October 1998 by the Ministry of Health and Welfare to study whether the donation of the gametes or embryo as well as surrogacy should be allowed (I happened to be a member of the expert committee). In December 2000, the committee published its report. It said that the donation of gametes and embryo is allowable, but surrogacy should be prohibited by the law with criminal penalty.

However, in May this year, one obstetrician, who had been expelled from the Society for breaking its notice of observation prohibiting egg donation for IVF-ET three years ago, reported a case of gestational surrogacy. In the case, the elder sister had had her uterus removed. The IVF was performed using the egg of the elder sister and sperm of her husband, and the embryo was implanted into the uterus of the younger sister.

Now, the Ministry, faced with the report of the surrogacy, is accelerating its effort to legislatively implement the report.

The 1988 proposal was followed by a 1990 proposal³¹ by a second Ministry of Justice working group on artificial reproduction appointed on the 8th of November, 1989. The major difference between the 1990 proposal and the previous one was that the child would not have a legal right to identifying information about the donor. In other relevant aspects, the 1990 proposal was the same as the previous one.

Because the issue of donor anonymity again prevented the proposal to be presented to the Parliament, the process of drafting legislation continued, this time by officials within the Ministry of Justice. Their report, dated the 24th of June, 1993, was not published.

Since none of the proposals thus far had led to a government bill, Stakes, the National Research and Development Centre for Welfare and Health, then under the Ministry of Social and Health Affairs, came up with a proposal of its own. Dated the 24th of April, 1996, *The Stakes Working Group Proposal to Hasten the Drafting of a Law on Infertility Treatments*,³² suggested the following solution to the problem of donor anonymity: the donor would decide, at the time of the donation, whether the information on his or her identity would become available to the recipient, that is, the intended parents. They would then decide whether they want gametes from a known or an unknown donor. If a known donor is preferred, the recipient will have to pick a donor who has agreed to have the information on her or his identity available to the recipient. The Stakes working group also revised the terms employed in the proposals arguing that, among other things, the term "artificial reproduction" is outdated and misleading and should be substituted with the term "infertility treatment".

Consequently, a third Ministry of Justice working group was appointed on the 15th of October, 1996. The published version of the proposal of the working group came out in October, 1997, entitled *The Use of Gametes and Embryos in Medical Fertility Treatment*³³. The third working group ended up proposing three rather significant changes to the previous proposals. First, terminology was updated. "Artificial reproduction" was dropped and "fertility treatment" became the prevalent parlance from then on. Secondly, a rather complicated provision on the access of the prospective child to donor information was drawn up. It read that the child, upon attaining 18 years of age, would have a right to access to identifying information on the donor provided that the donor had consented to it at the time of the donation or had consented to it after being informed by the National Board of Medicolegal Affairs that such a request had been made by the child. Even in the absence of donor consent, the child would be entitled to get to know the identity of the donor when ten years had passed after the death of the donor. Upon attaining 18 years of age, the child would also be entitled to receive an essay in which the donor describes himself or herself. Thirdly, and most unexpectedly, the working group suggested that surrogate motherhood be permitted under certain conditions. The "use of a surrogate", as worded by the working group, required that 1) the National Board of Medicolegal Affairs had given its authorisation to the arrangement, 2) both the surrogate and the intended parents were each at least 25 years of age, 3) the husband of the surrogate had consented to the arrangement, in case the surrogate was married, 4) the surrogate

³¹ Oikeusministeriön lainvalmisteluosasto, Ehdotus Hallituksen esitykseksi Eduskunnalle laeiksi ihmisen keinoalkuisesta lisääntymisestä sekä isyyslain muuttamisesta 18.12.1990.

³² Stakes, Hedelmättömyyshoitoja koskevien lakiesitysten valmistelun kiirehtimiseksi. Stakesin työryhmän ehdotus 14/1996.

³³ Oikeusministeriön lainvalmisteluosasto, työryhmän ehdotus, Sukusolujen ja alkioiden käyttö lääketieteellisessä hedelmöityshoidossa

had given her informed consent to the procedure, 5) her motivation was an altruistic one, and 6) she was reimbursed only for the direct expenses associated with her participation.

Unlike the previous proposals, the 1997 proposal resulted in a vivid public discussion centred, somewhat surprisingly, on the issue of access of single and lesbian women to assisted conception. The newly awakened public interest on the issue was unexpected since the eligibility criteria had remained the same since the very first paper of proposed legislation. Furthermore, the more controversial issue of surrogate motherhood had popped up.

The requested expert opinions were strongly divided on both of these issues. Also, the usual controversy on donor anonymity persisted. Several experts pointed out that not including single and lesbian women within the provision of assisted conception amounted to a violation against the prohibition of discrimination laid down both in the Constitution of Finland³⁴ and in the Law on the Status and Rights of the Patient³⁵. The violation was particularly severe, according to some experts, in that the proposal included a penal provision criminalizing (certain) acts in defiance of the proposed law, such as the provision on eligibility criteria. About half of the expert opinions opposed surrogate motherhood on various grounds. It was pointed out that surrogacy was banned in most European countries and, more significantly, in all the other Nordic countries. Were Finland to permit surrogacy, it would not only mark a deviation from the principle of legal uniformity among the Nordic countries but also open the country up a legitimate market in reproductive tourism (a phenomenon which already exists in Finland and to which we will return later in this chapter). It was further argued that it would be next to impossible to verify that the surrogate's decision to participate was based solely on altruistic motives.

Thus, when an unpublished proposal (the latest to date) by a joint Ministry of Justice and Ministry of Social and Health Affairs working group came out on September 1st, 1998, several provisions were modified. Because of the practical as well as ethical problems surrounding surrogate motherhood pointed out by the experts, the working group came to the conclusion that surrogacy should not be allowed. In addition, there was a shift for the first time on the issue of eligibility. The working group proposed that a single woman could be eligible for fertility treatment on two conditions: 1) she was involuntarily childless (i.e. infertile) and 2) the man whose gametes were used in the fertility treatment (i.e. the donor and biological father) consented to the treatment with the knowledge that he may later be declared, on the basis of his consent, to be the child's legal father. If paternity were established - and nobody has really fathomed the possibility - then presumably all the rights and responsibilities of legal parenthood would follow. The solution of the working group, striving to find a balance between the well-being of the child and the principle of equality, was bitterly criticised by feminist and lesbian commentators. It was argued that the provision would remain a dead letter; no woman and, indeed, no prospective donor, would even consider parenthood under these conditions.

As with the previous law proposals, the 1998 proposal was never presented to the Parliament. Therefore, there is presently no legislative position on infertility services,

³⁴ Suomen perustuslaki (Constitution of Finland) 11.6.1999/731, Section 2, Subsection 6.

³⁵ Laki potilaan asemasta ja oikeuksista (Law on the Status and Rights of the Patient) 17.8.1992/785. Section 2, Subsection 3.

the rights and responsibilities of donors, eligibility criteria, or the rights of children born as a result of the use of assisted reproductive technologies. In addition, there is no governmental institution controlling the practice of assisted conception in Finland.

Current practice

In the absence of legislation, infertility clinics have continued to offer a broad range of treatments under professional ethical standards. Finland is, in fact, among the most permissive countries in Europe with respect to the administering of infertility treatments. Assisted conception is available to single women and lesbian couples, the use of donated gametes is permitted, and surrogate motherhood is practised, albeit in a relatively small scale.

IVF surrogacy has been carried out in 4 clinics, a total of 16 couples completing 27 surrogacy cycles 1991-2000. A report on the experience of IVF surrogacy in Finland by V Soderstrom-Anttila, T Blomqvist and 8 others concludes that most treatments have gone smoothly and without 'any big problems.' Proper assessment of the surrogacy arrangements through patient participation, and careful counselling throughout the pregnancy and after the birth of the child are vital parts of the process and enable a high success rate and a favourable outcome for all parties involved; there were 2 cases of disagreement and unhappiness between the couple and the surrogate, in one of which the surrogate suffered from postpartum depression.

In each case it was reported that the surrogate acted altruistically without commercial involvement; in 11 cases the surrogate was a close relative of the intended social parents, (6 sister, 3 mother, 1 husband's sister; 1 cousin) with at least one child of their own. Each of these cases were where the presenting conditions by the intended social mother were exclusively medical; 5 were congenital absence of uterus and vagina; 4 were hysterectomy because of obstetric complications; 3 hysterectomy for severe uterine disease, 3 for uterine abnormality; 3 uterine abnormality and 1 for severe systemic lupus erythematosus.

One of the consequences has been a flow of reproductive tourists from other Nordic countries to the doorsteps of private clinics in Finland. Swedish couples seek artificial insemination in Finland to escape the provision in the Swedish law that establishes the child a right to information on the identity of the donor. A few surrogacy arrangements commissioned by Swedish, Danish, and Norwegian couples have been carried out in Finnish clinics.

Spain

Statutes:

Ley 35/1988, de regulación de las técnicas de reproducción asistida humana, establishes that

- surrogate contracts are void (art. 10.1 "será nulo de pleno derecho el contrato por el que se convenga la gestación, con o sin precio, a cargo de una mujer que renuncie a la filiación materna en favor del contratante o de un tercero."
- the woman that bears a child is always the legal mother, no matter if the child is the biological child of her (art. 10.2 "la filiación de los hijos nacidos por gestación de sustitución será determinada por el parto")
- the biological father can claim for the establishment of the legal

fatherhood (art. 10.3 "Queda a salvo la posible acción de reclamación de paternidad respecto del padre biológico conforme a las reglas generales").

Case Law:

There has been no litigation in Spain about this matter. Anyway, there are some fertility clinics that advice their clients to take a flight to California so that they can contract with a surrogate there.

Legal reform:

Spanish academics do agree in general in the position of banning surrogacy. Even if there are a few ones who defend that there should be an exception in case the surrogate is a friend or a sister of the infertile woman and she claims no material compensation for the pregnancy.

Spanish conservative government does not see as a priority to reform the ART law. In any case, if it would be done the terms would be more restrictive than the current legislation.

Germany

The legal situation in Germany is rather uncomplicated: surrogate motherhood is not allowed. In IVF the use of egg cells for fertilisation and embryo transfer is restricted to the woman who gives the egg cells (Embryo protection act from 1990). Thus surrogate motherhood would be theoretically possible when the egg cell comes from the surrogate mother. But the German family law says that as a "mother" of a child counts only the woman "who gives birth to a child". That means that any surrogacy contract is not valid. In fact we don't have surrogacy in Germany.

France

Le Code civil était muet sur la question, qui est pourtant arrivée devant les tribunaux. Comme vous le savez, en droit français, les juges n'ont pas le droit, dans le silence de la loi, de refuser de trancher, sous peine d'être condamnés pour déni de justice (article 4 du Code civil : « Le juge qui refusera de juger, sous prétexte du silence, de l'obscurité ou de l'insuffisance de la loi, pourra être poursuivi comme coupable de déni de justice »). Ils ont donc rendu un arrêt, le 31 mai 1991, en assemblée plénière de la Cour de cassation :

31 mai 1991 - N° 4**+, Plénière

CONTRATS ET OBLIGATIONS. - Nullité. - Atteinte à l'ordre public. - Maternité pour autrui. - Contrat tendant à l'abandon d'un enfant. - Contrat à titre gratuit. - Absence d'influence.

La convention, par laquelle une femme s'engage, fût-ce à titre gratuit, à concevoir et à porter un enfant pour l'abandonner à sa naissance, contrevient aux principes d'ordre public de l'indisponibilité du corps humain et de l'état des personnes.

Dès lors, encourt la cassation l'arrêt qui, pour prononcer l'adoption plénière d'un enfant, retient d'abord qu'en l'état actuel des pratiques scientifiques et des mœurs, la méthode de la maternité substituée doit être considérée comme licite et non contraire à l'ordre public, ensuite que cette adoption est conforme à l'intérêt de l'enfant qui a été accueilli et élevé au foyer de l'adoptant pratiquement depuis sa naissance, alors que

cette adoption n'était que l'ultime phase d'un processus d'ensemble qui, destiné à permettre à un couple l'accueil à son foyer d'un enfant conçu en exécution d'un contrat tendant à son abandon à la naissance par sa mère, constituait un détournement de l'institution de l'adoption.

31 mai 1991.

Cassation dans l'intérêt de la loi et sans renvoi.

Sur le pourvoi dans l'intérêt de la loi formé par M. le Procureur général près la Cour de Cassation:

Vu les articles 6 et 1128 du Code civil, ensemble l'article 353 du même Code;

Attendu que, la convention par laquelle une femme s'engage, fût-ce à titre gratuit, à concevoir et à porter un enfant pour l'abandonner à sa naissance contrevient tant au principe d'ordre public de l'indisponibilité du corps humain qu'à celui de l'indisponibilité de l'état des personnes;

Attendu selon l'arrêt infirmatif attaqué que Mme X..., épouse de M. Y..., étant atteinte d'une stérilité irréversible, son mari a donné son sperme à une autre femme qui, inséminée artificiellement, a porté et mis au monde l'enfant ainsi conçu; qu'à sa naissance, cet enfant a été déclaré comme étant né de Y..., sans indication de filiation maternelle;

Attendu que, pour prononcer l'adoption plénière de l'enfant par Mme Y..., l'arrêt retient qu'en l'état actuel des pratiques scientifiques et des mœurs, la méthode de la maternité substituée doit être considérée comme licite et non contraire à l'ordre public, et que cette adoption est conforme à l'intérêt de l'enfant, qui a été accueilli et élevé au foyer de M. et Mme Y... pratiquement depuis sa naissance;

Qu'en statuant ainsi, alors que cette adoption n'était que l'ultime phase d'un processus d'ensemble destiné à permettre à un couple l'accueil à son foyer d'un enfant, conçu en exécution d'un contrat tendant à l'abandon à sa naissance par sa mère, et que, portant atteinte aux principes de l'indisponibilité du corps humain et de l'état des personnes, ce processus constituait un détournement de l'institution de l'adoption, la cour d'appel a violé les textes susvisés;

PAR CES MOTIFS:

CASSE ET ANNULE, mais seulement dans l'intérêt de la loi et sans renvoi, l'arrêt rendu le 15 juin 1990 par la cour d'appel de Paris.

REQUETE DE M. LE PROCUREUR GENERAL PRES LA COUR DE CASSATION

Le Procureur général près la Cour de Cassation a l'honneur d'exposer:

- QUE, par jugement du 28 juin 1989, le tribunal de grande instance de Paris a rejeté la requête présentée par Mme X..., épouse Y..., tendant à l'adoption plénière de l'enfant Z... déclarée comme étant née de M. Y..., mari de la requérante, sans indication de filiation maternelle;

- QUE, pour ne pas faire droit à cette requête, les premiers juges ont retenu que les époux Y..., pour remédier à la stérilité de leur couple, avaient eu recours à l'association Alma Mater, aujourd'hui dissoute, l'enfant étant né d'une mère de substitution qui l'a abandonné à la naissance, pratique déclarée illicite;

- QUE sur appel de Mme Y..., la première chambre civile, section C, de la cour d'appel de Paris, a, par arrêt du 15 juin 1990, infirmé la décision entreprise et prononcé l'adoption plénière sollicitée par la requérante;

- QU'au soutien de leur décision devenue définitive, les juges du second degré ont tiré de nos principes généraux relatifs à la filiation, des

règles d'ordre public concernant les contrats et de certaines conventions ou déclarations internationales, des conclusions contraires à celles auxquelles était parvenue votre première chambre civile de la Cour de Cassation qui, dans un cas de figure pratiquement identique, a, par arrêt du 13 décembre 1989 (association Alma Mater contre procureur général Aix-en-Provence) reconnu le caractère illicite de la maternité pour autrui et les associations qui s'efforcent de la promouvoir;

- QU'il importe en cette matière particulièrement sensible, qui touche à un délicat problème de société et d'éthique, que soit mis fin à des divergences jurisprudentielles majeures et que la sécurité juridique soit assurée.

PAR CES MOTIFS:

Vu l'article 17 de la loi du 3 juillet 1967 relative à la Cour de Cassation;
Requiert qu'il plaise à la Cour de Cassation;

CASSE ET ANNULE, sans renvoi et dans le seul intérêt de la loi l'arrêt rendu le 15 juin 1990 par la cour d'appel de Paris ayant fait droit à la requête en adoption plénière présentée par Mme X..., épouse Y...

N° 90-20.105

Procureur général près la Cour de Cassation.

Premier président: M. Draï. - Rapporteurs: Mme Giannotti, M. Chartier. -

Premier avocat général: M. Dontenville.

A RAPPROCHER:

1re Civ., 13 décembre 1989, Bull. 1989, I, n°387 (1), p.260 (rejet).

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Dalloz, 1991, p.417, Chartier (Yves)

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Bulletin d'information de la Cour de Cassation, 1991, n°329, p.1,

Dontenville (D.-H.)

Puis le législateur s'est saisi de la question dans les lois dites bioéthiques de 1994, introduites notamment dans le Code civil et le code de la santé publique :

Article 16-7 du Code civil :

(L. n° 94-653, 29 juill. 1994, art. 3).

Toute convention portant sur la procréation ou la gestation pour le compte d'autrui est nulle.

Portugal

The agreement would be invalid under the general approach of the Civil Code

Greece

Although surrogacy might be considered as an aspect of the right to procreate contractual obligations cannot be enforced and the Greek Council of State has ruled that the birth mother cannot lose her parental rights.

Austria

Prohibited

Canada

There is still no legislation in Canada regulating surrogacy agreements. Therefore, private agreements are entered into between the parties and adoption processes are used to "legalize" parenthood. There is however, recently introduced draft legislation (yes, draft legislation, not an actual proper Bill) part of which relates to surrogacy arrangements. This is part of a broader legislative framework for regulating surrogacy in Canada that looks very much like the old proposed legislation of 1996 that died on the order paper. If you log onto the government of Canada Website and find your way to the Department of Health you are bound to run into this draft legislation. www.canada.gc.ca (I think) I don't have it before me, but basically the draft legislation would criminalize commercial surrogacy The Quebec Civil Code.

There are indeed provisions in the Code regulating surrogacy. I believe they state that the birth mother is the legal mother of the child, but you should double check this.

The basic legal position in Ontario is that set out in the Ontario Law Reform Commission Report in 1985 (Report on Human Artificial Reproduction and Related Matters). The federal government's Royal Commission on Reproductive Technology recommended banning of commercial surrogacy arrangements with criminal sanctions; legislation was introduced and died on the order paper when the election was called in 1997. I think that there is new legislation being considered. Diana Majury wrote a very good critique of the Royal Commission report in (1994) 17 Dalhousie Law Journal 279. See also the comments of the chair of the Commission, Dr. Patricia Baird in (1997) 15 Canadian Family Law Quarterly 103.

ⁱ 'Can you Buy Children?' (1999) 11 Child & Family Law Q 345 at 345

ⁱⁱ Donna Dickenson, Property, Women and Politics, (Cambridge, Polity Press, 1997) at 160 et seq

ⁱⁱⁱ Ken Mason, Medico-Legal Aspects of Reproduction and Parenthood, (Aldershot, Ashgate, 2ed., 1998) at 259

^{iv} op cit at 9

^v Human Fertilisation and Embryology Act 1990, ss.12-15.

^{vi} Human Fertilisation and Embryology Act 1990 s.13 (5)

^{vii} Code of Practice, part 3.16

^{viii} Code of Practice, part 3.15

^{ix} Human Fertilisation and Embryology Act 1990 s. 36 inserts section 1A in the Surrogacy Arrangements Act 1985 and provides that "No surrogacy arrangement is enforceable by or against any of the persons making it".

^x These following paragraphs are based on the evidence presented to and marshalled in the British Medical Association's report, Changing Conceptions of Motherhood, (London, BMA, 1995)

^{xi} Reported for example in The Times, 15 May 1997

^{xii} As Brazier has elsewhere noted, surrogacy is effectively prohibited in Austria, Germany and Sweden and payments to surrogates prohibited in France, Denmark and the Netherlands. Payments for gametes are prohibited in Germany, Switzerland, Italy, Denmark, France and Spain.

^{xiii} The Independent Tabloid, 31 January, 1997, pp1-3; in a nice example of cheque book journalism (you can pay two journalists the same money from the same cheque book to cover the same story and they will still come up with different detail) The Daily Telegraph, 3 February, 1997 p3, had bid this up to 'around £40,000).

^{xiv} As Freeman has noted, 'surprisingly, neither the Warnock report nor the 1985 Act addressed the question of payment to surrogate mothers.' 'Does Surrogacy Have a Future After Brazier?' (1999) 7 *Med. Law Review* 1 at 3

^{xv} Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation, (London, Cm 4068, 1998)

^{xvi} Although it has been reported that Ministers intend to relax this prohibition to the extent that lawyers would be able to charge for services such as advice in arranging a surrogacy agreement; see Independent on Sunday, 14 November 1999 at 12.

^{xvii} Ibid

^{xviii} Op cit, at 5

^{xix} Compare the state's policy on compulsory motor accident insurance. That too could be seen as a form of state paternalism, (indeed that argument is advanced by writers such as Robert Nozick in his Anarchy, State and Utopia (Oxford, Basil Blackwell, 1974)) albeit for the particular benefit of third parties. But it nonetheless detracts from my being an autonomous and responsible person as much as refusing to enforce certain types of contract, although in both cases we might disagree whether this truly characterises what it would be to be an autonomous and responsible person.

^{xx} Brazier Report at para 6.3, 6.5

^{xxi} See Derek Morgan, 'Making Motherhood Male: Surrogacy and the Moral Economy of Women' (1985) 12 *J Law and Society* 219-38