

ARTIFICIAL INSEMINATION BY DONOR—AND BEYOND

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ASCHE

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MEDICO-LEGAL considerations probably achieve their greatest degree of intimacy in the realm of human reproduction. Ten to fifteen years ago our two professions were closely involved in the issues on the legal rights of woman *not* to have children, through debates on abortion, birth control for minors and sterilization procedures. Many of these issues are still unresolved. Today, because of recent rapid advances in medical technology, we are now debating the rights of certain infertile members of our society to be *able* to have children, and that is what our discussion is largely about tonight. Another way of simply summarising the problem is that the former concept of preventing children involves sex without pregnancy, whereas tonight's theme is actually pregnancy without sex. Both enterprises are highly contentious and complicated by many social, religious, ethical and legal problems.

A.I.D. (artificial insemination by donor) involves the replacement of the natural father by a biological father in order to achieve a pregnancy in an otherwise barren mating. A number of factors have made A.I.D. popular; the decline in babies for adoption, the very poor results of medical treatment of male infertility, the growing acceptance by the community of changes in sexual-reproductive behaviour, the availability of sperm banks that can deal with a large number of patients, and the high success-rate of A.I.D. Less than 10 per cent of infertile men can be cured today, whereas A.I.D. using frozen sperm can achieve a cumulative pregnancy-rate of 65 per cent in 6 months which is equal to the general pregnancy-rate of natural insemination. A.I.D. may also be used to avoid the birth of genetically deformed children by providing a more suitable genetic father.

The disadvantages of A.I.D. include its cost, possible psychological upsets in the parents or the offspring and potential legal implications regarding the legitimacy of the child. In arguing ethical and legal issues, A.I.D. is compared to both natural childbirth and

adoption, which is not unreasonable, but not necessarily valid, as the people involved and the procreative process differ. In adoption, considerable effort is made to select suitable parents for the child, rather than a suitable child for the parents, while in the natural process the child and parents have no choice. It is difficult to know what right of choice anyone has in the unnatural process, assuming there are no rights of choice in the natural process.

History of A.I.D.

Artificial insemination is surprisingly only a relatively recent event in medical technology. The first successful human artificial insemination was carried out by the renowned English surgeon John Hunter in 1785 using the husband's semen (A.I.H.). However, it was not until 1884 that Dr Pancoast in the U.S.A. performed the first successful artificial insemination by donor (A.I.D.). During the first half of this century, several studies were reported in the medical literature from both Europe and North America, but the main impetus for this work began in these countries during the last 25 years.

In Australia prior to 1970, there have been no medical reports of any A.I.D. practice although it was carried out very infrequently by a few doctors in a clandestine manner. In 1970 Dr Arthur Hill published the first paper on A.I.D. in Australia and described the treatment of 16 patients over 22 years. Eleven conceived after an unknown number of inseminations. This provocative article was very important as it made a strong plea for the further collection of data in this field. He also correctly predicted that a timid attitude of many doctors to the possible medico-legal risks would be a main reason for its relatively slow uptake in Australia.

The Melbourne Family Medical Centre is the largest A.I.D. clinic in Australia and one of the largest in the world, but has had a difficult career. It began in 1973 at the Queen Victoria Medical Centre but the hospital board soon ordered it to close "for ethical reasons". Monash University was not keen at that time to associate itself directly with this uncertain enterprise, so in 1977 we set up a private clinic under a trust agreement. This has advantages for more efficient management but is disadvantaged by the potential threat of litigation as it is without the protection of an affiliated hospital.

The demand for A.I.D. in Australia is difficult to assess. Currently about 600 couples are being treated yearly in Australia and it is calculated that about 1000 new cases could occur annually. This would produce about 800 babies annually in Australia. As the current

birth-rate in Australia is about 240,000 per year, A.I.D. could account for 0.3% of births at the most in this country.

All our treatment is with frozen banked sperm that is inseminated about twice per cycle at the time of ovulation by a simple, painless out-patient procedure. Donors are recruited from a wide range and are usually students who receive \$10.00 per specimen. The fees charged for A.I.D. insemination are \$140-\$200 per month, which is largely covered indirectly by medical health insurance rebates.

For purposes of discussing the medico-legal aspects of A.I.D. tonight, I believe our short legal consent-form summarizes the main issues. This form is discussed in detail with all clients before signature and subsequent A.I.D. treatment and is therefore a most relevant document for us to study. Issues discussed include the following:

1. Matching of donor. Donors are matched with the physical characteristics of the husband. The frozen semen samples are carefully coded and special care is taken to separate semen of non-Caucasian donors from that of Caucasian.
2. Confidentiality must be guaranteed to both the parents and the donor. The Victorian Evidence Act states that doctors cannot be forced to give medical evidence "without the consent of the patient". However, an A.I.D. treated woman could give such consent thus allowing a subpoena on a doctor to produce his records and identify the donor. Records are usually kept for several years, but could be destroyed after a certain time lapse. Laws are needed to protect this confidentiality.
3. Successful pregnancy outcome cannot be guaranteed.
4. There is no risk of foetal anomalies related to the technique of A.I.D. beyond that risk associated with a naturally conceived pregnancy.
5. Legitimacy of the child is difficult to discuss with each client, but it is attempted. It is probably the key issue in our discussion tonight, and I will therefore leave this legal topic for the Hon. Mr. Justice Asche to cover in his address to follow.

The two unlikely but serious potential risks that could attract high litigation with A.I.D. treatment are mismatching of the donor and possible gonococcal infection from the insemination. The former problem is unlikely as strict check-lists and codes are used, and also only a very few non-Caucasian couples are treated. The second problem is also very unlikely as donor semen is screened bacteriologically for every specimen, and freezing certainly inhibits the viability of the gonococcus. However, both risks could possibly occur over the years despite strict surveillance, and a very occasional report of each mishap has been seen in the world literature. It is probably mainly because of

these factors that the cost of medico-legal indemnity cover for A.I.D. in this state is exceptionally high, i.e. approximately \$10,000 yearly premium, which is prohibitive for our clinic.

What possible future problems can we expect? One problem facing the medical profession already is the right and the desirability of single women to achieve pregnancy by this means. My legal consent-form (see Appendix) stipulates the couple being "lawfully married". In recent months I have been requested to supply A.I.D. services to a few single women. Some have quoted the relevant provisions of the Equal Opportunity Act 1977 in their submission. Section 26 of this Act prohibits discrimination in the provision of professional services:

"It is unlawful for a person who provides goods or services to which this section applies to discriminate against another person on the ground of sex or marital status.

(a) By refusing to supply the goods or perform the services of any profession, trade or business".

As I have stated already, it is difficult to evaluate the right of choice we have in the unnatural process assuming there are no rights of choice in the natural one. As a society we already condone pregnancy and childbearing in single women by granting reasonable maintenance allowances. If I forbid A.I.D. treatment to single women I have been reminded of Section 28 of the Act that "Where a person aids, abets, counsels or procures another person to act in contravention of this Act, these persons shall be jointly or severally liable under this Act". This is indeed a "doctor's dilemma" and I would value your thoughts on this difficult issue.

Beyond A.I.D.

I have discussed the current medico-legal problems associated with the practice of A.I.D., but where can this practice lead to in the future? At this point I must diverge into another experimental arena in which the Monash Department of Obstetrics and Gynaecology is heavily involved, i.e. in vitro fertilisation and human embryo transfer (I.V.F. and E.T.). This work is showing significant success which is occurring now and in Melbourne, so that we all have a real responsibility to structure the ethical and legal aspects of this new technology. The subject of I.V.F. and E.T. is broad and far-reaching and deserves a separate presentation—I could strongly suggest it to the Medico-Legal Society as a topic for future discussion. I will restrict my remarks tonight to those aspects of I.V.F. that are clinically related to A.I.D.

I.V.F. and E.T. involve the surgical collection of several mature eggs from the ovary of a woman that has been stimulated by fertility pills, fertilising this egg with the husband's sperm in vitro and transferring this fertilised egg (zygote-embryo) back into the woman's uterus about 2 days later where a pregnancy may develop. Where possible we transfer two embryos back instead of one, as the pregnancy success-rate is significantly improved. To date we have a 9 per cent success-rate with this method and hope to improve this figure significantly.

Not all of these pregnancies are conceived with the husband's sperm however; i.e. A.I.D. has been used on 1 occasion in these 9 pregnancies. Actually we can never be certain that a husband's sperm can fertilise his wife's egg in some cases, so that in doubtful cases we will try to obtain 2 eggs and attempt fertilisation with the husband's sperm with one egg and donor sperm for the other—the latter acting as a control. If both eggs are fertilised the couple could choose to have the embryo produced by the husband's semen implanted and decline the donor inseminated embryo. This embryo could then be deep-frozen with the long-term view to implantation into another sterile recipient woman at a later date. This could lead to the development of a human embryo bank. To date no frozen-thawed embryos have produced a pregnancy. Such a recipient woman = surrogate, but would be herself pregnant = "uterine" mother = "legal" mother. This is certainly an area requiring legal definition in the near future.

The couple could request *both* embryos to be implanted simultaneously to produce twins—one conceived by the father and one by the donor! The medical reasoning behind this decision is that twin embryos do significantly increase the chance of pregnancy, but I do appreciate the possible legal problem involved in this exercise. This problem should be solved when the Attorneys General of the States have brought forward legislation to render an A.I.D. child born to a wife with the consent of her husband as legitimate, so that there will not be any legal discrimination between the twins. I am certain there will be no other form of discrimination between them. One certainly hopes that the above legislation will not be too long delayed.

In the above programme with 2 eggs for I.V.F., if the husband's sperm fails to fertilise its egg but the donor sperm succeeds, the couple have the choice to have this donor-inseminated embryo implanted, i.e. a medico-legal concept similar to A.I.D. If this attempt fails, A.I.D. could be advised as follow-up, and several pregnancies have been conceived by this programme.

When A.I.D. fails after 12 months treatment, I.V.F. is then offered to each couple. Several pregnancies have also resulted from this

scheme. One can readily see the close clinical relationship between these two basically different treatment techniques.

Embryo Freezing

This is a topical debate in Melbourne now. These embryos could come from the donor-inseminated embryos I have mentioned, but are currently husband-inseminated embryos which cannot be immediately replaced because (1) there are more than two, or (2) when uterine bleeding prohibits transfer during that cycle. I appreciate the moral and ethical aspects of this programme and welcome this dialogue which must continue until "society" understands its aims and implications.

In summarising the medico-legal problems associated with this rapidly developing new technology, I was somewhat surprised by a recent quote in the Herald 11/4/81 by Mr Justice Kirby, Head of the Law Reform Commission. "The issue I pose is whether we should tolerate such a science, allowing scientists and technologists to take our society where they will with no opportunity for us to consider the implications and lay down the acceptable rules within which these developments may occur. Society itself must state its standards". I disagree with his first two statements, but agree with the last one. Medical technology in human reproduction has never led society "where they will", but has always followed society's needs, often after a too lengthy delay, e.g. abortion and sterilization. Also there has been medico-legal dialogue on A.I.D. and I.V.F. over the last few years, and our work at Monash University is closely controlled by a broadly-based Ethics Committee including several senior legal advisers. It should also not be forgotten that our society already exercises considerable control over the rate of technological developments in this area by means of its granting power and the power it invests on its scientists and physicians. There is no evidence of excessive funding in these areas, in fact the reverse is true.

A great deal must be known about a problem and the subject area in which it occurs before legislation can be devised. A further problem associated with statute law is that, while it may reflect social attitudes at a certain time, it is always hard to change later as circumstances change, e.g. abortion and legislation regarding A.I.D. legitimacy. On the other hand doctors involved in A.I.D., I.V.F. and E.T. have to make difficult decisions against uncertain ethical, legal and social backgrounds. As a result many are dissuaded from attempting these new human reproductive techniques, and the nett result in terms of relieving individual distress in patients and society will be sub-

optimal. The real danger then is that individuals will be forced away from attempting these more difficult medical techniques and will establish their own less technical solutions, e.g. surrogate motherhood, where a couple will draw up a legal contract with another woman to be inseminated by the husband's sperm, bear "their" child and hand it back to the couple at birth for a certain fee by adoption. There are very few medical conditions where such a programme would be justified, but it has already been carried out in the U.K. and the U.S.A., and several advertisements have already appeared in the lay press in this country. The legal, ethical and emotional problems of such transactions will be less acceptable than the medical techniques I have been discussing tonight.

I believe these new developments in human reproductive medicine should best be continually reviewed by broad ethics committees who should advise rather than legislate. The difficulty of passing legislation on contentious moral issues such as abortion and capital punishment is well known. The issue is essentially the relationship between ethical and moral principles on the one hand with the law on the other, and one cannot be easily translated into the other. The courts cannot make legal judgements on any of these medical techniques because their own influencing agent—the opinion of society itself—has not yet been formed and expressed. This can only be achieved through honest medical representing of all aspects of this work and broad inter-disciplinary discussions that are accurately reported through responsible information channels.

HON. MR JUSTICE ASCHE

In a chapter contributed to a book edited by Professor Wood, Professor Leeton and Dr Kovacs and published last year, I urged the necessity for legislation to clarify certain pressing legal problems arising from the growth of A.I.D. procedures.

I said this:

"A leisurely progression of precedent upon precedent extending old cases to new circumstances is a totally impracticable solution in the case of A.I.D. Firstly, time does not permit: the problems grow daily and it would be scant comfort or justice to children spouses donors or doctors to assure them that over the next 50 years, and just possibly, the Courts will work their way through to a solution. Secondly, such case law as can be found is sparse and indeterminate and may, in any event, not be relevant to Australian conditions".

Although the book I refer to was published late last year, further events have occurred in Victoria which underline the necessity for legislation at least for A.I.D. procedures. Furthermore there have been two births this year through successful in vitro fertilisation, and a prospect of several more to come. There has been much discussion of the prospect of surrogate mothers. And the A.I.D. programmes at the Queen Victoria Hospital and the Royal Women's Hospital, have proceeded apace. Indeed, such is the success of the improved techniques of the medical staff at these hospitals, that it is no secret that Victoria leads the world in this field and almost daily requests are coming in to these hospitals from people in other countries including such medically advanced countries as the U.S.A.

It should be, as I am sure it is, a matter of great pride to all of us as Victorians, that the outstanding skill and ability of our doctors and medical researchers is being so widely recognised. It should be, and I hope it is, a matter of concern to all of us and particularly the lawyers, to see that the law does not lag behind. Some of the legal problems appearing are simple of solution: others are complex. Parental rights and duties; spousal rights and duties; laws of succession; medical responsibilities and confidentiality; registration of births; Testator's Family Maintenance; obligations to children; legitimacy of children; custody and access rights to children; these are perhaps the most outstanding matters to be considered; and it behoves us who are lawyers to work towards just, sensible and humane legislation to meet these problems.

If it be objected that the law should adopt a policy of *festina lente* because the class of persons likely to be affected is yet very small, I would reply that all indications are towards an increase in A.I.D. births. The number of births through in vitro fertilisation is presently statistically minute. But again, the signs are for an increase. The publicity given to A.I.D. and I.V.F. over the last few months must necessarily generate its own momentum. And as techniques improve and skills are passed on to others, it would be surprising if there were not a substantial rise in births from both procedures. Furthermore, it is not only the child born of these procedures who is affected by the legal situation. The spouses or de facto spouses become involved; and so does the donor, if the procedure adopted is A.I.D. or A.I.D. combined with I.V.F. So that with the birth of each child, at least three other persons may be affected in law. And this, of course, does not include the doctors and medical staff whose legal responsibilities must be considered.

If it is objected that the whole matter is too complicated for the law to deal with adequately, I would hope that any lawyer would repel the suggestion. A profession which for hundreds of years happily immers-

ed itself in the glorious complications of the Rule Against Perpetuities or the Rule in Shelley's case will not be disheartened from considering the legal situation of the testator who, having donated his sperm to posterity, leaves his estate equally to such of his children who shall be born within the next 50 years and such descendants of such children to the third generation who shall be born during such period, with appropriate provision for financial reward and support to those women willing to bear such children.

If it is suggested that such a situation is unlikely to arise, I should remind you of three factors:

- (a) Provision for storing of spermatozoa has now reached a stage where it can be successfully stored for many years and a period of 50 years is not unthinkable.
- (b) There is already on record a case, to which some publicity has been given, where a wife who had already had two children by her husband, conceived and bore a third child two years after her husband's death by the use of sperm stored by her husband prior to his death.
- (c) I doubt if anyone would suggest that there are not in the community, persons of sufficient wealth and egotism to desire that children be born to them after their death.

Lest one should be accused of suggesting that egotism is entirely a male prerogative, I should add that, although the technique has not yet been achieved, there appears to be no technological reason, why ova could not be stored over a period of years; thereby enabling a woman to make provision in her will that children born of her after her death, inherit under her estate.

Finally, there is no technological reason why a couple could not leave fertilised embryos as children for the future; again making appropriate provisions by wills or settlements. And nothing in these provisions would seem to place such children when born, outside the sort of classes normally contemplated by discretionary trusts, unless their births fell outside the perpetuity period.

Leaving aside these possibilities, it may be appropriate to summarize what I consider to be the most immediate problems which arise from the fact that there are already children in Victoria born of the A.I.D. and I.V.F. processes.

In law, there seems little doubt that a child born to a wife with the consent of her husband through an A.I.D. procedure, is illegitimate. The Status of Children Act passed by the Victorian Parliament in 1974, removes the legal disadvantages of an illegitimate child and removes, for the purpose of succession under any will, settlement or

intestacy, any disqualification previously applying to an illegitimate child of a person. Hence, upon appropriate proof, an illegitimate child may succeed to the estate of his father or mother by will or upon an intestacy in the same way as a legitimate child. But it seems clear that in law the expression "child" still means "biological child". Hence, a child born to a wife through A.I.D. cannot be a child of the *husband* and the Status of Children Act would not assist in this aspect. Indeed, it creates the rather alarming consequence that such a child could, if he should discover his biological father, successfully claim on intestacy or through will or settlement of that father. This may create somewhat of a problem for donors; a large group of whom I understand are medical students. As we know, most impoverished medical students develop, in the course of years, into doctors with large and lucrative practices whose estates may well be worthy of exploration by interested persons. While there may be immense difficulties of proof because of the strict confidentiality with which records are kept, it is not beyond possibility that by carelessness, stealth, the aid of a sympathetic nurse or doctor's secretary, or many other of the vicissitudes of life, the relationship may be discovered.

Leaving aside what one would hope to be remote possibilities, the problem remains that a child born to a wife through A.I.D. procedures and with the consent of the husband and, indeed, accepted by the husband as his child, would not succeed on intestacy nor through will or settlement to the husband's estate if the fact of an A.I.D. birth were proved sufficiently to rebut the presumption of legitimacy; unless, of course, such child was, at least in the case of a will or settlement, specifically described. It is true that in many cases the spouses may never reveal the true situation: but in many other cases they will do so; either deliberately, on the basis that the child should know the truth, or accidentally, or in the course of a marital dispute. One would assume that the clear duty of trustees of the estate in those circumstances would be to reject the child's claim and put him to proof, even though such a rejection may well have been contrary to the settlor's intention. The presumption of legitimacy would play a part in this exercise; but increasingly sophisticated serological and other scientific techniques for proof or disproof of paternity may well counterbalance the presumption.

Because of the growth and acceptance of de facto relationships, a similar problem would exist in the case of a woman in a de facto relationship giving birth to a child conceived by the A.I.D. procedure and the male partner accepting the child as his but not appropriately specifying the child in his will or settlement. So far as I know, no doc-

trine akin to the presumption of legitimacy has been applied by the Courts to de facto relationships.

Similarly, again, the problem will continue to succeeding generations i.e., a will or settlement of a man devising and bequeathing his estate to his grandchildren, nieces or nephews etc.

Several States in America now have simple legislation providing that where a child is born to a wife through A.I.D. and with the husband's consent, such child shall, for all purposes, be the legal child of the husband and shall not be the child of the donor. If such legislation is adopted in Victoria, one would hope to see a similar provision *mutatis mutandis*, relating to de facto couples.

Even this would not entirely cover the situation if a single woman wished to conceive a child through A.I.D. I appreciate that medical practitioners in this field have so far discouraged requests of this nature by single women. But since the operation is a simple one, there seems little doubt that a single woman with sufficient tenacity may ultimately persuade some person other than a doctor, to carry it out. It is well known, for instance, that some women living in a lesbian relationship, are extremely anxious that one member of the relationship have a child without the preliminary of sexual intercourse with a male. Consequently, although in such a case there would be no need to provide that any male person be deemed the father, it would still be necessary to provide for the protection of donors that the donor would not be deemed the father. Whether it is a matter of public policy to discourage such attempts, made without proper medical consent and counselling, is a matter for further debate. But assuming that it becomes acceptable, the donor should have the same protections.

This brings us to the overall question of public control of A.I.D. procedures. There are good reasons why these procedures should remain in the hands of competent persons; not only medical practitioners, but counsellors who can determine whether a request for A.I.D. should be granted. There is little doubt that amongst those seeking the procedure will be the neurotic and psychotic; or that some may have, unknown to them, genetic or medical problems which an examination would reveal. Furthermore, those operating the procedure should keep in mind, as they now do, the statistical probabilities of inter-marriage of siblings in the future. Statistics are presently known to and controlled by the doctors in the field. Unauthorized practitioners may not observe strict statistical controls or proper examination of the genetic background of donors and the matching of donors to donees. One would expect that there should be legislative

safeguards for these matters. Again the legislation would be relatively simple—directed mainly to licensing appropriate medical practitioners with consequential provisions for counselling, and prohibiting dealings by non-licensed persons.

Then there is the problem of confidentiality. The Victorian Evidence Act section 28(2) provides that, “no physician or surgeon shall, without the consent of his patient, divulge in any civil action or proceedings (unless the sanity or testamentary capacity of the patient is in dispute), any information which he has acquired in attending the patient and which was necessary for him to prescribe or act for the patient”.

Assuming that a woman upon whom A.I.D. is consensually performed comes within the definition of “patient”—and I would consider this to be so—the protection of the doctor in Victoria may be sufficient except where it is the patient herself who demands the information. This again may not be outside the bounds of possibility. It may, for instance, arise in a domestic dispute that the wife may wish to prove, not only that her child is not the husband’s child, but that the child has a known father. Could the doctor in such circumstances refuse to name the donor? The wife may have acquired, by improper means, information that a particular donor is the father. Section 10 of the Status of Children Act, provides that a woman who alleges that any named person is the father of her child, may apply to the Supreme Court for a declaration of paternity. To prove her case, she may subpoena the doctor. The privilege is not his but hers. If the Court ruled it relevant, the doctor would have to make disclosure or face a charge of contempt.

So far as A.I.D. is concerned, our politicians have not been inactive. Last year, the Attorneys-General of the States announced their intention to bring forward legislation to render legitimate an A.I.D. child born to a wife with the consent of the husband. Legislation has not yet been brought forward in any State. But, if the matter is to be tackled, I would suggest that the question of de facto partners at least be also included.

Let me turn, therefore, to the somewhat different question of I.V.F. The usual I.V.F. procedure where the ovum of the wife is removed and fertilised by the husband and then replaced in the wife, should cause no legal problems vis à vis husband and wife. The resultant child is clearly a child of the spouses. Similarly, if the ovum is fertilised by a male who is not the husband, the position is analogous to A.I.D. with the problems and possible solutions already discussed.

But developments in this field have moved with such astonishing rapidity, that there are already cases reported of a surrogate mother

bearing an A.I.D. child, usually for a fee. That in itself raises certain problems, if the surrogate mother becomes so attached to the child she bears, that she refuses to hand it over to the persons for whom she bore it. Since the child is truly her child, she would no doubt be in the position of the mother of an illegitimate child with the usually strong claim to custody that her position as a mother gives her. Recent case law has indicated that the father of an illegitimate child may, in appropriate circumstances, have a right to custody or access of that child, the test being the established test of the welfare of the child. Therefore, the father would have some chance of obtaining at least access. That may be scant comfort for a couple who had planned their future with a child who would at least be a child of the husband.

But it seems inevitable that the development will go one stage further. Let us suppose a wealthy couple wish to have children. The wife is unable to bear children but capable of donating an ovum which can be fertilised by the husband. Or let us suppose, since human nature is capable of many things, that the wife is perfectly prepared to have children but not to go to the trouble of bearing them. We now reach realms undreamed of in any philosophy of law which I know of. A fertilised embryo is, with the consent of the "parents" and with the consent of another woman, and, no doubt pursuant to a contract for financial consideration, implanted in that other woman to bear that child on condition that she hands the child, upon birth, to the parents. If, during her pregnancy she becomes emotionally attached to that child and desires to keep it, who is to have the custody of that child? This problem strikes at the very definition of the word "mother". The OED defines mother as, "a female parent", "a woman who has given birth to a child". These two definitions are not of great assistance because no one at the time the OED was compiled would have imagined that a female *parent* at least in the biological sense, could be a person who did not give birth to the child. It is true that the OED goes on to define parent as "a person who has begotten or borne a child". In the case under consideration, has the surrogate mother "begotten" the child? Leaving aside, for the moment, the question of custody, does the child stand to inherit in the estate of the mother or the surrogate mother? By broad analogy with the question of paternity, the child is the child of the woman who gave the ovum. But this may be an oversimplification because of the obvious fact that paternity requires merely the donation of semen. Maternity may comprehend two factors, the donation of ovum and the child-bearing role.

I know of no legal authorities of any assistance in these cases. It is too simple to say merely that the Court will determine the matter in the paramount interests of the child's welfare. That is undoubtedly

the test which would have to be applied if the child were made a Ward of Court, to enable the question of custody to be decided. But it begs the question if the dispute is over a newly born baby who is the biological child of two persons, but the womb child of another. It is with some relief that I reflect that under the constitutional rules presently prevailing, the question would be determined by the Supreme Court and not the Family Court.

I doubt whether the question would be decided on any basis of contract law. Possibly the surrogate mother could be ordered to return the moneys paid to her in pursuance of the contract, although the broad question of public policy may well be a factor against this. In a custodial dispute, the principle of the welfare of the child would certainly override contractual principles. Nor would it assist very greatly to argue that a woman who had undertaken to give birth to a child for commercial reasons would, *prima facie*, not be a proper mother. On the other hand the fact that the child is the biological child of two persons who have planned to receive the child into their family with the resultant advantage to the child of being brought up in his true genealogical line, might be an important factor. Lawyers will remember the celebrated case of *The King v. Jenkins ex parte Morrison* [1949] V.L.R. 277; the "whose baby" case. There seems little doubt that in that case and on the blood tests, two children were exchanged at birth. Barry J. whose judgment was ultimately reversed said:

"The assumption generally accepted in English speaking communities and acted upon by the Courts in matters such as this that if there are no disqualifying factors, the proper place for a child is with its own parents and their other children, rests upon the experience of countless generations of the family as an institution in vicissitudes and tribulations as well as in good fortune and times of happiness".

The decision was reversed by the Full Court partly on the technical grounds of uncertainty of the blood tests—not a ground which would be applicable today—but also on the grounds that the welfare of the three and a half year old child brought up in its present relationship determined that it remain in its present relationship.

In the case however, of the child newly born, it may well be that the observations of Barry J. would still be of considerable weight.

I regret that there are some parts of this paper where I have posed more questions than I have purported to solve. It may be that in some of those there is merit in allowing the processes of the law to develop by individual cases. In others such as paternity of A.I.D. children, I would hope that a legislative solution can be brought forward speedily.

We are obviously on the threshold of important developments which will not go away. Lawyers cannot shut their eyes and hope they will. While we have all been concerned that George Orwell's novel "1984" should not be fulfilled, it may have escaped our notice that Aldous Huxley's "Brave New World" may be more dangerously close than we realise. The law may soon have to step in with appropriate safeguards and protections without negating those developments which assist childless couples to have that which they most desire.

APPENDIX

CONSENT FOR ARTIFICIAL INSEMINATION

To Associate Professor J. Leeton
We (full name of husband)
and (full name of wife)
of (full address)

being lawfully married and desirous of having a child and having been advised that this is impossible to achieve by normal sexual intercourse between us, hereby request and authorise you or your assistants to inseminate artificially
(full name of wife) by means of semen supplied by a donor selected by you. We agree never to seek the identity of any donor. We understand that success cannot be guaranteed and that there is no risk of fetal anomalies related to this technique beyond those associated with a pregnancy conceived in a normal manner. We have also been advised about the possible legal implications regarding the legitimacy of the child.

Date:

Witness:

Address of Witness:

Signature: Wife:

Husband: