REGULATING THE REPRODUCTION BUSINESS?

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I. INTRODUCTION

The Human Fertilisation and Embryology Act 1990 sets out to regulate selected parts of reproductive medicine in the United Kingdom. The Act subjects fertility specialists to constraints on their practice and their research quite separate from, and over and above, those legal and ethical constraints generally applicable to all medical practitioners. The Act places limits on what patients seeking certain treatments for infertility may ask for and receive. It creates in the Human Fertilisation and Embryology Authority an apparently powerful regulatory body with powers to control the practice and development of embryology and certain fertility treatments. Reproductive medicine is singled out as special, as a part of medicine of such particular social concern and significance that the state should have a direct stake in its evolution. In singling out reproductive medicine for especial regulatory concern, the United Kingdom is not alone.

This paper seeks to explore some of the issues arising out of the way in which the United Kingdom has tackled developments in reproductive medicine. Some brief comparison with other European jurisdictions is attempted. The potential range of questions which could be addressed is almost endless. Having sketched in the background to the development of what I (somewhat frivolously) designate the ‘reproduction business’, the paper attempts to address the following questions. What are we regulating, and why? Why interfere with private choices? Is surrogacy special? Why the fuss about donor gametes? Who cares about embryos? What shall we do about cloning? Finally, I consider whether in the context of the reproductive technologies we are today regulating a profession or a business.

I shall seek to demonstrate that the British model of regulating fertility treatment and embryo research has undoubted strengths. It

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ensures a degree of public accountability in the development and delivery both of new treatments and research procedures. It promotes high standards of medical practice and offers those lucky enough to benefit from the advances made in reproductive medicine assurances that their treatment is not likely to be marred by gross misadventure, delivered by maverick doctors, or rank ‘amateurs’. Because the British system is built on consensus, regulators, clinicians and scientists work well together. All those strengths benefit patients and promote British reproductive medicine as a success story. The price paid for consensus however is that all too often crucial issues of individual rights, the balance between individual rights and public policy, and issues of conflicting rights are skated over. There is little conceptual depth underpinning British law. The result is that again and again, as new medical developments emerge, we debate the same issues in different disguises. Professor Capron charges the US law in this field ‘ . . . is characterised by incompleteness, contradictions and indefensible policies’. British law too displays contradictions, no single, coherent, philosophy underpins the law’s response to reproductive medicine. Yet a regulatory system is in place and perhaps suggests that pragmatism has its advantages?

II. THE BACKGROUND

In July 1999, Louise Brown will celebrated her twenty-first birthday. The revolution in reproductive medicine heralded by her birth as the first child born as a result of in vitro fertilisation continues apace. That revolution has profoundly affected the way in which communities within the developed world perceive the age-old process of having children. What was until very recently seen as a couple’s private business has become in many cases the business of the state. An area of medicine, treatment of infertility, which was not long ago a ‘speciality’ which offered little more than minor surgery, advice and tender loving care has grown into a multimillion pound international business. Nor is that business limited to its origins in treatment of infertility. Developments in embryo research and embryology offer radical treatment options for a host of diseases with therapeutic cloning on the horizon perhaps promising to cure diseases such as Parkinson’s Disease and consign traditional transplant surgery to history.

Naturally lawyers and philosophers have not stood quietly to one

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2 It might be suggested that the ‘licensing’ of fertility specialists should be seen not as exceptional but as a model for all emerging specialties.


side and simply observed the transformation of reproductive choices from the private to the public arena and the growth of such a profitable new medical business. Reproductive medicine has brought rewards for them too. Committees exploring the legal, social and ethical implications of medical advances abound. Legislation has proliferated across the developed world, and beyond. Litigation has been lively; at least in common law jurisdictions.

For those not intimately involved, one of the delights of the burgeoning reproduction business is the glittering constellation of ethical and legal questions reproductive medicine poses for us. Some of those questions, endlessly debated, are deeply philosophical (and for some of us theological). What is the nature of human life itself? Does possessing human DNA have any moral significance? Others require us to reflect on just what intrinsic rights are involved in procreation. Few might dissent from a rhetorical assertion that men and women have a right to found a family. Begin to debate what that right entails and who enjoys it and dispute resurfaces. Yet other questions are, for the lawyers, delightfully technical as much as morally significant. Before 1979, paternity might on occasion be dubious, but even a rather dim child generally knew his mother.

Within these past two decades of the ascent of the reproduction business, one cry has often (though not universally) united the warring parties—‘something must be done’. That ‘something’ has tended to be the introduction of some form of external regulation of the reproductive technologies. Across Europe, states have elected to implement very different patterns of regulation. Regulation differs both in its extent and in substance. Perhaps a minority of European countries have adopted a scheme attempting a reasonably comprehensive coverage of the reproductive technologies. Others are more selective focusing on particular ethical and legal issues posed by those technologies. For certain countries, the level of disagreement generated by advances in reproductive medicine has meant that, while several attempts have been made to introduce laws regulating the reproductive technologies, only minimal progress has been made in doing so.7


6 In particular, in Egypt and South Africa.

7 For example, United Kingdom and Spain.

8 For example, Germany.

9 For example, Italy.
Whatever the nature or success of national attempts to regulate may be, that regulatory effort has focused almost exclusively on those reproductive technologies which involve either the creation of embryos *ex utero*, or the storage (and use) of donor gametes. Regulation of reproductive medicine remains partial and selective. Whole areas of fertility treatment are not subject to any special regulatory regime, nor are those medical technologies dedicated to the control of fertility. Legislative attention has confined itself to what are still (if somewhat erroneously) described as the *new* reproductive technologies.

The United Kingdom enjoyed perhaps a head start in both the inception of the reproductive business and its subsequent regulation. The Warnock Committee reported in 1984 proposing a comprehensive scheme of regulation for certain of the reproductive technologies.\(^{10}\) That it took six years for their proposals to be implemented illustrates the difficulty in translating agreement that those technologies should be regulated in some form or other to consensus on what form that regulation should take. Not all Warnock’s proposals were implemented in the 1990 Act. Notably their recommendations on surrogacy were only partially accepted by government and then hastily and ham-fistedly hurried through Parliament in the Surrogacy Arrangements Act 1985. Surrogacy in the event neither withered on the vine nor developed fruitfully.

### III. WHAT ARE WE REGULATING, AND WHY?

The core of the Human Fertilisation and Embryology Act lies in sections 3 and 4 of the Act. Those sections essentially prohibit the creation of a human embryo outside the human body and the storage of gametes without a licence. Section 3 additionally imposes a series of restrictions on what may, even subject to a licence, be done with human embryos, including what was originally believed to be an absolute ban on human cloning. Subjecting embryo creation and gamete storage to a licensing system confers on the licensing authority (the Human Fertilisation and Embryology Authority—HFEA hereafter) control of a limited sector of reproductive medicine. Virtually all the other provisions of the 1990 Act, which flesh out the rules governing the licensing function of the HFEA, are limited in their impact to procedures involving licensed clinics engaged in either embryo creation or gamete storage.

It is important to recall that the 1990 Act permits three different kinds of licence, all licences to engage in otherwise prohibited activities,

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\(^{10}\) *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (Cmnd. 9314 1984) (hereafter the *Warnock Report*).
(1) to provide treatment services, (2) to store embryos and gametes, and, (3) to carry out research on embryos. Once granted a licence, a licence holder must obey both the provisions made within the Act itself, directions of the HFEA and comply with the conditions of the licence.\textsuperscript{11} So a \textit{licensed} clinic approached by a single woman seeking donor insemination utilising stored donated gametes must ensure \textit{(inter alia)} that consent to donation was given in the requisite form,\textsuperscript{12} must assess whether that woman can adequately provide for the welfare of the child, and must consider the need of the child for a father.\textsuperscript{13} A \textit{licensed} clinic providing \textit{in vitro} fertilisation must comply with HFEA guidance not to replace in the woman more than three embryos to minimise the risk of multiple pregnancy.\textsuperscript{14} Both sets of constraints have (arguably) their justifications. Donors should give free informed consent. The welfare of future children is, many contend, a matter to be weighed in making reproductive choices. Multiple pregnancy endangers the health of both the pregnant woman and the foetuses she carries. The restrictions on what the licensed clinic may do prevents harms to others.

However, treatments available outside licensed clinics can result in more or less identical harms which escape the long arm of regulation by the HFEA. Artificial insemination using fresh sperm can be achieved on a do-it-yourself basis by couples, or offered with unlicensed medical assistance. The single woman desiring a child can select her own donor and no safeguards protect the future child or monitor the quality of the donor’s consent. Moreover, using fresh sperm carries risk to the woman herself via transmission of HIV or some other sexually transmitted disease. In the United Kingdom, GIFT (gamete intra-fallopian transfer) can be provided without a licence albeit the risk of multiple pregnancy is slightly higher with GIFT than with IVF. Fertility drugs to induce supra-ovulation are accessible without even any requirement for prescription by a fertility specialist and misused such drugs carry the highest risk of multiple pregnancy. Fertility drugs resulted in the tragic conception and stillbirth of Mandy Allwood’s octuplets.\textsuperscript{15} Paradoxically it seems that procedures more likely to cause harm are beyond the reach of regulation. A select group of fertility treatments only are regulated. The composition of the regulated group is not dictated by the level of risk they pose to the woman being ‘treated’, the child or any donor.

\textsuperscript{11} Note that a licensed clinic must comply with the provisions of the 1990 Act and the HFEA Code of Practice in relation to any treatments (including GIFT) provided within the clinic.
\textsuperscript{12} Sched. 3, para. 5.
\textsuperscript{13} Section 13(5).
\textsuperscript{14} \textit{HFEA Code of Practice}, 3rd edn, para. 7.9.
\textsuperscript{15} S. Sheldon, ‘Multiple Pregnancy and Re(pro)ductive Choice’ (1997) \textit{5 Feminist Legal Studies} 95.
Moreover, fertility treatment itself forms but a small part of what we might style reproductive medicine. Mason’s elegant work, *Medico-Legal Aspects of Reproduction and Parenthood* runs to 398 pages. Yet just 100 pages address fertility treatments and embryo research. Of course, the law in the United Kingdom and elsewhere engages with his other concerns, such as contraception, sterilisation and protection of the foetus. But these areas of reproductive medicine are not subjected to regulation by any external public authority analogous to the HFEA. A novel development in contraception such as a contraceptive vaccine or long term implant may have serious social, ethical and medical implications. Consider the proposal by Dr John Guillebaud that, prior to puberty, girls at risk of teenage pregnancy should (with their parents’ consent) have a contraceptive implant inserted to be removed only when they were sufficiently mature for motherhood.17

So what is the basis for the selection of certain treatments for regulation? The Warnock Report in recommending the creation of the HFEA puts the case thus:18

The protection of the public, which we see as the primary objective of regulation, demands the existence of an authority independent of Government, health authorities, or research institutions. The authority should be specifically charged with responsibility to regulate and monitor practice in relation to those sensitive areas which raise fundamental ethical questions. We therefore recommend the establishment of a new statutory licensing authority to regulate both research and those infertility services which we have recommended should be subject to control (emphases added)

Elaborating their proposals for a licensing authority, the Warnock Committee stressed that the authority would have two functions, as an advisory body monitoring developments in fertility treatment and embryo research and as a licensing authority for clinics. In its latter, arguably central, function, in the context of fertility treatments, emphasis is placed on ensuring adequate standards of good practice, in relation (*inter alia*) to the qualifications of staff, the screening of gametes, the storage of gametes and embryos. Effectively the authority regulates ‘health and safety’ or, to use Warnock’s words, ensures quality control. In relation to research licences, once again ‘quality control’ issues are addressed, but so is much more of the substance of

18 *Warnock Report*, para. 13.3.
what might be done with the embryos. It should be clear that the objectives of the research cannot be achieved without the use of human embryos, an indication should be given of the number of embryos to be used, and the researcher should have sought approval from an ethical body in his or her own institution.

Finally, in its key chapter putting the case for regulation, Warnock expressly proposes that the sale or purchase of human embryos be permitted only under licence and subject to conditions prescribed by the licensing authority. What can be gleaned from Warnock, and is it still of relevance today? Two features of their analysis of the case for regulation stand out, first, the pre-eminence given to concern for embryos, and second, the focus on regulating standards. Warnock speaks of the protection of the ‘public’, and of practice in sensitive areas raising ‘fundamental ethical concerns’. The Report ranges over other concerns arising out of the reproductive technologies but again and again the status and consequent fate of the embryo takes centre stage. The creation and use of embryos is arguably what triggers concern. That concern is not so much about the consequences for the woman, whose body will receive such embryos, who with her partner may have fundamental interests at stake, but with society’s engagement with the nature of humanity. GIFT (which does not involve the creation of embryos ex utero) slips out of sight.

I do not seek to argue that Warnock (or later the HFEA) were indifferent to a host of other questions and in particular the welfare of those receiving treatment. Indeed procedures such as donor insemination only come within the 1990 Act at all because of Warnock’s recognition that unregulated practice could endanger patients. And ‘quality control’ is central to Warnock. What I suggest is this:

(1) Absent the development of procedures opening the door to research on, and manipulation of, embryos, Warnock would never have happened. Embryology, much more than reproductive issues, triggered public concern. That focus on embryos endured and largely dominated Parliamentary debate. Unregulated embryo research was simply not an option, paradoxically because Warnock and ultimately the majority in Parliament favoured permitting such research. Regulation was the price for ensuring the ‘legitimacy’ of such research.19 Thus to ensure those opposed to embryo research could not undermine that ‘legitimacy’, any procedure which involved creating an embryo must fall within the jurisdiction of the ‘legitimating’ authority.

19 As elegantly argued by the current Chairman of the HFEA; see R. Deech, ‘Infertility and Ethics’ (1997) 5 Child and Family Law Quarterly 337.
(2) Warnock deliberated at a very early stage of the ‘reproduction revolution’. Neither the science, nor the infrastructure which now underpins the ‘reproduction business’ was well developed. Examples abounded of fairly crude, even disastrous, practices, for example, storing sperm in the same fridge as the clinic’s daily milk supplies. Fears of something going disastrously wrong, two-headed babies and so on, still coloured debate. ‘Quality control’ was crucial. ‘Safety first’ has been described as continuing to be the watchword of the HFEA. Consequently the Warnock ‘scheme’ concentrates on control of what happens in clinics. What happens beyond the clinics is outwith that remit, albeit concerns closely analogous to those raised by clinic-based practice may equally arise in other areas of reproductive medicine.

(3) Almost everything else within the British regulatory framework for embryo research and fertility treatment is consequential. That is not to say it is not important. The framework created for donor consent in relation to gametes is crucial and has provoked a host of legal problems. The provisions relating to payment for gametes, the sections of the Act addressing children’s rights of access to information about their genetic parents have profound significance. Section 13(5) of the 1990 Act requiring that clinics consider the welfare of the child, including the child’s need for a father, has provoked reams of commentary. All these matters have in practice much occupied the HFEA. Nonetheless because these are all issues not central to Warnock’s call for regulation and because Warnock’s focus was almost exclusively on public policy, with little attention to private rights, the wider implications of embracing such issues within the British regulatory framework were perhaps, with hindsight, insufficiently thought through in the lengthy process which resulted in the 1990 Act.

(4) Albeit it was chaired by a most distinguished moral philosopher, the Warnock Report itself (particularly in comparison to its counterparts elsewhere in Europe) is more of an exercise in pragmatism than an exploration of the philosophy underpinning issues of reproductive choice. Compromise dominates the British regulatory system. Compromise has its benefits. The United Kingdom has had in place for nearly a decade now a regulatory system which ensures patients who receive fertility treatment can be assured of basic

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20 Deech, op. cit.
21 Section 12(e).
22 Subsections 30–2.
standards of practice. Charlatans who might use their own sperm to father hundreds of children are excluded from the system. Risks of malpractice are minimised. The United Kingdom has a system which ensures that as scientific developments generate new areas of concern such issues are publicly debated. The HFEA is often used as an ‘Aunt Sally’, pelted with metaphorical rotten tomatoes for its pronouncements. In its often underrated advisory function, the HFEA promotes a process of public consultation sometimes absent in other jurisdictions. The HFEA is sometimes attacked for its lack of philosophical direction. But was that ever its brief? Britain opted for a limited and pragmatic regulation of research and treatment focusing on ensuring public accountability on the part of both researchers and clinicians, facilitating medical and scientific progress and largely skating over fundamental questions of reproductive choice. Ruth Deech states the question as ‘How was the humane treatment of infertile couples and the research appended to it, together with public fear and distrust to be managed?’24 The answer which has emerged is that managing the fertility business and keeping public fears of scientific progress at bay has been the central concern of the HFEA.

IV. WHY INTERFERE WITH PRIVATE CHOICES?

Just one subsection of the 1990 Act directly addresses access to fertility treatment, section 13(5). In a regulatory framework largely focusing on ‘quality control’ and the need for public control of scientific development, section 13(5) stands out as something of an anomaly. Clinics are licensed, controlled and inspected to assure the public of the quality of the professionals. Section 13(5) addresses the quality of the patients. Up until 1990, clinics offering donor insemination were subject to no conditions as to whom they treated. A clinic’s choice to treat (or not to treat) single women, lesbians, or couples where the husband was aged, was unrestricted. Section 13(5) purports to restrict access to fertility treatment to extend ‘quality control’ to users. Developments in reproductive medicine have expanded the scope of section 13(5). Once post menopausal women could be offered treatment, debate focused on should they be. Debate extended well beyond questions such as was treatment safe for the woman, were women fully informed of what the limited chances of success might be and what the additional risks their age entailed. Commentators ask whether any woman beyond the natural age of the menopause should be treated? What about the

24 Deech, op. cit.
welfare of a child who in her teens might be cared for by (or caring for) a mother well over seventy?

A number of commentators would answer all the above questions succinctly—‘nobody else’s business’. The law does not interfere with the reproductive choices of the naturally fertile. What justification is there for interference with the choices of the unfortunately infertile? The Warnock Report rather neatly evades the issue. A relatively mild preference is expressed for the raising of children in conventional two parent families but the Report concludes that the ‘. . . question of eligibility for treatment is a very difficult one’. Their answer is to accept that doctors may on occasion decline to treat certain patients. Such patients must receive a full explanation of why they are refused treatment. Section 13(5) is not obviously, at least, a translation of Warnock’s recognition of a wide margin of clinical discretion. It results from the translation of the process of legitimating fertility treatment to the Parliamentary arena. In the House of Lords a proposal which would have restricted all treatment to married couples was only narrowly defeated.

In the United Kingdom as elsewhere the debate on fertility treatment became in the legislature and in Parliament a debate on family structure, a weapon to attempt to defend conventional families. The justification for doing so was never articulated. It rarely rose or rises above ‘two parents good—one parent bad’, ‘young(ish) mothers good—old mothers bad’. Nor in the United Kingdom is the debate brought to any definitive conclusion. The law requires clinics take into account the welfare of the child and the need of the child for a father. The HFEA in giving guidance to clinics on applying section 13(5) excludes no category of patient from treatment. The Code of Practice sets out what is in effect a wish list of considerations any prospective parent should take into account in seeking to ensure a child to be born enjoys ‘a stable and supportive environment’. Section 13(5) has been described as ‘so imprecise as to be either all-embracing or meaningless’. The substance of HFEA guidance fleshing out the subsection can be similarly described. Clinics are directed what matters they should consider in making treatment decisions, but as long as the process demonstrates that these considerations are addressed,

26 Warnock Report, para. 2.11.
27 At paras 3.12 to 3.32.
28 Mason, op. cit. at 219.
decisions are left to the clinic’s discretion. Giesen\textsuperscript{29} has labelled British laws as representing a ‘permissive solution’ to the dilemmas promoted by reproductive medicine. Legislation permits virtually all principal forms of assisted conception. Only reproductive cloning even now looks like remaining a totally prohibited area. More importantly the 1990 Act and the HFEA place no absolute restrictions on the kinds of people who may receive treatment. Yet ‘permissive’ is not how many British commentators regard the criteria governing access to treatment. Accounts abound of the difficulties confronted by groups such as lesbians obtaining licensed treatment. Women at the comparatively early age of 37 are refused treatment because they are ‘too old’\textsuperscript{30}. How can this apparent paradox be explained?

Two factors help to explain the divergence in judgments as to the ‘permissive’ nature of access in Britain. First, there is the very obvious point about the distinction between access to NHS treatment and access in the private sector. The very limited availability of NHS treatment forces NHS clinics to operate a rationing policy. Even were the criteria set out by the HFEA to assess whether potential parents can offer the child a stable environment to be treated as a parenting test, NHS clinics would still (at their present resource levels) have to discriminate even between couples scoring near to 100 per cent. NHS clinics opt to solve their resource problems both by including criteria additional to those set out by the HFEA in their assessment of potential parents, and by operating much more rigid exclusionary rules. So, for example, to be treated in the public sector, a couple may both have to be childless. Infertile couples will be rationed to one child only. Patients seeking NHS treatment may face rigid age limits and those who do so outside an established heterosexual relationship often do not fare well. Couples with existing children, women well past NHS age limits, and, in many cases, single women will nonetheless be likely to obtain treatment in the private sector. If one concedes British legislation allows ‘permissive’ access to treatment, the British Treasury restricts such access at public expense.

The discrepancy between ease of access to treatment in the public and the private sectors illustrate the second reason for dispute about ‘permissive’ legislation. The effect of the general and ‘meaningless’ admonitions of the 1990 Act and the HFEA’s emphasis on the process of decision-making is that clinics enjoy an almost unlimited discretion whom to treat. Their licence will not be at risk unless they can be shown


to have failed to address welfare issues at all. Even within the private sector there is evidence of significant variation in what kinds of patient will or will not be treated. There are (private) clinics who will not treat women over 50. Others will treat women up until 55 or 57. A number of clinics will not touch surrogacy. One or two quite actively promote full surrogacy arrangements, and will assist in partial surrogacy. In this private sector, whether you gain access to treatment very largely depends on whom you ask for treatment.

The immediate response to evidence of such variations in access to treatment might be that in creating a fertility lottery British law is weak and inequitable. Comparison with other European jurisdictions promotes reflection. A number of European states have by contrast set out in legislation and in consequent regulatory guidance clear and rigid rules on who may benefit from fertility treatments. They have opted for what Giesen styles a ‘prohibitive’ solution. Only heterosexual couples may receive treatment. The woman must be of normal childbearing age. Posthumous insemination is unlawful. In France, treatment is available only within a projet parental. Nowhere in France could a post-menopausal woman or a lesbian couple lawfully be treated. France at first sight then appears distinctly ‘anti-permissive’. Yet in France, unlike in the United Kingdom, couples who fall within the category of patients lawfully entitled to be treated will gain access to treatment regardless of their finances. Fertility treatment is publicly funded. Patients denied NHS treatment in the United Kingdom would, as Latham has noted, be better off in ‘illiberal’ France.31

Inequity in access between the public and private sectors in Britain will only disappear by an act of political will. Either, as the government recently promised, greater resources must be committed to fertility treatment within the NHS, or fertility treatment should cease to be publicly funded at all. Neither rational solution is likely to be implemented. Both are politically too risky. Given a continuing state of affairs where fertility treatment is patchily available and partly rationed by postcode, honesty is required. Clinics choosing between patients who meet the basic criteria set out by the HFEA should not be subject to a ‘welfare-plus’ assessment. Rationing should be overt and not dressed up as a judgment on parenting skills.

Much more fundamental to the question of how effectively British law meets the challenges of the reproductive technologies is the issue of whether the wide discretion entrusted to health professionals in policing access is satisfactory. Professional discretion is attacked from two fronts. ‘Liberals’ argue that the notion of evaluating parenting ability,

the very concern with the welfare of the child, invades areas of private choice and family life. ‘Conservatives’ maintain that in certain quarters the law is flouted. Assessment of the welfare of the child is a farce. Yet what is the alternative? Equal access to treatment across the spectrum of fertility clinics can only be achieved in two ways. (1) Any discretion to refuse to treat a patient, save on clinical grounds, is withdrawn. If it is technically possible to attempt egg donation and IVF with a single female patient of 61, it must be tried, whatever the qualms of the clinicians. Clinicians become mere technicians.32 (2) The United Kingdom follows the example of France and Germany and centrally determines what groups of patients may and may not be treated.33 The HFEA, if you like, answers its own questions. Rather than clinics simply being adjudged to bear in mind a couple’s (person’s) health and age, the HFEA declares that, as in general someone of 65 might find coping with a lively teenager problematic, no woman over say 48 should be treated. Imagine the outcry. What about the woman of 50, whose partner is only 35, we would hear. How can you generalise about the effect of ageing?

The central role granted to professionals in British law relating to reproductive medicine is one of its key features. The law grants to doctors powers to make social judgments with the inevitable result that the substance of any ‘right’ of access to regulated fertility treatments is determined by clinics, by doctors, generally working with ethics committees. The disadvantages of such a system are patent. A group of professionals who gain their position as licence-holders predominantly as a consequence of their scientific and clinical expertise are granted a quite different function. Patients denied treatment will have a sense of grievance and injustice. Yet the system is not without some merits? It allows access decisions to reflect individual circumstances. It avoids arbitrary classifications of ‘good’ and ‘bad’ parents. It allows society of the hook from addressing in this context the debate on family structure. All the difficult questions that as a community we have problems in answering are delegated to the professionals. Given the responsibility the law entrusts to them, it is often somewhat unfair to turn round and criticise them however they elect to exercise that responsibility. British law in many respects expressly professionalises the day to day control of regulated fertility services. Having done so the law cannot blame all the consequences of professionalisation on the professionals.

32 For an analysis arguing professionals must be recognised as independent moral agents see M. Brazier, Liberty, Responsibility, Maternity (1999) Current Legal Problems (forthcoming).
V. IS SURROGACY SPECIAL?

One highly controversial infertility service currently escapes in Britain both most of the regulatory reach of the HFEA, and the professionalisation which so characterises other services. Surrogacy, British style, evolved haphazardly. Perhaps of all the various infertility ‘treatments’, surrogacy has attracted the greatest critical attention despite the paradox that surrogacy need not involve, in any real sense, treatment. National legal responses to surrogacy have also differed markedly. Many European states have opted for overtly ‘prohibitive’ solutions. Germany simply bans surrogacy, be the arrangement altruistic or commercial. France, Denmark and the Netherlands criminalise any payment for surrogacy services whether made to the surrogate or any third party. Yet, as I understand it, in parts of the USA, surrogacy flourishes as a lawful business. But for good or bad, legislators and judges perceive surrogacy as both special and especially problematic.

‘Prohibiting’ surrogacy was an option rejected in the United Kingdom by Warnock largely because of that committee’s belief no child should be born affected by a ‘taint of criminality’. Nonetheless, the majority in Warnock hoped that surrogacy would go away. They sought to achieve this end by proposing that it should become a criminal offence for any third party to assist in a surrogacy arrangement, whether for payment or otherwise. The majority expressly rejected professionalisation of surrogacy. Suggestions put to them that a limited non-profit making surrogacy service should be licensed met with the response that ‘...the existence of such a service would in itself encourage the growth of surrogacy’.

A minority dissent took a rather different view. They doubted that surrogacy would simply disappear and feared the development of risky do-it-yourself arrangements. The minority endorsed regulated surrogacy. The licensing authority responsible for other fertility services should have powers to license surrogacy agencies. Access to a surrogacy agency, and thus surrogacy services, would be exclusively by referral from a gynaecologist.

Had the minority proposals been accepted, surrogacy services too would have been thoroughly professionalised. In the event the Surrogacy Arrangements Act 1985 partially implemented the majority view prohibiting any third party from assisting in the making of a surrogacy arrangement on a commercial basis. Altruistic surrogacy, if surrogacy

34 With the consequences graphically described by Alex Capron, *op. cit.*
35 The debate on surrogacy within the Warnock Committee and thereafter is described in the *Review for Health Ministers of Current Arrangements for Payments and Regulation*, (Cm. 4068) (1998) (hereafter Surrogacy Review).
was supposed to be at all, was to be the order of the day in Britain. No criminal penalties attached to couples who paid the surrogate herself (or *vice versa*) but both applications for adoption and for parental orders under section 30 of the 1990 Act prescribed that no more than reasonable expenses should be paid to the surrogate. Surrogacy contracts were made expressly unenforceable.

Surrogacy did not wither on the vine. At least two non-profit making groups, COTS and SPC, established themselves as ‘agencies’ who introduced surrogates and couples, and advised and assisted with surrogacy arrangements. A number of infertility clinics actively started to engage themselves in helping to establish surrogate pregnancies. Reported payments to surrogates reached, in some instances, levels of £10K to £15K. Despite some favourable media attention, a number of high profile cases emerged where surrogacy had gone disastrously wrong. In July 1997, the British government decided to institute a review of certain aspects of the law pertaining to surrogacy.\(^{36}\) Essentially, government concern focused on whether some additional degree of regulation of surrogacy was desirable and whether payments to surrogate mothers should be allowed. In this section of the paper, I address primarily the regulation question.

Surrogacy’s current freedom from much of the regulatory regime controlling other infertility services has for many of those personally involved in surrogacy arrangements perceived advantages. Where a couple seek a full surrogacy arrangement and must thus resort to IVF in a licensed clinic, they are subject to analogous conditions of assessment designed to address the welfare of the child as any other client of a licensed clinic. Where partial surrogacy suffices, insemination of the surrogate by the male partner can be and, is usually, achieved without medical supervision or assistance. In either case, the nature and progress of the surrogacy arrangement itself is entirely in the hands of the parties themselves with support from a surrogacy agency if desired. Those who truly endorse a *genuinely permissive* approach to infertility treatment might applaud a state of affairs that leaves access to surrogacy so very much in the realm of private choice.

Yet surrogacy involves a multiplicity of risks, risks acknowledged by all those involved in surrogacy. They are well-rehearsed.\(^{37}\) The surrogate is asked to accept the physical risks and discomfort of pregnancy and childbirth and the unpredictable risks to her psychological well-being if she goes ahead and surrenders the child as agreed. Should the

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\(^{36}\) *Ibid*.

arrangement fail, the child’s infancy may be clouded by bitter dispute about its future, and the hopes of the couple are devastated. How children as they grow up will respond to knowledge of their origins remains unknown. Surrogacy takes families and society into uncharted waters. Moreover, three particular factors about British surrogacy exacerbate concern. (1) Evidence about comparative levels of income and education suggest a significant disparity of bargaining power between surrogate and couple. Most British surrogates are young women living on low incomes or state benefits, with few qualifications and supporting children on their own. (2) The overwhelming incidence of partial surrogacy established via self-insemination occasions danger both of physical risk to the surrogate from disease and emotional risks in that the very ease of the process may preclude time for reflection. (3) In navigating the uncharted waters of surrogacy the principal sources of advice, the voluntary surrogacy agencies, are essentially amateur operations.38

I plead guilty to hyperbole, but the current state of the law on surrogacy suggests a scenario in which the most dangerous infertility ‘activity’ is the least regulated. It is as though the government decided to regulate and license most watersports, including swimming, water aerobics, and springboard diving, yet omitted to regulate high diving.

In evidence submitted to the Surrogacy Review, nearly all respondents favoured some sort of additional regulation.39 To ensure surrogacy fits neatly into the British regulatory pattern, professionalisation along the lines of the minority proposal in Warnock might appear to be the obvious answer? Before examining why professionalisation (or at least medicalisation) was rejected in the context of surrogacy, a little more needs to be said about why professionalisation failed to take control of surrogacy in 1990. In 1984, when Warnock reported, the medical profession expressed profound opposition to surrogacy arguing that professional involvement in surrogacy was unethical. Prompted originally by the BMA,40 the profession has undergone a sea-change in attitude. Professional involvement in surrogacy where surrogacy offers the only realistic prospect of overcoming a couple’s inability to have a child is now endorsed by the majority of the profession. Certain clinics now regard repeated failed cycles of IVF, particularly in an older woman, as a sufficient indication to suggest resort to surrogacy. Both full and partial surrogacy are available under medical supervision.

38 See Surrogacy Review, paras 3.29 to 3.36.
39 Surrogacy Review, Annexes E1 and E2.
What of course private sector clinics cannot do is involve themselves directly in recruitment of a surrogate.

So why not medicalise surrogacy? The jurisdiction of the HFEA could be extended to license clinics (and associated agencies) to provide comprehensive surrogacy services. The British Fertility Society argued that regulation should make it ‘. . . necessary for all surrogacy arrangements, IVF and natural, to go through a proper process of medical assessment counselling and review by an Ethics Committee’.41 Professionals would ensure physical and psychological risks were addressed. Access to surrogacy would be put on just the same basis as access to IVF and gamete donation, entrusted to the doctors, under guidance from the HFEA, albeit at yet greater cost than other treatments. The British Fertility Society additionally recommended that surrogates should be paid for their service. They echoed a view put strongly by many respondents to the Review. If doctors, nurses and counsellors involved in IVF are paid for their services why should the surrogate not be paid for her reproductive labour?

Those groups currently involved in assisting in surrogacy arrangements also sought regulation, preferably a system which permitted them to be licensed and adequately funded. COTS argued eloquently that surrogates should be paid, but also that surrogacy contracts should be enforceable.42 COTS’s case highlights why surrogacy is special and would be difficult to fit neatly into the current framework of professionalisation. COTS advocates a novel variant of professionalisation, the recognition of surrogacy itself as an occupation (if not a profession). Surrogates should be regarded as service providers entitled to the same benefits as other fertility specialists (monetary reward) and subject to the same limitations, external regulation of how they do their ‘job’ and a contractual obligation to do what they agreed to do.

Thus two variants of professionalisation arrive on the agenda. We could develop and regulate medical surrogacy services, or, endorse and regulate professional surrogacy. The first option was rejected by the Review team because most of the aspects of surrogacy which make it ‘special’, which raise social and ethical questions absent in relation to other fertility services, are not medical questions. The professional expertise required to advise and assist those contemplating surrogacy is not a clinical expertise. Surrogacy is more closely analogous to adoption than IVF in its problematic areas. Moreover, given surrogacy services within the NHS are limited to one or two rare instances, clinics acting as, or in concert with, agencies would have profound difficulty in acting impartially between couple and surrogate. The couple would be

41 Surrogacy Review, para. 6.10.
42 Ibid., para. 3.34.
their clients and inevitably their prime concern. The second ‘solution’, professional surrogacy, radically challenges both our perceptions of fertility services as an essentially clinical and scientific endeavour, and, society’s understanding of motherhood.

To endorse the latter solution, to create in effect a regulated market in motherhood, would take Britain in a markedly different direction from its European partners and well down the road to recognition of a reproduction business. That road will be further explored in the final section of this paper. The proposals made to the government in the Surrogacy Review Report seek to develop special solutions for the special problems of surrogacy. Regulation should be implemented by requiring all agencies involved in assisting in surrogacy to be registered with the Department of Health and subject to a Code of Practice. That Code, binding on agencies, would also operate as an advisory document for all surrogacy arrangements, a manual of good practice. Given that the Review also rejects overt payment for a surrogate’s services, the number of surrogacy arrangements would be unlikely to grow. Were the Review’s proposals to be accepted, a policy of ‘containment’ might best describe the legal response to surrogacy.

VI. WHY THE FUSS ABOUT DONOR GAMETES?

At least in the context of surrogacy, the potential harms to the surrogate (and indeed to commissioning couples)\(^43\) may be universally recognised, albeit disagreement surfaces about how far the minimisation of such harm is anybody’s business but theirs. The various fusses about the use of donor gametes in the nine years since the passing of the 1990 Act may be harder to understand. Warnock’s concerns with ‘quality control’ have largely been met. Protection of the interests of the gamete recipient and her child are adequately addressed. Concerns about long term risks of freezing gametes, especially eggs, problems with poor success rates in unfreezing eggs remain.\(^44\) However, clinicians, scientists and regulators have an adequate framework in which to address problems. Any weakness in this system can not be charged against British laws.

A sharp focus of legal and social concern has in practice turned to questions of control of genetic heritage. How absolute, how rigorously enforced, should an individual’s command of his or her genes be? What rights have children to their heritage? When interests in genetic heritage


conflict with an individual or couple’s immediate interest in overcoming infertility, which set of interests takes precedence?

Informed and free consent on the part of gamete donors appears both fundamental and unexceptional, albeit in the Warnock Report itself there is much greater emphasis on the quality of consent of the couple receiving treatment, in particular the person who will ultimately parent a child to whom he or she is not genetically related. Schedule 3 of the 1990 Act nonetheless establishes detailed rules for ‘effective consent’ to gamete donation. Schedule 3 demands that all donors are offered relevant counselling, provided with all relevant information, and that consent be ‘given in writing’! English law imposes no legislative rule requiring that I consent in writing to surgical removal of all my reproductive organs. Yet I must consent in writing to the less invasive procedure of egg retrieval if those eggs are destined for another recipient. Is Schedule 3 be designed to protect my sovereignty over my genetic heritage?

Genetic heritage was at the heart of the Diane Blood controversy. I deal only with this one aspect of the Blood affair. Diane Blood and her husband Stephen had hoped to start a family. Tragically Stephen Blood contracted meningitis and lapsed into a coma. Doctors complied with his wife’s request to take sperm from her husband as he lay dying. His sperm was stored at a licensed clinic. The HFEA ruled that treating Mrs Blood with her husband’s sperm was unlawful. He had not given an ‘effective consent’, a consent in writing to storage and use of his sperm. Challenging the Authority’s decision by way of an application for judicial review, Mrs Blood argued (inter alia) that her husband had expressed to her his wish that, should he die before their planned family arrived, if it was possible, sperm should be taken from him so she could bear their child posthumously. Both the trial judge and the Court of Appeal ruled that treatment in the United Kingdom prohibited use of gametes without the written consent of the donor. The Court of Appeal, of course, did find in Mrs Blood’s favour on the issue of whether European Union law should have been considered by the HFEA in their original decision to refuse to allow the stored sperm to be exported so that Mrs Blood could be treated outside the United Kingdom. She was ultimately successfully treated in Belgium and a son born to her late last year. However, the appeal court categorised the taking of the sperm as unlawful, an assault on Mr Blood, and made it clear domestic law

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remained unchanged and that the Blood case was a ‘one-off’ which should never recur.

The principle of sovereignty over genetic heritage remains inviolate then. The donor’s interests in his gene pool trump the interests of the infertile individual? Such a position has been challenged as lacking in logic and consistency. Nature affords men no analogous control of their genes? Women have been known to deceive, seduce, entice reluctant partners into parting with their genes. If the principle is sound, should it prevail in private as well as public reproductive activity? In the USA a man is seeking to assert his right to control his genes by suing his former lover for stealing his sperm.46 That sovereignty over genes however can never truly be absolute is illustrated if we consider our prospective grandchildren. My daughter currently possesses 50 per cent of my gene pool. My interest in my genetic heritage dictates that I should have a say in how those genes of mine are utilised by her. Should I seek a declaration that her choice of my grandchildren’s father should be subject to my consent?

Diane Blood’s battle to have her deceased husband’s child provoked a storm of protest. Her plight attracted public sympathy. Calls were made to amend the 1990 Act to allow clinicians discretion to waive the requirements to written consent in deserving cases.47 The government asked Professor Sheila McLean to review the law relating to removal and use of donor gametes.48 She recommended retention of the rules arguing that the special status of gametes demanded a high standard of proof of the donor’s intent. Control of genetic material was not to be surrendered lightly.

In conceptualising Schedule 3 of the 1990 Act as protecting genetic heritage, do I read too much into the Act? I suspect I may, because elsewhere in the Act the interests of infertile individuals tend to gain priority over competing claims. Consider other provisions of the Act protecting the anonymity of donors and the recent debacle over continued payments of donors. Genetic heritage is not the sole domain of progenitors. My interest may be in the future of my genes. My descendants’ interests are in the history of their genes. An understanding of who they are involves an understanding of who I am. British legislation currently allows access only to non-identifying genetic information. Were I to have acted as an egg donor, my genetic daughter could at 18 apply to the HFEA, discover whether a proposed fiancé might be related

to her and receive such other information as the Authority is by regu-
lations required to give. But if my hypothetical daughter already exists,
those regulations cannot include information as to my identity. Access
to identifying information can be introduced only from a time when all
gamete donors are informed that their anonymity will no longer be
protected. Rightly or wrongly it is feared that granting children access
to their genetic identity will reduce the supply of donor gametes.

In relation to buying gametes, the HFEA Consultation Paper on
payment for gametes, expressed a principled stand against payments yet
for the time being payments are to continue. In issuing directions
allowing payments to continue, the HFEA reiterated their support for a
‘culture of altruism’. They justified continuation of payment because of
fears that removing payment ‘would seriously jeopardise the supply of
sperm donors’.49

Mrs Blood would no doubt characterise the British laws on donated
gametes as ‘prohibitive’, contrary to the interests of those seeking treat-
ment. She was unlucky. The framework for supply of donor gametes in
British law is deceptive. It appears to centre on protecting the interests
of donors. In reality its purposes are often to facilitate the supply of
gametes. Donors are ‘protected’ to encourage donation. They are
granted continuing control of their gametes to reassure future donors.
Their interest in anonymity is prioritised over their offspring’s interest
in their genetic heritage to forward the interests of those who seek to
benefit from fertility service, and are dependent on an adequate supply
of donor gametes.

VII. WHO CARES ABOUT EMBRYOS?

So far this paper has concentrated on fertility services, putting embryo
research to one side. Yet I initially asserted that controlling the use of in
vitro embryos was the engine which drove the Warnock proposals
which in turn resulted in the 1990 Act. Warnock was very bothered
about embryos. Who cares any more? Embryo research has flourished
in the United Kingdom. Within Europe, Britain again stands out as
‘permissive’ in its regulatory approach to experimentation on embryos.
Many of our partners in the European Union either prohibit research
outright, as does Germany, or hedge research around within often con-
tradictory restrictions on what kind of research are permitted.50 In
addition to a range of prohibitive controls on research, many European

49 Directions Given Under the Human Fertilisation and Embryology Act (Ref. D.1998/1)
7 December 1998.
countries impose other legal constraints on the creation, use and transfer of embryos, notably prohibiting embryo use for commercial or industrial purposes. Trade in embryos is banned.

British legislation permits research under licence from the HFEA for five specific ends.\(^{51}\) The HFEA may license research to promote advances in infertility treatment, to increase knowledge about the causes of congenital disease, to increase knowledge about the causes of miscarriages, to develop contraceptive treatments, and to develop methods for detecting genetic or chromosomal abnormalities. Additional purposes for which embryo research may be licensed may be specified in secondary legislation. The HFEA (in consultation with the Human Genetics Advisory Commission) recently proposed that two such new purposes should be specified in regulations, developing methods of therapy for mitochondrial diseases and developing methods of therapy for diseased or damaged tissues or organs (i.e. therapeutic cloning).\(^{52}\)

Embryo use in Britain is certainly controlled, yet the purposes for which human embryos may be used are widely drawn, and the boundaries are set to expand further. No restrictions are placed on the creation of embryos expressly for research purposes. Hundreds of thousands of embryos have in the United Kingdom been the subjects of inevitably destructive research. Are embryos in reality now treated any differently from laboratory artefacts, and treated with caution only because of their tendency to generate moral panic?

Such conceptual basis as there is to British law’s approach to embryo status is equivocal. The Warnock Committee declared that ‘the embryo of the human species ought to have a special status’.\(^{53}\) Similarly, in the USA the Ethics Advisory Board adjured that human embryos were entitled to ‘profound respect’. Mason robustly dismisses both statements as a nonsense. Embryos are either young humans with rights and interests common to their species or no more in truth than laboratory artefacts.\(^{54}\) If the latter, protecting or respecting a laboratory artefact would seem indeed a nonsense. Controlling research becomes important not because of any moral claim on behalf of the embryo but solely because of the potential consequences to society of where that research may lead.

Embryo equals artefact is a proposition which is anathema to those (including myself) who opposed allowing experimentation on embryos

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\(^{51}\) Sched. 2, para. 3(2).


\(^{53}\) Warnock Report, para. 11.17.

\(^{54}\) J.K. Mason, Human Life and Medical Practice (Edinburgh University Press 1988) at 94.
at all. However, we lost the war. Does that mean that the regulatory framework for controlling research should now ignore any notion of embryos as special, or at least any more special than human gametes? Anyone opposed to or even uncomfortable with embryo research should simply shut up? I hope not. Attempts to agree some intermediate status for embryos continue. Article 18 of the Council of Europe Convention on Human Rights and Biomedicine demands ‘adequate protection of the embryo’. Cries of vacuous may be heard, for the Article begs the question of what is adequate and adequate for what purpose?

To understand concern for embryos *qua* embryos we need to move beyond the scientific disciplines of medicine, law and philosophy and into the more human social sciences particularly social anthropology. Embryos retain symbolic importance.\(^{55}\) Reflect on the controversy over orphan embryos. Outrage greeted suggestions that where donors could not be traced, embryos should either be donated by the clinics to other infertile couples or used for research. Imagine any other abandoned human body product, for example, several pints of a very rare blood group. No one knows who donated the blood or who first had possession of the supply. Nonetheless screening proves the blood to be A1. If scientists who had control of the blood announced that they would neither release the blood for transfusion into a dying patient nor use it to further their research into blood cancers, that they would simply chuck it away, what public response might be predicted?

British legislation is muddled about embryos no doubt because the society it represents is muddled too. Embryos as laboratory artefacts (whatever the logic of the case) remains an unacceptable resolution of the debate or basis for control of research. Embryos as human beings with independent moral claims on society and the law is (alas) equally unrepresentative of either public judgement or public sentiment. For nine years British regulators have muddled through issues of embryo status. The advent of cloning forces us all to re-evaluate our understanding of embryo status and what controls should be placed on embryo research.

**VIII. WHAT SHALL WE DO ABOUT CLONING?**

Section 3(3)(d) of the 1990 Act prohibited one form of cloning (properly named nuclear substitution), that is the replacement of the nucleus of an embryo with a nucleus taken from any other person, embryo or development of an embryo. I suspect that legislators believed

section 3(3)(d) would outlaw the creation of ‘carbon copy’ clones. Dolly, the sheep who brought cloning into the public arena, was, however, created utilising nuclear substitution into an egg cell, not an embryo. Section 3(3)(d) does not prohibit that form of cloning. The HFEA argue that nonetheless human cloning by whatever means falls within their remit. Section 3(1) requires a licence from the HFEA to bring about the creation of an embryo. But what constitutes an embryo? Section 1 provides that ‘embryo means a live human embryo where fertilisation is complete’. When a cell, with its own complete complement of DNA, is taken from an adult fused with an unfertilised egg and cultured to divide and develop, is that process fertilisation? The Department of Health and the HFEA took counsel’s opinion and are content that the entity (embryo) created from fusion of egg and alien nucleus is fertilised, and so within the 1990 Act. I cannot agree.

Consider the analogy of plant production. You can reproduce your favourite rose in two ways. Ensure pollination and the creation of seeds resulting in a new rose, and you have a rose resulting from fertilisation. Take a cutting of that rose, root it in compost, and once again you have a new rose. But your second rose is genetically identical to its original and created by propagation not fertilisation. Nuclear substitution constitutes propagation not fertilisation. Consequently I would contend that nuclear substitution into an egg cell is unregulated in the United Kingdom today.

Debate about fertilisation or propagation is more than a lawyer’s tiff. Nuclear substitution challenges our understanding of what a human embryo is and what its moral claims may be. Many opponents of embryo research centre their opposition to destruction of embryos on the view that from the creation of a zygote a new genetic person comes into being. From fusion of egg and sperm begins a new human creature, endowed by God with a life separate from her parents. She has a novel genetic identity and, actually or potentially, her own immortal immaterial soul. What then of my clone? ‘She’ shares my DNA. She is me? Of course, while reproductive human cloning is almost certainly technically feasible, an English academic is unlikely to be able to afford reproductive cloning. More realistically I might look to use therapeutic cloning to repair damage to my tissue or organs. Nuclei taken from me could be inserted in (preferably) donated eggs and stem cells cultured to develop whatever cells or tissues I needed. Is an embryo created? I can (as yet) find no way through my own personal dilemma as to the fundamental nature of cloned cell tissue or organs.

What has been the public and legislative response to cloning? Once again a distinction must be drawn between reproductive cloning and

56 Cloning Report, para. 3.4.
what has come to be styled therapeutic cloning. Reproductive cloning has met with an almost universal negative response from governmental and official bodies. UNESCO and the Council of Europe have both condemned cloning of human beings as contrary to human dignity. The HFEA and HGAC in the United Kingdom endorses prohibition. Despite their belief that section 3 of the 1990 Act already prevents nuclear substitution into an egg cell without a licence from the HFEA, they state that the UK government ‘. . . may, nevertheless, consider the possibility of introducing primary or secondary legislation explicitly banning reproductive cloning regardless of the technique used’.

So what is wrong with cloning? The HFEA/HGAC Consultation, albeit endorsing a ban on reproductive cloning, seems lacking in passion in its opposition to reproductive cloning. They express concerns about its safety, yet only trial and error will prove or disprove such concerns. They float scenarios where cloning is used to ‘copy’ a dead child and argue it would be ‘. . . morally demeaning and psychologically damaging for someone to learn that the primary reason for their existence lay not in their own value, but in their utility for another purpose, as the substitute for someone else or for the benefit of someone else’. Yet might the same argument not be made in the not uncommon scenario of the landed gentry of England having five, six or more children just to ensure at last the birth of a son and heir.

The august bodies warm a little to cloning as an extreme measure to relieve infertility where nuclear substitution appears to be the only way to produce a genetically related embryo. The ‘relief of the pain of infertility is, in general, a good end’ we are told. That good, however, is balanced against an ‘unbalanced genetic relationship of an entirely unprecedented kind within a family’. The key to the British ‘official’ stance against reproductive cloning perhaps lies in the following sentence:

> For any type of infertility treatment to function satisfactorily there has to be a degree of social acceptance of the measures being taken. It is quite clear the human reproductive cloning is unacceptable to a substantial majority of the population.

Contemplating the advisory function entrusted to the HFEA, one might have hoped that body would inform public opinion promoting reasoned debate. Alas on this issue for Authority simply submits to a public sentiment uninformed by evidence. Astonishingly virtually none

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57 Cloning Report, para. 9.2.
58 For an incisively critical review of the Report, see J.M. Harris, ‘Cloning and Balanced Ethics’ (forthcoming).
59 Cloning Report, para. 4.8.
of the truly difficult questions ventilated elsewhere by Ruth Deech who chairs the HFEA are addressed in their report.60

Therapeutic cloning in contrast is endorsed by the HFEA and HGAC. The endorsement in the United Kingdom (unlike some other European jurisdictions) of the creation of embryos for research is seen as giving the green light to the specific creation of cell nucleus replacement, (cloned embryos), to develop cultured cell lines. Thus people suffering from injury or degenerative disease could provide their own nuclei, which would be replaced in eggs and stem cells would be developed. The resulting tissue (or organ) could be transplanted into the patient with no risk or rejection. The goods of therapeutic cloning outweigh any objections, which in any case the HFEA/HGAC appear to regard as simply rehashing the old debate on embryo use all over again. The only significant concern expressed by the HFEA/HGAC relates to commercialisation of such techniques which begs my final question of just what sort of an enterprise British law now seeks to regulate.

IX. PROFESSION OR MARKET?

The most profound change in regulating reproductive medicine since Warnock is, I would argue, the dramatically increased role of commerce. Warnock based its recommendations in relation to both fertility treatment and research on the supposition that fertility services would be integrated into the NHS and that research was essentially an ‘academic’ endeavour. The enormous commercial potential of developments in reproductive medicine was hardly foreseen, and opposition to commodification of reproduction was almost a given. Yet debate on commodification and commercialisation is at the forefront of debate today. A fertility ‘industry’ has developed to provide treatment on a profit-making basis both to British citizens and ‘procreative tourists’ escaping more prohibitive regimes elsewhere in Europe.61 Pressure to pay gamete donors and surrogates continue. Accepting HFEA/HGAC proposals to use embryos to develop therapies opens up new vistas for the biotechnology industry. Difficult questions confront regulators. (1) Whatever the pros and cons of recognising a reproduction market, is a covert market more dangerous than an overt market? (2) Given the diversity of regulation worldwide can any single jurisdiction continue to enforce its own rules?


The reproduction business, even in the United Kingdom, it set to
spawn two rather different sorts of market. The first, which effectively
exists today, is the market in fertility services. The private sector,
involving both private licensed fertility clinics and the companies who
will seek to develop both new fertility treatments and therapeutic
cloning, necessarily operates on a profit-making basis. They have a
vested interest in the expansion of their business. The more treatment
cycles a woman undergoes, the more people who seek treatment, the
greater the profit to a clinic. In the early years of the reproduction
revolution, feminist critics voiced considerable concern about the
potential exploitation of women in the name of science.62 Such criticism
has been more muted of late but regulators need to be vigilant to ensure
that their stated aim of ‘safety first’ is comprehensively met by the
fertility industry. And ‘safety first’ must mean more than minimisation
of physical risk. It extends to a mission to ensure that individuals are
enabled to make their own informed choices of how they spend their
money, and when, or if they confront the hazardous enterprise which
fertility treatment so often involves.

The second sort of reproduction market, existing only in embryo this
side of the Atlantic, involves trade in gametes and uteruses. It is a
market which in part derives from the market in fertility services. The
argument goes that if Dr Pater can be remunerated for harvesting
gametes or establishing a surrogate pregnancy, why should the gamete
donor and the surrogate mother not be paid for their services? Repro-
ductive labour should be valued and compensated.

The law in the United Kingdom has long outlawed trade in children.
Some proponents of markets in gametes and surrogacy contend paying
for gametes, remunerating surrogate mothers does not constitute in any
sense buying a child. In the context of surrogacy at least that claim is
hard to sustain. Who would be willing to pay for the surrogate’s labour
unconditionally, to commit themselves to compensate her for her
services regardless of whether or not she surrendered the child. Others
however have argued eloquently that buying children is not necessarily
wrong or dangerous.63 Objections to markets both in children and in
bodily services64 are based on prejudices or intuitions that profit some-
how debases an activity we commend when performed altruistically.65
Alex Capron argues the case against markets persuasively backed by

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   University Law Review 50–72.
64 See M.C. Nussbaum, “Whether from Reason or Prejudice”: Taking Money for Bodily
   Services’ (1958) 27 J. Legal Studies 693.
evidence of the operation of the US reproduction market.\textsuperscript{66} The debate in the United Kingdom has only just begun. It needs to be openly articulated. The proponents on markets may commend their advantages, but all concede that markets must be regulated as such. Allowing the development of a market in gametes or surrogacy within a system in no sense designed to police such a market could undermine the good work British regulators have done to far.

Another nightmare awaits the HFEA and its counterparts in Continental Europe. Each national jurisdiction has sought to fashion a scheme of regulation acceptable to its own culture and community. However those wealthy enough to participate in reproduction markets can readily evade their domestic constraints. If I can order sperm on the Internet, or hire a surrogate mother from Bolivia, are British regulators wasting their time? The international ramifications of the reproductive business may prove to be a more stringent test of the strength of British law than all the difficult ethical dilemmas that have gone before.

\textsuperscript{66} Above at n. 3.