‘A Good Horse in the Stable’

by

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Royal Australian College of Surgeons.
The Chairman of the meeting was Dr. M. Cunningham.

The title of this address is taken from Oliver Goldsmith's comedy The Good Natur'd Man. The goodnatured man of the play is Mr. Honeywood, a young man having a character owing much, I suspect, to Goldsmith's own. Boswell said of Goldsmith that 'he, I am afraid, had no settled system of any sort, so that his conduct must not be strictly scrutinised: but his affections were social and generous, and when he had money he gave it away very liberally'. It was owing to the defects of such a character that Mr. Honeywood's uncle, Sir William, had in mind to disinherit the good-natured man as his heir. The play opens with Sir William telling Jarvis, Mr. Honeywood's loyal factotum, of his concern: he has written his nephew letters, he says, which 'taught him only that philosophy which might prevent, not defend his errors'. Jarvis replies:

> 'Faith, beggin-your honour's pardon, I'm sorry they taught him any philosophy at all; it has only serv'd to spoil him. This same philosophy is a good horse in the stable, but an errant jade on a journey.'

It will have been evident to you all that at the time when I was asked to give a paper I did not decide on the subject. The late Kevin Coleman, once said to me 'There is a golden rule for a lawyer when he undertakes any matter: he must throughout give himself room to swerve'. It is a wise remark, and not only because it came from a judge; members of the judiciary are often indeed wise but, we must remember not so well-informed in one respect as the rest of us. Everyone in this country is assumed to know the law — except the judiciary who are subject to appeal.

My subject to-night, you may be surprised to hear should be subtitled A Review and Some Comments on the Report of the Committee of Inquiry into Human Fertilisation and Embryology. It is known as the Warnock Committee after its distinguished Chairman Dame Mary Warnock, Mistress of Girton College Cambridge and Senior Research Fellow of St. Hugh's College Oxford. In the end I hope you will conclude that, nevertheless, the primary title was not inapt.

The Inquiry was established in July 1982, its terms of reference being:

> 'To consider recent and potential developments in medicine and science related to human fertilisation and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical and legal implications of these developments; and to make recommendations.'

It reported two years later, in July 1984 (Cmnd. 9314, H.M.S.O.). The Committee excluded totally from consideration related matters of abortion and contraception (para 1.3). They clarified the terms of reference in two ways: first by defining embryology for the purposes of the Report. The 'embryonic stage' they took to be the six weeks immediately following fertilisation, when the egg and sperm met: (para 1.4). Secondly they limited examination of potential developments:

> 'We took the pragmatic view that we could react only to what we knew, and what we could realistically foresee. This meant that we must react to the ways in which people now see childlessness and the process of family formation, taking into account the range of views encompassed by our pluralistic society, the nature and value of clinical and scientific advances and the benefits of research.' (para 1.5)

The body of the Report is thereafter concerned with two principal topics.

> 'We found it convenient to divide our task into two parts. The first concerned processes designed to benefit the individual within society who faced a particular problem, namely infertility; the second concerned the pursuit of knowledge, much of it designed to benefit society at large rather than the individual.' (para 1.6)

Accordingly the Report dealt under the first of those divisions with the following:

I *Artificial insemination (AI)* —
  (a) AIH, i.e., where the donor is the husband and thus the apparent parents are in fact also the genetic parents;
  (b) AID, i.e., where the donor is not the husband, and thus the carrying mother is the genetic mother but her husband is not the genetic father.
  (Chapter Four)

II *In Vitro fertilisation* (IVF). In the Report this heading is reserved for those cases of *in vitro* fertilisation where a mature egg is extracted from the ovary of the wife and is mixed with semen of the husband. The embryo (the fertilised egg) is then transferred to the wife's uterus; thus, the apparent parents are in fact the genetic parents.
(Chapter Five)

III *Egg Donation*
Where a mature egg is extracted from the ovary of a donor and is mixed with the semen of the husband; the resultant embryo is then transferred to the uterus of the wife; thus the carrying mother, the wife, is not the genetic mother but the husband is the genetic father.
(Chapter Six)

IV *Embryo donation*
This expression is used to cover —

(a) cases where a donated egg is fertilised *in vitro* with donated semen and the resulting embryo transferred to a woman who is unable to produce an egg and whose husband is infertile: thus neither is the wife the genetic mother nor the husband the genetic father;
(b) a method known as lavage in which at the time when the egg in the donor woman is naturally released she is artifically inseminated with semen — of the husband if he is fertile, of a donor if he is not. Three or four days later the donor's uterus is washed out, and the embryo is retrieved and transferred to the wife's uterus.

(Chapter Seven)

(Note: It is a curiosity that the Report does not use the term IVF to cover cases where the the semen with which the extracted egg is mixed is not that of the husband: this particular case is not in terms dealt with in the Report. In principle, however, it must, I think be understood to have been covered.)

The Report then deals with Surrogacy (Chapter 8) which it defines (para 8.1) as 'the practice whereby one woman carries a child for another with the intention that the child should be handed over after birth.' The Report speaks of the persons to whom the child is to be handed over as 'the commissioning parents'. The term surrogacy is then used to cover cases where the egg comes from the carrying mother and is fertilised by artificial insemination using the semen of the commissioning father or of a donor and, also, cases where the embryo is donated coming from the fertilisation of an egg of the commissioning mother or a donor, with the semen, in either case, of the commissioning father or a donor.

Chapters Three through Eight dealing with the foregoing matters are all entitled 'Techniques for the Alleviation of Infertility'. Chapter Nine deals with associated matters: it is entitled 'The Wider Use of These Techniques' and touches on the transmission of hereditary disease, sex selection and gender identification. Chapter Ten deals with a necessarily incidental matter — 'The Freezing and Storage of Human Semen, Eggs and Embryos'.

The second part of the division made by the Committee is substantially represented by Chapter Eleven on Scientific Issues, which deals with the question of whether or not there should be any use made of human embryos in experimentation and research.

Chapter Twelve deals with Possible Future Developments in Research (in particular, trans-species fertilisation). Chapter Thirteen concludes the body of the Report: it deals with the establishment of a statutory licensing authority to regulate both the research and the infertility services.

The whole is comprised in 100 pages more or less.

It is useful before looking at the recommendations to recall briefly what would now, no doubt, be termed the state of the art, and also certain published reports in the United Kingdom in earlier years.

It was accepted:

(i) that semen was able to be frozen so that when unfrozen it would be fertile;

(ii) that an egg was not, presently at least, able to be frozen so that when unfrozen it would be fertile;

(iii) that an embryo was able to be frozen so that when unfrozen it could resume division and hence growth;

(iv) that semen could be transferred to a uterus by artificial insemination. Moreover, although statistics were not available, the procedures of AIH and AID, though not commonly undertaken, were often employed, in particular under the National Health Service (NHS) pursuant to a decision of the Minister of Health in 1968 that both AIH and AID should be available within the NHS if recommended on medical grounds: these procedures are not, of course, *in vitro* fertilisation;

(v) that the procedure for extraction of an egg for prompt fertilisation with semen had been established for perhaps 15–20 years;

(vi) that I.V.F., the production *in vitro* of an embryo, was a scientific procedure known for a good number of years;

(vii) that the lavage procedure to which I have referred had been employed sometimes with success — that is, so that a fertilised egg was made available for transfer: on other occasions, the procedure had not produced the desired result and the woman who underwent the procedure retained the fertilised egg and bore the resultant child;

(viii) that an embryo could be transferred to a uterus and that IVF had been a procedure used successfully in the United Kingdom since 1978 and elsewhere for a number of years: not only were AIH and AID available within the NHS, IVF was also available. Again statistics were imperfect but they disclosed that from some thousands of cases where the IVF procedure had been employed, implantation (as evidenced by pregnancies) had occurred in some hundreds of cases; in cases in which implantation had occurred, a substantial proportion had resulted in live births; a substantial proportion had ended in miscarriages (or ectopic pregnancies).

(ix) that cases of surrogacy were known of, but were not provided for in the NHS.

The Committee noted (para 4.7) that in the immediately post-war years AID appeared to have been generally regarded as undesirable and wrong. Apart from the fact that a Commission appointed by the Archbishop of Canterbury (Artificial Human Insemination: the Report of a Commission appointed by His Grace the Archbishop of Canterbury, SPCK 1948), while not denying the propriety of AIH, had said in 1948 that AID was unacceptable, and the Archbishop had himself been 'highly critical' of the practice of AID, the Feversham Committee (Home Office and Scottish Home Department. Departmental Committee on Human Artificial Insemination Chairman: The Earl of Faversham HMSO 1960 Cmnd 1105) set up by the Government

> 'considered that AIH was an acceptable form of treatment for some couples, but believed that the majority within both society and the medical profession was opposed to the practice of AID. It concluded that AID was an undesirable practice strongly to be discouraged.'

As noted above, 'society', in the person of the Minister for Health, departed from that standpoint in 1968: then in 1971 the medical profession in the form of the British Medical Association appointed a panel to report on the medical aspects of AI. Sir John Peel was the Chairman and the Panel reported in 1973 recommending that the procedures of AID should be available within the NHS for those couples for whom it was appropriate — a number the panel apparently thought would not be large: the panel also recommended that in the NHS the service should be available only at accredited centres. Thereafter, the Warnock Committee remarked, 'the trend of increasing acceptability and demand for AID has continued.' But none of the centres where the procedures were the subject of advice or were made available was accredited. There was in fact no system of licensing or accreditation in existence for any of the procedures which are the subject of the Warnock Report.

As well the Warnock Committee took into account evidence from some three hundred persons or organisations.

The Committee itself consisted of sixteen distinguished members including several members of the medical profession, three lawyers and a number of professors, one of them a professor of theology. The Committee was not, as we shall see, unanimous on every topic, though it was on most.

The Committee's recommendations on the several aspects of relief of infertility were as follows:

(i) it saw no objection, moral or other, to AIH (para 4.4): nor did it see the need for or practical possibility of regulation save that the procedure should be administered by or under the supervision of a registered medical practitioner (para 4.5): but it added one limiting recommendation — that where a husband who had placed semen in a semen bank died, his widow should not be inseminated with that semen;

(ii) it recommended 'that AID should be available on a properly organised basis and subject to (certain) licensing arrangements . . . to those infertile couples for whom it might be appropriate' (para 4.16);

(iii) it recommended that the service of IVF should continue to be available, and within the NHS, and be subject to similar licensing and controls as recommended in regard to AID (para 5.10);

(iv) it recommended that egg donation be accepted as a recognised technique in the treatment of infertility subject to similar licensing and controls (para 6.6);

(v) it recommended that the form of embryo donation involving donated semen and egg which are brought together *in vitro* be accepted as a treatment for infertility, subject to similar licensing and controls (para 7.4);

(vi) it recommended that the technique of embryo donation by lavage should not be used at the present time (para 7.5);

(vii) it recommended that "legislation be introduced to render criminal the creation or operation in the United Kingdom of agencies whose purposes include the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wish to utilise the services of a carrying mother: such legislation should be wide enough to include both profit and non-profit making organisations. It further recommended that the legislation be sufficiently wide to render criminally liable the actions of professionals and others who knowingly assist in the establishment of a surrogate pregnancy (para 8.18);

(viii) it recommended that it be provided by statute that all surrogacy agreements are illegal contracts and therefore unenforceable in the courts (para 8.19);

(ix) it recommended that it should be accepted practice to offer donated gametes (the term used to cover semen and eggs) and embryos to those at risk of transmitting hereditary disorders (para 9.3).

From those recommendations directly concerned with procedures for the relief of infertility there was an expression of dissent from two members of the Committee limited to the question of surrogacy: (Expression of Dissent: A. Surrogacy — from Dr. Wendy

Greengross and Dr. David Davies.) The dissentients said that they endorsed in general the review of the question of surrogacy (para 2) and that 'we go along entirely with our colleagues in our disapproval of surrogacy for convenience' and with the proposed ban on profit-making agencies (para 3). They considered, however, that 'there are . . . rare occasions when surrogacy could be beneficial to couples as a last resort' (para 1). They concluded that because surrogacy was only a recent manifestation it was 'too early to take a final decision one way or the other' (para 9); 'it would be a mistake to close the door completely on surrogacy being offered as a treatment for childlessness' (para 5). They recommended careful licensing in some detail.

It would be possible, though in many cases, no doubt, not easy, to implement all the procedures recommended by the majority, and surrogacy too, without recourse to using frozen semen or embryos. In particular, the committee accepted that in the cases of IVF and embryo donation, superovulation, the production of a number of eggs for fertilisation with semen, was desirable and it was also desirable to transfer a number of embryos to the uterus of the carrying wife: probability of successful implantation was thereby markedly increased. There would thus be surplus embryos, and should a second or subsequent transferral for implantation be required (whether because the implantation did not take place, or because a child was not born of the pregnancy, or otherwise) storage of embryos would be a facility promoting the objects primarily recommended. Accepting that frozen semen and embryos had been used with success but frozen eggs not, the Committee recommended that the use of frozen semen and frozen embryos be continued, but not frozen eggs 'until research has shown that no unacceptable risk is involved.' Facilities for the storage of frozen semen and frozen embryos should be established, licensed by and under the supervision of the proposed statutory licensing authority.

The Committee necessarily considered the legal aspects incidental to these procedures. In substance they turn principally on the question of legitimacy and status, but by way of foundation it was recommended first that any third party donating gametes for infertility treatment should be unknown to the couple at any time and equally the third party should not know the identity of the couple being helped: (para 3.2). Secondly the Committee recommended that (except, of course, in cases where the ostensible parents were both the genetic parents) any child born by use of these procedures should at the age of eighteen have access to information about the donor's (or donors') ethnic origin and genetic health — that and no more: (para 4.21). Then, in the case of AID, the consent in writing of both parties to the treatment must be obtained (para 4.23), and in the more specialised procedures such consent in writing should be obtained 'wherever possible': (para 4.21). In accordance with a prior recommendation of the English Law Commission, in cases of AID the husband's consent should be presumed unless the contrary be proved (para 4.24). It seems that the Committee thought such a rule should apply generally to the procedures it approved. (The wife's consent was not a subject adverted to, for evident reasons). Any donor as contemplated by the Report should have no parental responsibilities in relation to a child born by use of his/her gametes: (paras. 4.22 and 6.8). (The number of children born from use of the semen or eggs of any one donor should be limited to ten: (paras. 4.26 and 6.6).) The central problems of legitimacy were then dealt with as follows:

(i) subject to his consent having been given (see above) any AID child (para. 4.17) and presumably any child resulting from embryo donation where the semen was donated, should for all purposes be regarded in law as the child of the husband of the carrying mother (who in most of the cases would be the genetic mother) notwithstanding that the husband was not in fact the genetic father: where non-consent was proved the child would not be his child and would accordingly be illegitimate;

(ii) in cases of egg donation (covering, that is, embryo donation) the carrying mother should for all purposes be regarded in law as the mother of the child (para 6.8);

(iii) any child born by AIH or IVF who was not *in utero* at the date of death of its genetic father should be disregarded for the purposes of succession to and inheritance from that father (paras. 10.9 and 10.15): but the Report appears to contemplate that where a commissioning couple have caused semen or an embryo to be stored, upon the death of the husband the wife might yet have that semen placed in or that embryo transferred to her uterus and bear a child (para 10.12); and

(iv) for the purpose of establishing primogeniture the date and time of birth and note the date of fertilisation should be the determining factor.

A consequential change in the law also recommended is that the husband where he is not the genetic father and the wife where she is not the genetic mother should be permitted to register themselves as father and mother with liberty, should it be desired, to add the words 'by donation' (paras. 4.25 and 6.8). In the present state of the law to do those things would be an offence, Section 4 of the Perjury Act (England and Wales); Section 53 of the Registration of Births Deaths and Marriages (Scotland) Act 1965.

I have in the above account spoken of husband and wife and impliedly, therefore, of marriage. The Report, which uses like terminology explains (para 2.6) that it uses these words to denote a relationship, not a legal status: the Report's reasoning and recommendations as to the availability of the procedures, consent and obligations apply to all heterosexual couples living together in a stable relationship. That appears to apply also to the recommendations as to registration. Of course, if the husband and wife are not married a child deemed in this way to be a child of such 'marriage relationship' will not be legitimate any more than any other child of such 'marriage relationship'.

The Committee made recommendations with a legal aspect in relation to semen frozen and stored and embryos frozen and stored. It appears to have contemplated that a donor of semen that was stored should have no rights as to that semen: where the semen of a husband (or, semble, of a man not at the time in any marriage relationship but not acting as a donor) was stored the couple involved or as the case might be, such unmarried man, should, subject as noted below, have the right of disposal (para 10.8). Presumably like rules would apply in the case of stored eggs should that procedure become possible. Where an embryo was frozen and stored no donor of gametes brought together and resulting in that embryo should have any right, in respect thereof but, subject to as noted below, the commissioning couple should have the right of disposal (para 10.12). In the language of the Report, a donor is not a depositor: but both a husband and a man not at the time in a marriage relationship but intending the semen to be stored for his use or disposal are depositors; and where an embryo is frozen the commissioning couple are depositors. So too, if freezing the eggs becomes possible, a wife and a woman not at the time in a marriage relationship but intending the eggs to be stored for her use and disposal would be depositors.

In the case of frozen semen and, should freezing of eggs subsequently become possible, frozen eggs, the Committee further recommended that there should be five-yearly reviews of semen and egg deposits. 'We recommend . . . that where a person dies during the storage period or cannot be traced at a review date the right of use or disposal of his or her frozen gametes should pass to the storage authority' (para 10.8) — that authority being the licensing authority. That appears not to apply to donors — for if it did, records identifying donors precisely and not merely their ethnic origin and genetic health would be kept. This does not appear to be contemplated — and if that is so the Report does not deal with the length of time during which donated semen or eggs may be kept or who may decide about their disposal — otherwise, that is, than by use in one of the procedures referred to.

As to stored embryos the Committee recommended that legislation be passed to ensure that there is no right of ownership in a human embryo (para 10.11). Nevertheless, the depositing couple who have stored an embryo or the survivor of them should together have the right of 'use or disposal' of that embryo for a period of ten years from the date of deposit (para 10.10 and 10.11). The right to use or disposal of that embryo should pass to the authority at the end of that period and also during that period if both husband and wife should die or if husband and wife should not agree to the manner of its use or disposal (paras 10.10–10.13).

There is a common element (other, that is, that the regulating and supervisory role of the statutory licensing authority) between those proposals and the recommendations at which the Committee arrived concerning experimentation with embryos. First let me state the recommendations on research and experimentation. The basic recommendation of the majority (for the matter was the subject of the second dissent) is that legislation should provide that research may be carried out on any embryo resulting from *in vitro* fertilisation, whatever its provenance, up to the end of the fourteenth day after fertilisation, but subject to all other restrictions as may be imposed by the licensing body (para 11.30). The Committee made clear that they contemplated that 'spare' embryos — that is embryos brought about by the IVF procedures but not required — should be available for use for research and experimentation (para 11.23), but only with the consent of the commissioning couple whenever that was able to be obtained. That period accorded with a prior recommendation that no live human embryo derived from *in vitro* fertilisation, whether frozen or unfrozen may be kept alive, if not transferred to a woman, beyond fourteen days after fertilisation (para 11.22). In neither of those cases was the 14-day period to include any time during which the embryo might have been frozen (para 11.22). The Committee further recommended that the handling of and research conducted on human *in vitro* embryos should be permitted only under licence (para 11.18) and that any such handling or research beyond the 14-day period referred to above should be a criminal offence. As to the limits of research, the Committee believed 'that a broad division into two categories can be made. The first which we term pure research, is arrived at with increasing and developing knowledge of the very early stages of the human embryo; the second, applied research, is research with direct diagnostic or therapeutic aims for the human embryo, or for the alleviation of infertility in general. Research aimed at improving IVF techniques would come into this 'second category' (para 11.10). In particular (para 11.18) human embryos should not be frivolously or unnecessarily used in research.

> In relation to the foregoing there was dissent; Expression of Dissent: B. Use of Human Embryos in Research was subscribed by three members of the Committee, Mrs. Carriline, Professor Marshall and Mrs. Walker. They recommended that embryos be created only for transferring to the uterus for implantation (para 1) and that experimentation on the human embryo be not permitted (para 5). They also recommended (para 10) that the embryo of the human species be afforded special protection under the law. They concluded that embryos should not be created with a view to their destruction in order to improve the results from *in vitro* fertilisation. Their second paragraph, 'When does life begin?' might well have appeared in the Report itself. They pointed out that the problem is not that the embryo is also living. They went on to say that the question 'When does the human person come into existence?' is susceptible to many

answers. The ultimate question was, they suggested, 'At what stage of development should the status of a person be accorded to an embryo of the human species?'. But even before then, a special status was in their view appropriate. On the factual side they said (para 6):

> 'A ban on experimentation will not halt progress in the treatment of infertility. Progress can still be made by animal and other experimentation and by the constant endeavour to improve the treatment procedure. Comparison with heart transplantation makes this clear'.

This statement of fact contrasts with the majority's statement (para 11.15).

> 'Although many research studies in embryology and developmental biology can be carried out on animal subjects, and it is possible in many cases to extrapolate these results and findings to man, in certain situations there is no substitute for the use of human embryos. This particularly applies to the study of disorders occurring only in humans, such as Down's syndrome, or for research into the processes of human fertilisation, or perhaps into the specific effect of drugs or toxic substances on human tissue.

There was a further dissent.

Expression of Dissent: C. Use of Human Embryos in Research was subscribed by four members, Mr. Barker Q.C., Professor Dyson, Mrs. Edwards and Dr. Greengross. Those members dissented from the view that 'research should be permitted on embryos bought into existence specifically for that purpose or coming into existence as a result of other research.' That is, they were prepared to allow research on embryos only if the embryos were 'spare' (in the terminology of the Report) — that is fertilised for the purpose of transfer for implantation. The dissenters took the view that it was wrong, morally wrong, to produce embryos by IVF on any basis other than that they were intended for transfer and implantation.

That survey of the Warnock report has, I fear, been long but not I hope tedious. It is difficult to summarise and do justice to a report which is itself densely written. I have omitted reference to some matters, such as trans-species fertilisation (which the Committee was against) because they are peripheral for present purposes. Now I have covered the extent of the observations about the role of the recommended statutory authority, which included collection of statistics and follow-up studies as well as licensing and supervision. The reason for the omission is that its powers were to be regulatory and administrative whereas the purpose this evening has been to concentrate on principles and substance. Because of the involvement of the NHS, the consequence of the recommendations would be to devote a proportion of national revenue — of the health services budget, whether augmented for the purpose or not — to their implementation. I shall not comment on the desirability of using public funds in this way — the allocation of resources for this purpose, as the current idiom would be. Again, I confine myself to the primary question of whether, assuming moneys to be available, such procedures should be engaged in at all. I turn, therefore, to the reasoning given and attitudes set out in the Report.

No doubt the Committee took into account and was influenced, rightly if I may say so, by the fact that the procedures with which it was concerned were being used (and had in some cases long been used) to a greater or lesser extent, and by the views expressed in the earlier reports to which I have referred. Two things are, however, clear. The first is that the Committee was conscious from the outset that a central question was whether the existing state of affairs, the availability of such procedures, their conduct within the NHS and the condition the law, should be reformed. The Committee rightly did not shrink from that implication or take the view attributed to the Duke of Cambridge (1774–1850):

> 'They say I am against reform; I am not against reform. There is a time for everything — and the time for reform is when it can no longer be resisted.'

The second is that, consistently, they made clear that they were facing fundamental issues of ethics and morals: their concern was to recommend what it was right to do — to approve and allow, to forbid or facilitate. The Report begins with a Foreword from which I take the following excerpts by way of illustration:

> As to ethics: 'We had to direct our attention not only to future practice and possible legislation, but to the principles on which such practices and such legislation would rest': (para. 1)

> As to morals: 'If, as we believe, it was our task to attempt to discover the public good, in the widest sense, and to make recommendations in the light of that, then we had, in the words of one philosopher, to adopt "a steady and general point of view" ': (para. 2)
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> 'A strict utilitarian would suppose that, given certain procedures, it would be possible to calculate their benefits and their costs. Future advantages, therapeutic or scientific, should be weighed against present and future harm. However, even if such a calculation were possible, it could not provide a final or verifiable answer to the question whether it is *right* that such procedures should be carried out': (para. 4)
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> 'The law itself, binding on everyone in society, whatever their beliefs, is the embodiment of a common moral position. It sets out a broad framework of what is morally acceptable within society. Another philosopher puts it thus: 'The reasons that lead a reflective man to prefer one . . . legal system to another must be moral reasons: that is he must find his reasons in some priority of interests and activities, in the kind of life that he praisies or admires'. In recommending legislation, then, we are recommending a kind of society that we can, all of us, praise and admire, even if, in detail, we may individually wish that it were different': (para 6)

This philosophy is, to my mind, a good horse in the stable, but does it prove to be an errant jade on the journey on which the Committee then embarked?

Let me deal with one preliminary matter which involves moral considerations of a separate though connected kind. The Report speaks of husband and wife as including a couple in a stable *de facto* marriage relationship: the procedures recommended are to be equally available to them as to an actually married couple. No doubt it may be said with justice that if such procedures are available to married couples why should the benefit and happiness which are predicated upon their use be denied to those in a stable, de facto, marriage-relationship. Moreover, the policing of an exclusion would be very difficult not to say invidious. (There is as well a practical aspect. The Office of Population, Census and Surveys in the United Kingdom has recently reported that about 17 per cent of all babies born in England and Wales last year were illegitimate, 108,000 out of 637,000. There were, incidentally, wide variations in illegitimacy rates according to national or ethnic backgrounds. The percentage of illegitimate births to mothers who were born in India, Pakistan, Bangladesh and 'the East African Commonwealth' is low — between 1 and 3 per cent. The comparable figure for mothers born in 'the Carribean Commonwealth' is around 50 per cent.) How is the characteristic of stability to be determined in any case? It may be said that counselling will solve the problem, but it seems hard to contemplate the prospect of a counsellor having a power of discretion of that kind. It may be that counselling will lead to the result that in general only those who are in fact in a stable relationship will undertake the procedures, but that is another matter. This criterion of a stable relationship will prove to be an errant jade in the journey of life. I suspect that if these procedures are to be available to couples who need not be married then no further criterion such as that conveyed by the word stable will be useful or effective; they will simply be available to all. The Committee themselves effectually acknowledge that 'stable' is window-dressing: 'we recognise that it is impossible to predict with any certainty how lasting such a relationship' (i.e. a two-parent family) 'will be': (para 2.11).

The second observation of that sort which I should make is in relation to the Committee's views as to eligibility for treatment. After expressing the view that 'every patient is entitled to advice and investigation of his or her infertility', they go on to say (para 2.12) 'we can foresee occasions where the consultant may, after discussion with professional health and social work colleagues, consider that there are valid reasons why infertility treatment would not be in the best interests of the patient, the child that may be born following treatment, or the patient's immediate family'. The consultant is, or is principally, the doctor. They go on (para 2.13):

> 'We recognise that this will place a heavy burden of responsibility on the individual consultant who must make social judgments that go beyond the purely medical'.

They decided that 'it was not possible to draw up comprehensive criteria that would be sensitive to the circumstances of every case'. (To interpolate, that surely *must* be true — and obvious). 'We recognise however that individual practitioners are on occasions going to decline to provide treatment and we recommend that in cases where consultants decline to provide treatment they should always give the patient a full explanation of the reasons. This would at least ensure that patients were not kept in ignorance of the reason for refusal, and would be able to exercise their right to seek a second opinion.'

In my respectful view those passages amount to little and insofar as they go beyond suggest the impractical. We all know that doctors are accustomed to informing their conclusions and advice with considerations going beyond the specifically medical and embracing wisdom derived from experience and from a wider knowledge of the individual patient. If that is what the passage means the pronouncements are effectively window-dressing: it states what would in any event be the case. If it is intended to mean more, then the burden referred to is not merely heavy but intolerable. The doctor would be required to venture beyond his functions and, many would think, would be invested with a discretion which no system of government of which we approve should be prepared to confer.

The sensible conclusion from making the procedures available is that patients who consult a doctor will be entitled in accordance with the ordinary rule to help, within the perceived limits of medical advice. That will naturally include cases where the doctor will decline treatment, and in doing so he should be allowed to exercise his customary discretion as to what he says. So far as non-medical counselling is concerned I should suggest that those who seek it should be informed and, if they seek it, advised, but subject to that, the decision must be theirs.

The provisions for, and, it may fairly be said, the observations about, the welfare of the children who are the result of these procedures, are limited. The body of empirical knowledge about them must, I should have thought, be small. I should agree with the recommendations about legitimacy: it would be quite wrong, where such procedures are followed involving donated gametes, to burden the resulting children with illegitimacy. In that regard if in no other their case must surely prevail over any general, however well-based, views as to the ordered state and proper inferences of the marriage bond. As to reservations about the availability of the procedures to unmarried couples in the context of considering the children, I doubt the value of debate. If the procedures are available at all they will be available to them. In general, this horse is not to be found in the stable: it has bolted already. In particular, it is not yet another matter to load onto the doctors. As to the advisability of telling children born of donated gametes (semen or eggs or both) of the ethnic origins and genetic health of the donor or donors, there are two problems. First, whether children or all children should be told: the question arises for fear of the effect it may have on them. There must be an empirical answer and I accept that Warnock Committee's Report reflects that. Secondly, if the names of donors of gametes are to be kept — and surely they should be for reasons of subsequent evidence as to their health — I suspect that as with adopted children, limiting the information given to children of the ethnic origin and genetic health of donors will break down.

A reader of the Warnock Report cannot fail to be struck by the fact that after the emphasis in the Foreword on morals and ethics there is very little analysis of moral aspects and no exegesis at any point on a system of moral considerations. Such analysis as there is aside from occasional references to individual goods on a utilitarian or quasi-utiliarian basis, is found in Chapter Two. There (para 2.14) the following points are made:

(i) To the objection of over population it is said, rightly so far as I am in a position to judge, that the increase in population by use of these procedures will in relative terms be negligible;

(ii) That the objection that such procedures are not 'natural', is unconvincing: the concepts 'natural' and 'unnatural' are ambiguous: they might have added, in my view, that on a broad definition such procedures would be regarded as natural, just as other advanced medical treatments may be said to be comprehended within the order of things;

(iii) To the objection that the procedures meet only wishes not needs, the Committee said:

> 'Medicine is no longer exclusively concerned with the preservation of human life, but with remedying the malfunctions of the human body. On this analysis, an inability to have children is a malfunction and should be considered in exactly the same way as any other. Furthermore infertility may be the result of some disorder which in itself needs treatment for the benefit of the patient's health. Infertility is not something mysterious, nor

> a cause of shame, nor necessarily something that has to be endured without attempted cure. In addition, the psychological distress that may be caused by infertility in those who want children may precipitate a mental disorder warranting treatment. It is, in our view, better to treat the primary cause of such distress than to alleviate the symptoms. In summary, we conclude that infertility is a condition meriting treatment.'

To that should be added the Committee's later recommendation, covering *fertile* couples, that donated gametes and embryos should be available to those at risk of transmitting hereditary disorders.

My time has vitually expired. Like all sensitive speakers, I do not mind members of the audience looking at their watches: but I am put out when I see them holding their watches to their ears. In conclusion may I make these points:

1. AIH appears to me to be unexceptionable in every aspect.
2. AID is with us and as a medical procedure is unexceptionable. Furthermore, given consent, it is less of an assault on the established social order than adoption: it raises no further question.
3. IVF — in all its forms, with donated gametes or not, again appears to me to constitute assault on the social order to an extent no greater than long-practised adoption.

If there is a problem it is with IVF. The simplicity of the problem is not stated in the Report. It is twofold.

First if IVF is practised then in all, most, or certainly many cases, there will be, in the terminology of the Report, surplus embryos after employment of the procedure of transference for implantation. Those surplus embryos could be frozen and within limits used for subsequent transfers for implantation. Some will not be suitable, and it may be expected that some simply will not be required. Permanent freezing can be no different from termination of life; it is a form of termination.

It seems to me a fact, though I am open, of course, to correction, that the use of IVF necessarily involves termination of the existence of embryos brought into being.

Secondly, if IVF is practised, I see no way out of some experimentation or research on embryos at least within the time limit within which transference for implantation is indicated — say, as the Warnock Report suggests on an explained medical basis, fourteen days. In speaking of such research and experimentation I mean *only* such programs as are designed to make the production of embryos for transference and implantation as safe and successful as possible. That must surely be owed to resulting children. If IVF is practised at all there will be terminations of the existence of embryos. It should be clearly seen, so far as my understanding goes, that the fact is that that will occur in the use of IVF procedures aside from research and experimentation.

In what has become a great debate I have attempted in this paper to present a framework for discussion and understanding. I do not conclude by stating my own imperfect beliefs: to do so would be superficial and it is unnecessary, since in the Committee's words 'matters of ultimate value are not susceptible of proof'. Many here will no doubt have been long persuaded one way or the other and I apologise if the paper has therefore been of little interest to them, but to them, and to you all, I should say that I have throughout been mindful of this saying:

> 'All men wish to have truth on their side: but few to be on the side of truth'.
>
> Richard Whately (1787–1863) Archbishop of Dublin.