

[Emily Jackson](#)

## The law and DIY assisted conception

### Book section

**Original citation:**

Jackson, Emily (2015) The law and DIY assisted conception. In: Horsey, Kirsty, (ed.) Revisiting the Regulation of Human Fertilisation and Embryology. Biomedical law and ethics library. Routledge, Abingdon, UK, pp. 31-49. ISBN 9781138021891

© 2015 [The Routledge](#)

This version available at: <http://eprints.lse.ac.uk/64232/>

Available in LSE Research Online: April 2016

LSE has developed LSE Research Online so that users may access research output of the School. Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in LSE Research Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain. You may freely distribute the URL (<http://eprints.lse.ac.uk>) of the LSE Research Online website.

This document is the author's submitted version of the book section. There may be differences between this version and the published version. You are advised to consult the publisher's version if you wish to cite from it.

# The Law and DIY Assisted Conception

Emily Jackson, LSE

## 1. Introduction

In the UK, fertility treatment services have been the subject of intensive regulation for nearly twenty five years. When the Human Fertilisation and Embryology Authority (HFEA) was set up in 1991, it was largely taken for granted that British citizens with a need for fertility treatment would seek treatment in a licensed centre in the UK, normally following referral from their GP. When the original Human Fertilisation and Embryology Bill was debated in both Houses of Parliament, the assumption was that the activities governed by the Act could not and would not take place in the UK without a licence from the HFEA. In defending the Bill, Lord Hailsham explained that:

The road which I believe is right to pursue is that responsible people with a responsible licensing system should be allowed to proceed with responsible activities with which some people do not agree but which others regard to be necessary or desirable.<sup>1</sup>

If treatment were to take place only in licensed centres, it could be subject to a wide array of controls: age limits for sperm and egg donors, for example, and restrictions on the number of embryos that can be put back in one IVF cycle. The outcomes of treatment could also be recorded, giving the HFEA a comprehensive overview of the provision of fertility treatment in the UK and enabling it to monitor success rates and to track trends (such as donor insemination's replacement by ICSI (*Intra-cytoplasmic sperm injection*) as the preferred treatment for men with reduced fertility). Largely as a result of the internet, the picture is now rather different. Finding out about services offered by clinics in other countries, where regulation may be absent or patchy, is now straightforward. Within the UK, 'introduction' websites, where potential gamete donors and surrogate mothers make contact with would-be parents, have emerged. On these websites, 'members' make private arrangements that are intended to lead to the birth of a child, but they do so in a regulatory vacuum. Opting out of regulation may raise safety concerns, in the case of unscreened sperm, and it also means that there is very little information about the incidence and outcomes of these arrangements. When the Human Fertilisation and Embryology Act 1990 was amended in 2008, it was assumed that the regulation would continue to be comprehensive. As a result, strictly regulated fertility treatment in the UK now coexists with almost completely unregulated DIY assisted conception. Whether or not this matters is the subject of this chapter.

---

<sup>1</sup> HL Deb 08 February 1990 vol 515 cc950-1000, 967.

## 2. Regulated Reproduction

In 1982, the Committee of Inquiry into Human Fertilisation and Embryology, chaired by Mary Warnock, an academic philosopher, was commissioned to make recommendations on the regulation of fertility treatment and embryo research.<sup>2</sup> Published in 1984, the Warnock Report's principal focus was the moral status of the human embryo and the acceptability, or otherwise, of using embryos created by IVF in research. When the government finally introduced a Bill to implement the recommendations of the Warnock Report, in 1989, unsurprisingly parliamentary debates were also dominated by the question of whether and in what circumstances, embryo research should be permitted, under licence.

Insofar as there was debate over the rules governing access to fertility treatment, it was assumed by many parliamentarians that most fertility treatment would be provided by the NHS, alongside a handful of private clinics. Some parliamentarians were concerned about the costs of IVF, believing that it would be better to spend the money on research into the causes of infertility. Lord Kennet, for example, asked:

Why are all these people infertile in the first place? The reasons are known in general but no particular attempt is made to address them. Some of the reasons are environmental – toxins in the environment – some social, the use of unsafe contraceptive methods, the transmission of infectious diseases by sex, and even stress. There is a condition called athletic amenorrhoea, which sounds fairly curable. ... It seems fairly likely that the number of infertile couples could be reduced by attention to these problems far more expeditiously than by spending £25,000 per birth on IVF.<sup>3</sup>

But although the costs of treatment might have caused some disquiet, the legislation which was intended to create a 'comprehensive' regulatory framework did not attempt to regulate what has become a market in fertility treatment. Most fertility treatment in the UK is provided privately, but the statute does not give the HFEA any powers over the prices clinics charge, their marketing materials or the practice of recommending additional, expensive interventions after a couple has embarked on a cycle of IVF, when they may feel under considerable pressure to agree to anything which might increase their chance of success. Any concerns over sharp practices can be addressed by the regulator only tangentially, through its jurisdiction over the Person Responsible's duty to ensure 'that suitable practices are used in the course of the activities' carried out at their centre.<sup>4</sup>

---

<sup>2</sup> *Report of the Committee of Enquiry into Human Fertilisation and Embryology* (HMSO, 1984).

<sup>3</sup> HL Deb 07 December 1989 vol 513, 1028

<sup>4</sup> Human Fertilisation and Embryology Act 1990, section 17(1)(d).

In addition to assumptions that treatment would take place within the NHS, it was also assumed that it would be relatively straightforward for the regulator to be able to exercise comprehensive control over fertility treatment, backed up by criminal sanctions if anyone did anything set out in the Act without first obtaining a licence from the HFEA. Kenneth Clarke MP, then Secretary of State for Health explained that:

the Bill is the first comprehensive measure dealing with all the issues addressed by the Warnock committee concerning the legal, social and ethical implications of new methods of assisted reproduction attempted anywhere in the world.<sup>5</sup>

The comprehensiveness of the regulatory scheme was widely welcomed by parliamentarians in both Houses. Lord Walton, for example, said:

I welcome warmly the proposal to establish a statutory human fertilisation and embryology authority with functions as clearly defined, and the proposal that all such work in the United Kingdom may be conducted only in centres approved for the purpose and open to regular inspection with the individual scientists concerned being licensed to conduct that work, subject always to the provision that such licences may be revoked or varied, given due cause. Anyone carrying out such work without a licence would be committing a criminal offence.<sup>6</sup>

For many years, it was taken for granted that, aside from its inability to control prices, the UK's regulatory system was capable of exercising almost complete control over the treatment of infertility in the UK. Indeed the UK's regulatory regime served as a model for regulation worldwide.

Through its licensing and inspection functions, the HFEA could monitor and regulate practices in fertility clinics. In addition to an initial inspection before a licence is issued for the first time, thereafter centres are subject to a programme of regular, scheduled inspections, with additional unannounced inspections, which can be random but are also sometimes targeted at centres where there are particular concerns. At these inspections, consent forms and patient information sheets are checked for compliance with the Act and the HFEA's Code of Practice; labels on the 'straws' containing embryos are audited for errors and low nitrogen alarms are monitored. Patients are interviewed, and the clinic's standard operating procedures and patient records will be scrutinised. Inspection reports are then considered by the HFEA's Executive Licencing Panel or Licence Committee, and if anything gives cause for concern, the Licence Committee has a range of powers at its disposal, including, in extreme cases, revoking the clinic's licence.

Because all treatments and their outcomes have to be reported and recorded on the HFEA's Register, the HFEA holds a very large dataset about the practice of fertility treatment in the UK. Data are produced and published about every clinic in the UK, enabling success rates to be

---

<sup>5</sup> HC Deb 02 April 1990 vol 170 917

<sup>6</sup> Lord Walton of Detchant, Hansard HL Deb 07 December 1989 vol 513, 1052

compared. Although used by the media to produce crude and misleading 'league tables',<sup>7</sup> the HFEA has employed sophisticated data analysis to demonstrate that, in fact, clinics' success rates vary very little. Aside from a handful of outliers, which can often be explained by the characteristics of the patients rather than the practices in the clinics, most apparent differences between licensed clinics in the UK are not statistically significant.

Of course there have always been a few types of fertility treatment that happen outside of this tight regulatory regime. Informal sperm donation, not uncommonly involving a lesbian couple asking a friend to act as a sperm donor, does not require treatment in a licensed centre and hence the sort of controls that would be exercised within a clinic – testing the sperm first to make sure that it was suitable for use in treatment and quarantining it to eliminate the risk of HIV infection, for example – are absent.

There were always also some aspects of a patient's treatment cycle that did not require a licence from the HFEA, perhaps most notably the prescription of super-ovulatory drugs, with their obvious risks for patients. Nevertheless, insofar as gaps existed in the regulatory framework, they affected relatively few people. They certainly did not cast doubt on the HFEA's ability to exercise almost complete control over the provision of treatment using sperm, eggs and embryos outside of a woman's body in the UK.

### **3. Gaps in the Regulatory Framework**

In 1999 Margaret Brazier presciently remarked upon the HFEA's inability not only to control the market in reproduction, but also to exercise any control over cross-border reproductive treatment:

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 of the difficult ethical dilemmas that have gone before. (1999, at p 193).

Fifteen years ago, evading national regulation by seeking treatment abroad was an unusual step to take, principally because navigating access to healthcare services in another country was much more difficult than it is today. Now clinics worldwide directly target their online materials at

---

<sup>7</sup> See, for example, 'League table highlights best and worst fertility clinics' Daily Mail 10 January 2007 (<http://www.dailymail.co.uk/home/article-427863/League-table-highlights-best-worst-fertility-clinics.html>)

overseas patients. There is no shortage of Spanish fertility centres with websites in English: the *Instituto Murciano de Fertilidad (Imfer)*'s website, for example, explains that:

Every year Imfer assists many foreign patients who want to undergo an assisted reproduction treatment. In order to serve them better, Imfer offers a department devoted exclusively to foreign patients.

Its website also offers foreign visitors information about its location:

Located in the southeast of Spain, the Region of Murcia is characterized by its mild temperatures and its many hours of sun. Here, as in a small continent, a variety of environments and landscapes offer countless possibilities to the visitor. Beaches, rural environments, cities, traditions, folklore, culture, sports and health mix together in a dynamic and active touristic offer.<sup>8</sup>

Typing 'surrogacy in India' into Google returns over one million 'hits', many of which are from clinics clearly keen to attract Western customers. The website of *Surrogacy Centre India*, for example, features dozens of pictures of happy couples and smiling babies, almost all of whom are white.<sup>9</sup> The market in cross-border reproductive treatment enables thousands of UK couples each year to completely bypass the UK's regulatory scheme.

Another growing gap in the regulatory framework in the UK is internet-assisted conception, mainly but not exclusively involving sperm donation. A licence from the HFEA is only necessary if sperm is 'procured'. In 2010, Ricky Gage and Nigel Woodforth were given suspended jail sentences for procuring sperm without a licence (*The Guardian*, 2010). Their service, from which they had made £250,000, had involved using couriers to deliver sperm to purchasers. This was held to involve 'procuring' sperm, and since they did not have a licence from the HFEA, they had committed a criminal offence.

'Introduction' websites, which operate in much the same way as dating websites, do not involve procuring and therefore are both lawful and unregulated. These are websites on which would-be donors and would-be recipients give a short description of themselves and their motivations. Only those who have paid a subscription fee (one such site, *coparents.co.uk*, charges its members £22 for one month and £54 for six months) can make contact with each other. Members then get in touch with each other directly in order to work out if to they wish to proceed, and the terms on which they plan to do so. *Coparents.co.uk* claims to have helped 'thousands' of people in the UK to find sperm donors, but its only records of outcomes are the testimonials on its site, such as 'I've found a sperm Donner [sic]. Thank u so much for helping me and my wife finding a daddy for our child.' There is no systematic data collection, and the site offers no screening services at all.

---

<sup>8</sup> <[www.ivfeggdonation.es](http://www.ivfeggdonation.es)>

<sup>9</sup> <[surrogacycentreindia.com](http://surrogacycentreindia.com)>

Finally, the regulation of surrogacy was never within the HFEA's powers, although where an IVF cycle is involved, that would clearly have to happen in a licensed clinic. The HFEA's Code of Practice contains guidance on the information that should be provided to all those involved in IVF surrogacy arrangements. They should, for example, receive information about legal parenthood and parental orders (HFEA Code of Practice, paras 14.2-14.6). The Code of Practice also specifies that all those involved in the arrangement should be subject to a welfare of the child assessment (para 14.1). The HFEA can exercise no control at all over 'partial' surrogacy arrangements, where the surrogate is artificially inseminated at home. Nor does it have any jurisdiction over the increasingly common practice of employing a surrogate mother in another country, such as India or the US. Taken together, it is clear that the HFEA's almost watertight regulatory umbrella is now rather full of holes, even after the legislation was updated in 2008 in order to render it 'fit for purpose'. In what follows, I consider the significance of cross-border reproductive treatment, internet-assisted conception and surrogacy for the future of the regulation of reproduction.

**(a) Cross-border reproductive treatment**

There are a variety of reasons why people seek reproductive treatment in another country. Worldwide, the most common reason is that the treatment is not available in one's home country (Ferraretti et al, 2010). Within Europe, for example, gamete donation is illegal in several countries, and it is therefore routine for couples and individuals to travel to other European countries with more liberal regimes in order to access treatment with donated eggs or sperm (Ferraretti et al, 2010). The UK's liberal regulatory framework means that there are not many illegal treatments that UK couples might seek overseas. One example would be sex selection for social reasons, for which anyone willing to pay at least \$18,000 per cycle might travel to the US.

It is more common for British people to seek treatment abroad in order to avoid waiting lists or because they perceive that treatment might be 'better' or cheaper overseas. The shortage of egg donors in the UK, and the resulting waiting times, has meant that people seeking treatment with donated eggs might travel to Spain or Cyprus, for example, where donors are more readily available, perhaps because they are paid. People who find that they have a need for fertility treatment are often patients 'in a hurry'; anxieties about declining fertility, and the fact that a diagnosis of infertility commonly happens at least a year after people have decided to try to start a family, means that the prospect of waiting another year to find an egg donor will often prompt people to investigate more immediately available options. First or second generation immigrants

have reported difficulties in finding ethnically matched donors in the UK, and some express a preference for being treated in their country of origin (Inhorn, 2011).

When people seek treatment abroad because they perceive it to be better than treatment at home, this may be because of dissatisfaction with the treatment that they have received in the UK, perhaps because they feel that they have run out of options and need to 'try something new' (Culley, 2011). In their study of the motivations of people seeking treatment abroad, Culley et al found that 29 per cent mentioned better success rates. Dutch patients seeking treatment in Belgium believe that treatment there is more patient-centred and, as a result, more likely to succeed, even though there is, in fact, no difference in success rates between the two countries (Van Hoof et al, 2013). There is evidence that some patients are willing to try anything in order to increase the chance of pregnancy, regardless of the risks. For example, in their study of women presenting with higher order multiple pregnancies at a London hospital, McKelvey et al (2009) found that the fact that an overseas clinic was prepared to put back more than two embryos was regarded as a good reason for seeking treatment abroad.

The notion that having more than two embryos returned to the woman's uterus is preferable to treatment in the UK, where this ought not to happen, is troubling, however. Multiple pregnancy represents the most serious and largely avoidable health risk from IVF. Twins and triplets are much more likely to be born prematurely, and the risk of death around the time of birth is between three and six times higher for twins and nine times higher for triplets.<sup>10</sup> Women pregnant with twins are at higher risk of hypertension, pre-eclampsia and gestational diabetes; they are also twice as likely to die during pregnancy or childbirth.

In order to reduce the multiple pregnancy rate associated with IVF, for some years the HFEA has worked with professional bodies on its multiple birth policy. Since 2007, the HFEA has set a maximum multiple birth rate that clinics should not exceed, which has progressively dropped from 24 per cent to 10 per cent. In order to meet this target, each centre is expected to devise its own 'multiple births minimisation strategy', which essentially sets out which patients it considers suitable for elective single embryo transfer (eSET). A properly targeted eSET protocol can ensure that the risk of multiple pregnancy is virtually eliminated in those women who are most likely to get pregnant. And the HFEA's policy has been successful: the multiple pregnancy rate has dropped significantly in the UK without a corresponding drop in pregnancy rates.<sup>11</sup> The health gains for women and children are considerable, as are the savings to NHS neonatal services.

---

<sup>10</sup> See further <[www.oneatatime.org.uk](http://www.oneatatime.org.uk)>

<sup>11</sup> Ibid.



Of course, it is only possible for the HFEA to exercise control over embryo transfers that happen in licensed clinics in the UK. It may have had considerable success in ensuring that good prognosis patients receive eSET in order to dramatically reduce the multiple pregnancy rate, but if women are regularly returning from having had IVF in India, pregnant with triplets or quadruplets (McKelvey et al, 2009), the HFEA's ability to eliminate iatrogenic higher order multiple pregnancies is clearly significantly weakened.

Facilitators of cross-border reproductive treatment sometimes emphasise the advantages to undergoing stressful and disruptive treatment at the same time as a holiday. One of Whittaker and Speier's interviewees (2011), the owner of a company called *IVF Holidays*, explained:

it's bad enough when you do it in the States, you gotta go to work, there's more stress at work, you have that going against you, plus you're trying to do these shots, and you're thinking about your upcoming donor cycle. I think it really helps a lot that it's a true vacation.

It is not clear that this view is shared by patients. Blyth (2010) found no evidence that patients themselves regarded the possibility of taking a holiday at the same time as an advantage of cross-border reproductive treatment. Indeed, it appears that patients find the term 'reproductive tourism' insulting, with its implication that travelling abroad for treatment is a desirable leisure activity, rather than something they feel compelled to try after failing to become pregnant through treatment in their home country. Some have argued that the equally emotive but less positive term 'reproductive exile' would be a more accurate description of the experience of those who seek treatment in other countries (Inhorn and Patrizio, 2009).

Although clinic staff may complain about the administrative burden of submitting comprehensive data to the HFEA, the statutory requirement that it gathers a complete record of treatments, patients, donors and outcomes means that the UK has a comprehensive dataset that can be mined in order to provide invaluable information about the quality and effectiveness of treatment. It also means that, if something goes wrong, it is comparatively easy to trace the source of the problem. In contrast, we know very little about cross-border reproductive treatment and its risks and outcomes. Patient survey data is incomplete and likely to be inaccurate. In his internet survey of people who had sought treatment abroad, Eric Blyth (2010) found that over half of his respondents had 'come away with a child'. This could be evidence that for the majority of patients, treatment succeeds in the end. But it could also illustrate the reluctance of ex-patients whose treatment has failed to engage with this sort of survey.

Not only does increasing resort to cross-border reproductive treatment expose the existence of significant gaps in the regulatory scheme, but it is also almost impossible to imagine what could be done to plug those gaps. We can bemoan the lack of accurate and comprehensive data about its

prevalence and outcomes, and advocate better information for would-be patients, but it is very difficult to work out what could be done, other than issuing warnings about the risks of treatment abroad.

One country has attempted to control its citizens' access to treatment overseas. Turkey strictly prohibits third party involvement in reproduction, and has tried to stop Turkish citizens receiving treatment using donor eggs, sperm or surrogacy overseas by requiring that 'the person who has conducted this procedure, the persons who have referred patients or acted as intermediaries, the impregnated person, and the donor will be reported to the state prosecutor' (Gurtin, 2011). In practice, this provision is likely to be completely unenforceable against both overseas doctors and Turkish patients who receive treatment abroad. Worse still, it is likely to be counter-productive since its chief consequence will be to make Turkish clinics reluctant to provide any advice, support or preliminary treatment to couples seeking treatment with donated gametes overseas. As Zeynep Gurtin (2011) explains:

It will effectively amount to tying the hands of professionals, thereby significantly curtailing the resources (to information, guidance and preparatory treatment at home) of men and women who are already in an extremely difficult situation. If, being afraid of repercussions, practitioners stop referring patients to trusted partners and cease providing preliminary care and information, the potential dangers and discomforts of [cross-border reproductive care] for patients will undoubtedly increase. Those intent on pursuing CBRC may have to travel further and for longer and find themselves making decisions on the basis of insufficient knowledge and incomplete information.

Ironically, then, the only country that has attempted to control its citizens' access to cross border reproductive treatment has probably simply made it less safe for them.

## **(b) Internet-assisted conception**

It is impossible to know how common it is for people to find gamete donors or surrogate mothers online via social media and introduction websites. The internet exercises no control over would-be donors and recipient; there is no screening and no recording of data. Judging by the profiles on introduction websites, some of the people seeking sperm donors or offering their sperm for donation are looking for a coparenting arrangement, with ongoing contact throughout childhood. In those cases, it is possible that the donor will be recorded as the father on the child's birth certificate. Others are looking for 'no contact' arrangements and in those cases, it may be that no father is recorded on the birth certificate, or, if the mother has a partner, his name might be recorded as that of the father.

Despite the apparent ease with which these arrangements can be made, it is worth spelling out the risks in seeking a sperm donor through the internet. First, unlike sperm supplied by licensed clinics, it is impossible to know if the sperm will even be capable of resulting in a pregnancy. It is therefore possible that men who are azoospermic or who have very low sperm counts will donate sperm without realising that there is very little or no chance of conception. Secondly, there are no age limits on donors. The upper age limit for sperm donors in licensed clinics is there for both health reasons and to increase the chance of success (Simon et al, 2012; Lewis et al, 2013). Thirdly, the sperm will not have been screened for HIV or common genetic conditions. Infection of the woman is then possible, as is passing on a disease to any child who is born.

Fourthly, the child's ability to access information about the donor will be both variable and patchy. Unlike children conceived in licensed clinics, children conceived through informal sperm donation will not have the right to access non-identifying and, for children conceived since 2005, identifying information about their donor when they reach the age of 18. It is not just the child's interest in information that is at stake. If the donor or the child is subsequently diagnosed with a genetic condition, it may be impossible to trace either offspring or donor in order to pass on information about their elevated risk. Fifthly, unlike treatment in a licensed centre, there are no restrictions on how many times a man could donate, meaning that it would be possible for a man to father hundreds of children in this way, all of whom would have no way of knowing whether or not they are related to each other. Finally, there is plainly scope for these sorts of arrangements to go quite badly wrong. For obvious reasons, it is impossible to know how common it is for informal reproductive agreements to break down. We are only likely to know about the breakdown of these agreements if either the case reaches the courts, or one or other of parties chooses to publicise their situation via the media.

The most likely reason why a court might become involved in the aftermath of informal reproductive arrangements is to resolve questions of parentage. This was the case in *M v F*,<sup>12</sup> in which the legal fatherhood of a child, whose biological father was a donor who, in his evidence to the court, had claimed to have fathered around 30 children through both artificial insemination and sexual intercourse, depended upon whether he had been conceived through artificial insemination or sex. If conception had been achieved through artificial insemination, the special provisions of the Human Fertilisation and Embryology Act 2008 would apply to recognise the mother's husband as the child's father, provided he had consented to her insemination.<sup>13</sup> If, on the other hand, conception had been the result of sexual intercourse, the donor would be the child's legal father.

---

<sup>12</sup> [2013] EWHC 1901 (Fam).

<sup>13</sup> Section 35.

Whether or not conception was achieved artificially or as a result of sexual intercourse was clearly a question of fact, but it was one on which the accounts of the mother and the donor differed. It was a difficult question for the judge to resolve, not only because of the obvious absence of witnesses, but because both parties were untrustworthy. According to Peter Jackson J, the mother and the donor were both

individuals that have over long periods of time been untruthful, devious and manipulative. In relation to contested issues, I regret that they both lied extensively throughout their evidence, and one of them was of course lying about the central issue of the child's conception.

The mother was 'a fluent fabricator' with 'a capacity for determined and malevolent action to achieve her ends'. She showed 'no sign of discomfort when caught in an obvious lie [and] freely stated that she is motivated by her own need for [the donor] to be punished'. The donor was a man with 'an unmistakable track record of inveigling or encouraging recipients into engaging in sexual activity with him from the very first meeting', who had once 'advertised himself in graphic terms as willing to participate in a "breeding party", i.e. a male-dominated orgy designed to get a woman pregnant'. Peter Jackson J found that he had taken 'the strategic decision to tell the truth where possible and to lie where necessary'.

Peter Jackson J's judgment starts with a remarkable timeline of events. The mother alleges that she had sex with the donor on multiple occasions and towards the end of the timeline, that this took place without her consent. The donor claims that insemination took place artificially, although he admitted to having had sexual intercourse with the mother when she was pregnant for the second time, her first pregnancy having been terminated after her husband reacted 'violently' to the news of her pregnancy. In order to take revenge on the donor, the mother was said to have adopted a number of aliases in order to publicise his activities to newspapers and to his professional body.

Peter Jackson J remarked upon the risks involved in these arrangements, as compared with regulated sperm donation:

regulation is broadly successful in protecting participants from exploitation and from health risks, while providing some certainty about legal relationships. ... In comparison, participants in informal arrangements have to judge all risks for themselves. They may not be in a good position to do so. Those seeking to conceive may be in a vulnerable state and not all donors are motivated by altruism.

Participants in these arrangements cannot rely on those behind the website to protect their interests. In *M v F*, Peter Jackson J commented that the website had charged 'not inconsiderable fees to those looking for donors while projecting a rose-tinted account of successful, problem-free conception'. And the strain he found this dispute had placed upon the participants had been considerable: 'It has taken a high toll on the well-being of each of the adults and has threatened Mr F's career. The costs are enormous. The parties have spent almost £300,000 in legal fees'.

We have no evidence of the impact of this sort of arrangement on the children born as a result. In time, it is to be hoped that the scope of researchers' interests in the children born following assisted conception is broadened out to include children conceived through DIY arrangements (see, for example, P Casey et al (2013), S. Golombok et al (2013)). Of course, the child in this case may never be told about the circumstances of his conception, and so may never find out about his parents' behaviour. But it is hard to imagine what it would be like to read Peter Jackson J's judgment, in the knowledge that he was talking about one's own conception.

It is not just sperm donors who can be found online. In *Re TT (Surrogacy)*<sup>14</sup> Mr and Mrs W, the commissioning couple, had met the surrogate mother online. She refused to hand over the baby after birth, and although Baker J refused the father's application for a residence order, the case is notable for his criticism of all parties' behaviour, and in particular of their use of the internet. The mother had been deceitful and lied to the court, and she was, as Baker J explained, a 'heavy user of the internet':

In one chatroom, she has chosen to use the soubriquet: "Thongs, G-Strings, French Knickers, IT'S ALL GUD". I am concerned that she is at risk of exposing herself to malign and possibly dangerous influences via the internet which could in turn affect the children. For the sake of her children, I advise her to adopt greater restraint in the use of the internet.

Baker J was also 'concerned about the dangerous and murky waters into which [the commissioning couple], and particularly Mrs. W, have strayed via the internet'. Before they met T's mother, Mr and Mrs W had invited a woman known as CL into their home. Although Mrs W claimed to have met her in an internet chatroom, rather than on a surrogacy introduction website, Baker J did not believe her. The Children's Guardian appointed by CAFCASS<sup>15</sup> to protect the child's welfare had made inquiries about CL and found that CL was:

a prostitute, with seven children in care in Scotland. It is alleged that she is known on the internet as a surrogate parent and has claimed (to whom and in what terms is unclear) that she had 13 children. She left Edinburgh when pregnant with her sixth child and went to stay with the Ws in England, claiming that Mrs. W was her sister. When social workers visited the Ws' home, Mrs. W told her that the woman she knew as D was someone she had met over the internet. The social workers were concerned that the Ws might have arranged to take over the baby that CL was carrying. The Scottish social worker told the Guardian that CL had met the Ws on an internet surrogacy site and was going to sell her baby to the Ws.

Although it was impossible to corroborate the allegation that the Ws intended to 'buy' CL's baby, Baker J gave them a stern warning about the risks of their conduct:

It cannot be said too strongly that it is extremely unwise to invite someone into your home whom you have only met over the internet. If the information obtained by the Guardian is correct, CL may pose a

---

<sup>14</sup> [2011] EWHC 33 (Fam).

<sup>15</sup> Children and Family Court Advisory and Support Service

serious risk to children. It was wholly irresponsible of the Ws to invite her into their home, and the fact that they have no awareness of this risk is alarming.

Insofar as *M v F* and *Re TT* are among the first cases in which internet-assisted conception has come before the courts, they paint an unedifying picture of the sort of arrangements people make via the internet and how wrong they can go for all concerned.

### (c) Surrogacy

Anyone entering into a surrogacy arrangement in the UK or, as is becoming increasingly common, abroad, receives comparatively little protection from UK law. It is, perhaps, especially noteworthy that the government did not use the opportunity presented by reform of the Human Fertilisation and Embryology Act in 2008 to make anything more than piecemeal changes to the law relating to surrogacy. The arrangements continue to be unenforceable and hence precarious, and given that it is still a criminal offence to be paid to negotiate a surrogacy contract, there continue to be obstacles to accessing professional advice. For many years, the judiciary has been warning of the dangers of unregulated surrogacy arrangements, and crucially it has been doing so in proceedings brought in order to settle the parenthood and/or residence arrangements of a child who already exists as a result of a surrogacy arrangement.

Both the Warnock Report and the Brazier Committee's 1998 report (Brazier et al, 1998) took the view that the law should not encourage surrogacy. Liberal, facilitative regulation was ruled out by both Committees on the grounds that the law should be discouraging people from entering into surrogacy arrangements, or, at the very least, ensuring they do so only as a last resort. In practice, however, far from deterring people from entering into surrogacy arrangements, the lack of legal clarity instead is resulting in more and more cases coming before the courts. Indeed there are now so many reported surrogacy cases that they now follow a very familiar pattern.

The child's existence means that the court is essentially presented with a *fait accompli*: a child whose best interests will generally be served by enabling her to stay in her settled home. In most cases, the court's task will be to make decisions about the parentage and/or residence of a child who is already living with the couple or individual who employed the surrogate mother. In these circumstances, the judge effectively has no choice but to employ whatever tools he or she can to transfer legal parenthood to the person or people caring for the child. Where there is an application

for a parental order, invariably this means retrospectively authorising payments that would ordinarily be judged to be in excess of reasonable expenses.<sup>16</sup> As Theis J explained in *Re W*:

A parental order will give permanency and security to the day to day arrangements that exist at the moment. Most importantly a parental order will confer joint and equal legal parenthood and parental responsibility upon both applicants. This will provide lifelong security for the children's relationship with the applicants, which is what the welfare of each child overwhelmingly demands.

Where parental orders are not an option, then other family law tools such as wardship and residence orders have been employed in order to ensure that the child's carer(s) also have parental responsibility for her.<sup>17</sup>

Although in theory, the courts suggest that an order might be refused if the amount paid was 'an affront to public policy', in practice the child's welfare operates as a trump card. In one of the first overseas surrogacy cases to come before the courts, Hedley J was clear that he was 'most uncomfortable' with the process of retrospective authorisation, but his hands were tied:

The difficulty is that it is almost impossible to imagine a set of circumstances in which by the time the case comes to court, the welfare of any child (particularly a foreign child) would not be gravely compromised (at the very least) by a refusal to make an order.<sup>18</sup>

In addition to the routine retrospective authorisation of payments to surrogate mothers, it is also now almost customary for judges to warn of the dangers of entering into surrogacy arrangements without proper legal advice. Back in 2008, Hedley J drew attention to the 'many pitfalls [which] confront the couple who consider commissioning a foreign surrogacy.'<sup>19</sup> Three years later, in *Re IJ (A Child)*,<sup>20</sup> which was, like *Re X & Y*, a surrogacy case involving a child born in the Ukraine, Hedley J was once again spelling out the dangers:

One reason for adjourning these reasons into open court is to emphasise once again the legal difficulties that overseas surrogacy agreements can create. In the experience of the court to date, all overseas jurisdictions can confer parental status on the commissioning couple but that status is not recognised in our domestic law nor (at least where a commercial agreement has been in place) could it be. Those who travel abroad to make these arrangements really should take advice from those skilled in our domestic law to be sure as to the problems that will confront them (not the least of which is immigration) and how they can be addressed. Reliance on advice from overseas agencies is dangerous as the provisions of our domestic and immigration law are often not fully understood.

Two years later, in *Re W*, Theis J was yet again explaining that

---

<sup>16</sup> See, for example, *Re W* [2013] EWHC 3570 (Fam); *Re C (A Child) (Parental Order)* [2013] EWHC 2408 (Fam); *J v G (Parental Orders)* [2013] EWHC 1432 (Fam).

<sup>17</sup> *JP v LP* [2014] EWHC 595 (Fam).

<sup>18</sup> *Re X & Y (Foreign Surrogacy)* [2008] EWHC 3030 (Fam).

<sup>19</sup> *Ibid.*

<sup>20</sup> [2011] EWHC 921 (Fam).

This case is another timely reminder of the importance for intended parents embarking on surrogacy arrangements abroad to ensure they have appropriate legal advice in the jurisdiction where the surrogacy arrangement is entered into.<sup>21</sup>

And it is not just overseas surrogacy arrangements that can lead to difficulties. As Eleanor King J explained in *JP v LP*,<sup>22</sup>

the facts of this case stand as a valuable cautionary tale of the serious legal and practical difficulties which can arise where men or women, desperate for a child of their own, enter into informal surrogacy arrangements, often in the absence of any counselling or any specialist legal advice.

Bizarrely, the law works to put obstacles in the way of specialist legal advice. The ban on commercial involvement in surrogacy arrangements was intended to prohibit baby selling, but in an echo of the counter-productive Turkish ban on receiving treatment overseas, in fact it increases the risks surrogacy poses to children. In the absence of professional advice, it is more likely that children will be handed over without any formal transfer of parenthood, with the result that the people caring for the child have no legal relationship with, or obligations towards her.

In *JP v LP*, the hospital where the child was to be born had insisted on seeing a surrogacy contract before they would allow the baby to be taken away by the commissioning couple. An agreement was drawn up but the solicitors who had done so for payment had done so for the preparation of the agreement were negotiating surrogacy arrangements on a commercial basis in contravention of section 2 of the Surrogacy Arrangements Act 1985 and had therefore committed a criminal offence. In addition to drawing up an illegal contract, the solicitors had not advised their clients that a strict time limit applies to parental orders and hence the parents were out of time before their application was made. A failure to know about, or at the very least check the rules governing parental orders will have lifelong consequences for this child, whose parents will never be able to both have legal parenthood for him. The parents had split up which meant that adoption by the 'mother', in order to give her legal parenthood would extinguish the father's parental responsibility, and adoption together was not an option because the parents were neither married nor living in an enduring family relationship.<sup>23</sup>

The central problem is that it seems to be the exception for people contemplating surrogacy to appreciate the complex legal ramifications of these arrangements until after the child is born. Perhaps it is time to think about subjecting surrogacy arrangements to some sort of pre-conception scrutiny, not necessarily in order to vet participants, although that could be a possibility where the arrangements reveal family circumstances of which social services should be aware, but more

---

<sup>21</sup> [2013] EWHC 3570 (Fam).

<sup>22</sup> [2014] EWHC 595 (Fam).

<sup>23</sup> Adoption and Children Act 2002, s.144(4)(b).



commonly simply to ensure that everyone involved understands what the intended parents would have to do in order to ensure that they acquire legal parentage for their child.

#### **4. Does unregulated assisted conception matter?**

Of course, it could be argued that by breaking free from the tight restrictions that govern regulated assisted conception services in the UK, unregulated assisted conception is in fact going some way to equalise the positions of those who do, and those who do not need third party assistance in order to conceive. If two people are capable of conceiving through sexual intercourse, they do not need the prior approval of a clinic or regulatory body in order to have sex. They are not screened to check that they will not pass on a disease to the other person or to any child that might be born. Data about the incidence of sexual intercourse and its outcomes are not collected by a non-governmental public body. Of course, children's births must be registered, but aside from birth registration, sexual reproduction – just like internet-assisted conception – takes place relatively free from external scrutiny and data collection. It is increasingly common for people to meet their sexual partners online, so does it matter if they are also looking for sperm donors or surrogate mothers online?

Perhaps the best way to answer this question is to think about the purposes of regulation. While many clinicians and patients experience it as overly bureaucratic, placing obstacles in the way of doctors just 'getting on with' treating their patients, there are reasons for many of the restrictions and requirements in the HFE Act. Keeping a register of treatments and their outcomes facilitates epidemiological research into the safety and outcomes of treatments that have never been subjected to randomised controlled clinical trials. It also means that children can find out if they are related to a prospective sexual partner. Screening of sperm protects the safety of women and children, and increases the chance of a successful pregnancy.

Opting out of regulation can mean opting out of some of the benefits of regulated treatment. Where this means receiving unscreened sperm, then the risk is mainly, but not exclusively to the woman who is looking for sperm online, and since the risks of unprotected sexual intercourse are well known, perhaps it would be unduly paternalistic to seek to protect her from the foolishness of her decision to inseminate herself with a stranger's sperm. But there are other benefits of regulation, where opting out could have negative effects for people aside from the adults making arrangements for themselves, and which are not necessarily obvious to people contemplating travelling overseas for IVF treatment or surrogacy, or looking for a sperm donor online. People may not appreciate that it is in a child's interests for there to be a register of treatments, for example. It is evident from the

surrogacy cases reaching the UK courts that many potential parents do not understand the rules governing legal parentage, which may leave them caring for a child with whom they have no legal relationship, and to whom they owe no legal obligations.

If there is a widespread lack of understanding about the benefits of regulation, a two-pronged strategy may be necessary. First, it might be important for the regulator to broaden the scope of its public education function. It might not only be important to have authoritative advice about the risks of opting out from regulation, but also, more positively, a clear and accessible explanation of what the benefits of regulation are, for patients and for children. For example, if it is a benefit of treatment with donated sperm in licensed centres that the sperm has been screened in order to increase the chance of the birth of a healthy child, and to minimise the risk to the mother, then this should be clearly communicated to patients. Or if there are women in the UK who believe that it is an *advantage* of treatment overseas that more than two embryos can be put back, then the message about the dangers of multiple pregnancy has not been effectively communicated.

In addition to persuading people of the advantages of seeking regulated treatment services, there may be circumstances in which it would be appropriate to provide *incentives* to seeking regulated treatment services. Certainly in relation to surrogacy, any attempt to introduce a system in which surrogate mothers and commissioning parents went through a formal approval process before embarking on a surrogate pregnancy would have to be accompanied by some sort of advantage to doing so, otherwise few people would be willing to submit themselves to a potentially intrusive process which would have no possible benefits for them. If pre-approval of the surrogacy arrangement meant pre-approval for a parental order, then perhaps some would-be parents might be persuaded that going through an official pre-approval procedure could make their lives easier in the long run.

## 5. Conclusion

The cases that are now reaching the courts involving unregulated assisted conception suggest that many people only become aware of the potential pitfalls of such arrangements after the event, once a child has been born. In *M v F*,<sup>24</sup> for example, it does not seem likely that the child's mother understood the rules governing fatherhood before becoming involved with Mr F. In *JP v LP*,<sup>25</sup> the

---

<sup>24</sup> [2013] EWHC 1901 (Fam).

<sup>25</sup> [2014] EWHC 595 (Fam).

parents clearly had no idea that parental orders following surrogacy could only be obtained within the first six months of the child's life.

Of course, there is no reason why members of the public should understand the complex set of rules governing assisted conception and parentage, but on the other hand, it is perhaps shocking that the public knows so little about infertility treatment and its legal consequences. Sex and relationships education (SRE) in schools understandably concentrates on those sex and relationships issues that are more likely to affect teenagers, such as 'puberty, menstruation, contraception, abortion, safer sex, HIV/AIDS and STIs'.<sup>26</sup> It is clearly important that girls and boys understand the risk of pregnancy, but the unintended consequence of SRE's emphasis on avoiding unwanted pregnancy is that girls and boys grow up believing that sex will lead to pregnancy, and while this may be true for most of them, for some it will not. Infertility often comes as a profound shock to people who have spent many years strenuously trying to avoid pregnancy at all costs.

Of course, teenagers are not likely to be a receptive audience for education about infertility, its treatment and the legal pitfalls of unregulated treatment. Nevertheless, it would seem sensible for sex and relationships education in schools to at least prepare pupils for the fact that parenthood cannot always be achieved through sexual intercourse. For teenagers who know or suspect that they might be gay, it is also important for them to understand that parenthood can be achieved without heterosexual intercourse. The difference between legal and biological parenthood is clearly poorly understood but of critical importance to people who start their families in unconventional ways. As the internet increasingly becomes people's first port of call for information about almost everything, including assisted conception, it may be valuable to at least introduce the idea that there are significant risks from conceiving a child via an internet contact or overseas. Although people may not remember much that they are told in school, for sex and relationships education not to acknowledge the reality of infertility, and the existence of alternative means of conception, is to paint a misleading picture of future family life for a significant proportion of the population.

Public information about the risks of unregulated treatment and the benefits of regulated treatment should be clearer and more accessible. Although the HFEA has a role in explaining the purposes of regulation, is not necessarily fair to expect the HFEA to play the role of public educator about treatments over which it has no control at all. Rather, it may be time to increase the scope of its public information function, or to give some other body responsibility for ensuring that people can readily access information that enables them to understand the potential consequences of the steps they are contemplating taking in order to have a baby. If one searches for 'find a sperm donor online', there is nothing from the HFEA on the first page of matches. Unfortunately, people are

---

<sup>26</sup> FPA Factsheet, SRE Education (FPA, 2011).

therefore more likely to click on a site like California Cryobank's *Donor Look-a-Likes*<sup>TM</sup>, which carries links to pictures of celebrities that donors are said to resemble, than they are to come across clear, authoritative guidance about much more important issues like the legal parentage of any child who may be born.

E. Blyth, 'Fertility patients' experiences of cross-border reproductive care' (2010) 94 *Fertility and Sterility* e11–e15.

M. Brazier, 'Regulating the Reproduction Business?' (1999) 7 *Medical Law Review* 166–93.

P Casey et al, 'Families created by donor insemination: Father-child relationships at age 7' (2013) 75 *Journal of Marriage and Family* 858-870.

Margaret Brazier, Alastair Campbell, and Susan Golombok, *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* (HMSO, London 1998)

L. Culley, 'Crossing borders for fertility treatment: motivations, destinations and outcomes of UK fertility travellers' (2011) 26 *Human Reproduction* 2373-2381.

A.P. Ferraretti et al, 'Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies' (2010) 20(2) *Reproductive BioMedicine Online* 261–266.

S. Golombok et al, 'Children born through reproductive donation: A longitudinal study of child adjustment' (2013) 54 *Journal of Child Psychology and Psychiatry* 653-660.

The Guardian, 'Illegal fertility company owners given suspended prison sentence', 12 October 2010.

Z.B. Gurtin, 'Banning reproductive travel: Turkey's ART legislation and third-party assisted reproduction' (2011) 23 *Reproductive BioMedicine Online* 555-564.

M.C. Inhorn and P. Patrizio, 'Rethinking reproductive 'tourism' as reproductive 'exile'' (2009) 92 *Fertility and Sterility* 904-6.

M. Inhorn, 'Diasporic dreaming: return reproductive tourism to the Middle East' (2011) 23 *Reproductive Biomedicine Online* 582-592.

S. Lewis et al, 'The impact of sperm DNA damage in assisted conception and beyond: recent advances in diagnosis and treatment' (2013) 27 *Reproductive BioMedicine Online* 325-337.

A. McKelvey et al, 'The impact of cross-border reproductive care or 'fertility tourism' on NHS maternity services (2009) 116(11) *British Journal of Obstetrics & Gynaecology* 1520-1523.

L. Simon et al, 'Sperm DNA damage has a negative association with live-birth rates after IVF (2012) 26 *Reproductive BioMedicine Online* 68-78;

W. Van Hoof et al, 'Reflections of Dutch patients on IVF treatment in Belgium: a qualitative analysis of internet forums' (2013) 28 *Human Reproduction* 1013-22.

A. Whittaker and A. Speier, "'Cycling Overseas": Care, Commodification, and Stratification in Cross-Border Reproductive Travel' (2011) 29(4) *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 363-83.