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Date: 31 October 2021 – UK Department of Health and Social Care

Consultation: **Technical Consultation – Donor Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts**

Consultation response on behalf of the Scottish Council on Human Bioethics:

The **Scottish Council on Human Bioethics** (SCHB) is an independent registered Scottish charity composed of doctors, lawyers, biomedical scientists, ethicists and other professionals from disciplines associated with medical ethics.

The principles to which the Scottish Council on Human Bioethics subscribes are set out in the **United Nations Universal Declaration of Human Rights** which was adopted and proclaimed by the UN General Assembly resolution 217A (III) on the 10th of December 1948.

The SCHB is very grateful to the UK Department of Health and Social Care for this opportunity to respond to the consultation on **Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts**. It welcomes its intention to promote public consultation, understanding and discussion on this topic.

Note: Because this UK Department of Health public consultation only lasted four weeks, the SCHB was unable to consider and discuss the relevant questions in an appropriate manner. This means that the SCHB responses, below, cannot represent appropriately those of the Council.

In this regard, the SCHB is very concerned that such a short consultation period undermines ethical conventions, the democratic process, and the rule of law in the UK. As a result, the SCHB is now questioning the manner in which the London Department of Health (1) values public consultations (2) respects the relevant stakeholders and (3) uses the responses given by these stakeholders.

Response to the Questions

Are you responding as an individual or an organisation?

Individual
 Organisation

Full name or organisation's name: **Scottish Council on Human Bioethics**
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Where are you resident? (Please see one of the options below)

Scotland Rest of the UK Rest of the world

Background

In the UK, laws and regulations of assisted reproduction, including fertility preservation, are governed by the *Human Fertilisation and Embryology Act 1990* (the 'HFE Act'). The HFE Act was introduced in 1990 and was amended in 2008 by the *Human Fertilisation and Embryology Act 2008* ("the 2008 Act"). Today, family units and family formation are vastly different than they were in 2008. Many more people are accessing assisted conception and fertility preservation; for example, same-sex couples, individuals who are choosing to start their families later in life, those who become prematurely infertile due to medical conditions, or less commonly, those who undergo gender re-assignment.

Fertility preservation is achieved through the freezing and storage of gametes (egg and sperm) or embryos. There are currently three pieces of legislation governing the storage of gametes and embryos in the UK:

- *HFE Act*, which currently sets out the baseline storage limit for gametes and embryos at a maximum of 10 years;
- *Human Fertilisation and Embryology (Statutory Storage Period for Embryos and Gametes) Regulations 2009*, which allows those who can demonstrate a medical need to extend the storage limit for ten-year periods up to a maximum of 55 years;
- *Human Fertilisation and Embryology (Statutory Storage Period for Embryos and Gametes) (Coronavirus) Regulations 2020*, which allows an additional two-year storage on top of the maximum base limit of ten years for those with material in storage on 1 July 2020. This was introduced as a response to the COVID-19 pandemic, which resulted in the closure to fertility clinics and ongoing delays to fertility treatments.

Since the last review of the legislation on statutory storage limits, when limitations to the technology meant that egg freezing in particular was poor, cryopreservation techniques have improved significantly. Today frozen eggs have the same developmental potential as fresh eggs. Clinical pregnancy rates from embryos created from thawed eggs are equivalent to fresh IVF treatment.^{1,2} There are therefore no technical barriers in place for the use of frozen gametes and embryos.

The 2020 Consultation

In view of the significant scientific innovation and societal changes, the UK Government launched a [public consultation](#) on 11 February 2020, to seek views about changing the statutory storage limits. The consultation ran for 12 weeks and closed on 5 May 2020. The consultation asked:

- whether the current ten-year statutory storage limit for gametes and embryos should increase, decrease, or stay the same, and why;

¹ HFEA Fertility treatment 2017: trends and figures: <https://www.hfea.gov.uk/media/2894/fertility-treatment-2017-trends-and-figures-may-2019.pdf>

² The BMJ: Freeze-all versus fresh blastocyst transfer strategy during in vitro fertilisation Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts

- whether there should be additional conditions on those seeking to freeze gametes or embryos beyond a certain limit, and if so, what these should be;
- whether eggs, sperm, and embryos should each have their own storage limit, and if so, what these should be;
- whether there should be a different storage limit for those with a medical need; and if so, why and what the new limit should be.

On 6 September 2021, the Government published its Response to the consultation.³ A summary of the outcomes and policy changes is provided below.

Following careful consideration of the views expressed in the consultation and applying a number of policy tests to the preferred options, the Government concluded that the option which meets these tests is to offer 10-year renewable storage periods to everyone, up to a maximum of 55 years.

The four key policy tests applied were:

- ensuring equity for all patients;
- facilitating greater reproductive choice;
- reducing administrative burden on fertility clinics and the regulator;
- ensuring public acceptability.

As part of this new settlement, there will be a statutory requirement for 10-year review periods. Explicit written consent from the patient will be required to continue storage.

The policy change is intended to facilitate greater reproductive choice and will allow for less stressful decision-making in family formation. Importantly, it will provide equity for all, Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts regardless of medical need, and will help reduce administrative burden for clinics and the regulator.

2021 Supplementary consultation: consequential impacts of the new policy

The 2020 consultation sought to identify whether there was substantial need and justification for changing the current statutory storage limits, as set out in the *HFE Act*. During the detailed analysis of the consultation responses, other parts of the legislative framework were identified which would be consequentially impacted by the new approach to the current statutory storage limit.

This additional consultation aims to gather views from interested organisations, including the regulator and medical professionals in women's health, fertility charities, ethics and legal groups, and faith-based organisations, on the consequential impacts of changing the legislation. The following areas were identified in the 2020 consultation feedback, which will be impacted by the legislative changes, and which require further review:

³ <https://www.gov.uk/government/consultations/egg-sperm-and-embryo-storage-limits/outcome/gamete-egg-sperm-and-embryo-storage-limits-response-to-consultation>

- third-party donations;
- known or family donations;
- surrogacy;
- posthumous use;
- research use.

Section 1: Third-Party Donations

Background

Donations of gametes are used by individuals or couples who are unable to conceive using their own gametes. For some, this is their only option to start a family. Donations may come from unknown third-party donors, from family members, or from friends. Third-party donation in this context refers to situations when the couple or individual uses donor gametes or embryos in fertility treatment from a person not known to them (as opposed to 'known or family donation' where the couple or individual knows the donor).

Using third-party donated eggs might be the only option for some women to use their partner's sperm (if they have one) and experience a pregnancy. There are several reasons why a woman might not be able to use her own eggs; for example, if she's had cancer treatment or if her children are at high risk of inheriting a serious genetic condition.

Donated sperm can be used in instances where the man is not producing enough sperm, or the sperm is of low quality; this could be a side effect of medical treatments for conditions such as cancer. Couples may also choose to use donated sperm to avoid passing on serious genetic conditions. In addition, same sex female couples and single women will need donor sperm to be able to start a family.

Similarly, third-party donated embryos might be the only way for some couples and single women to conceive and it might be the only way for the affected women to achieve a pregnancy.

To note, in the context of this document, in relation to the storage of eggs and embryos, women providing eggs or embryos for their female partner's treatment are not currently, and will not be, treated as donors since together the couple would be using their own material(s).

Existing Legislation

The *HFE Act* permits the use of donated embryos and gametes in fertility treatment, subject to informed written consent and proper counselling specific to the use of donated embryos or gametes. More information can be found in the Human Fertilisation and Embryology Authority's [Code of Practice](#). Furthermore, sections 33 to 55 of the *2008 Act* make provision about who is to be treated as the parent of a child who is born as a result of assisted reproduction treatments.

Since 2005⁴, donations are not allowed to be anonymous in the UK and must be recorded on the Human Fertilisation and Embryology Authority's Register. Under Sections 31ZA and 31ZE of the *HFE Act*, the Register allows children born from third-party donations to be able to access

⁴ The Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004

information, should they wish to, about their biological parentage. This also allows them to contact their donor and any donor conceived siblings once they turn 18, should they wish to do so.

Key Issues

The 2020 consultation feedback suggested that the statutory storage limit for donor gametes and embryos should be treated differently from other limits, so that donor-conceived individuals have a reasonable opportunity to make contact with their donors and donor conceived siblings when they reach 18, should they wish to. The intentions are to increase the chances that the donor is still alive when the donor conceived child comes of age and that there are no large age gaps with potential donor conceived siblings.

The new settlement would require gamete or embryo donors to renew their consent for storage and use every 10-years, up to a maximum of 55 years. Currently, fertility clinics are required to provide sufficient information and time to donors to reflect on their decision to continue consenting to the storage and use of their gametes or embryos. These review periods provide an opportunity for the donor to consider any implications for themselves and for any children born as a result of the donation. Fertility clinics should also reflect on any implications for the donor conceived children, *i.e.* whether using the gametes or embryos of the prospective donor could result in physical, medical, or psychological harm to the resulting child. This could include an assessment about whether any resulting children would have a reasonable opportunity to contact the donor later in life.

The 2020 consultation response indicated that gametes and embryos should have the same maximum storage limit applied to them. The Government supports this key principle but recognises that certain situations may require a different approach. We therefore wish to further consider the arguments for and against the application of a different maximum time period to an individual or a couple who have created embryo(s) using donated gametes, and some or all of these embryo(s) are subsequently entered into storage.

This situation is likely to disproportionately affect same-sex couples and single people who rely on donated material to have children. In these instances two competing priorities need to be balanced; that couples or individuals using the same donor for their own family should be able to have siblings using the same donor and should be able to decide on any gaps between siblings, against the fact that lengthy storage of their embryos may create a large age-gap with any donor siblings from other families and prevent some donor-conceived people making contact with their donor, if so much time has passed and they have died.

If a different approach is applied to storage of donated material, then it would be a reasonable expectation for these couples or individuals to benefit from whatever that maximum time period is – for example 20 years, and not be penalized for having to use donated materials. This would mean that fertility clinics would be responsible for ensuring that when donated gametes are used to create embryos, patients are well aware of the different rules for storage, so that if a couple or an individual decides to have siblings using that material at a later date, there is sufficient time to undergo treatment. There may be unintended consequences, with pressure on clinics to always use freshly donated materials and consequential problems if there are insufficient donors.

It is worth noting that in cases of donations, the gametes or embryos can be used in treatment regardless of whether the donor is dead or alive provided that the donor's consent for storage and use is still in place (*i.e.* within any given 10-year consent period). The HFEA donation consent forms state that by consenting to donate, you are also agreeing to your eggs, sperm, or embryos

being used and stored if you were to die or lose the ability to decide for yourself (become mentally incapacitated).

It is however possible for the donor to specify that their gametes or embryos cannot be used for treatment following their death. Clinics must then make reasonable attempts to check that the donor is still alive before using their gametes or embryos. Some clinics conduct annual checks to ensure that the donors they are using are still alive and they choose not to use a donor after death as the resulting child would not be able to have contact with the donor later in life.

Taking into consideration the information set out above, the questions below seek views on whether the maximum storage limit should be different in the case of third-party donated gametes and/or embryos or whether there are sufficient safeguards in place so that the maximum 55 years should still apply.

Questions

Please read these questions carefully, as they are very similar and might look the same but are not.

Question 1

Should the maximum statutory storage limit of 55 years apply equally to all third-party donated gametes and embryos?

~~• Yes~~

• No - X

If you answered Yes, please go to Question 8. If you answered No, please go to Question 2.

Question 2

Should third-party donated **gametes, and **embryos** created using third-party gametes, have the same maximum statutory storage limit as each other?**

~~• Yes~~

• No - X

If you answered Yes, please go to Question 3. If you answered No, please go to Question 4.

Question 3

~~If yes, what should the new limit be for third-party donated **gametes** and **embryos** created using third-party donated gametes? Please select from the list below.~~

~~• 10 years~~

~~• 20 years~~

~~• 30 years~~

~~• 40 years~~

~~• 50 years~~

~~Please go to Question 8 next.~~

Question 4

Should there be a different maximum time-limit applied to third-party donated **gametes, rather than the new statutory storage limit of a maximum of 55 years?**

~~• Yes~~

• No

If you answered Yes, please go to Question 5. If you answered No, please go to Question 6.

Question 5

~~If yes, what should the new limit be for third-party donated gametes? Please select from the list below.~~

- ~~• 10 years~~
- ~~• 20 years~~
- ~~• 30 years~~
- ~~• 40 years~~
- ~~• 50 years~~

~~Please go to Question 6 next.~~

Question 6

Should there be a different maximum time-limit applied to **embryos** created using third-party donated gametes, rather than the new statutory storage limit of a maximum of 55 years?

- ~~• Yes~~
- ~~• No~~

If you answered Yes, please go to Question 7. If you answered No, please go to Question 8.

Response from the Scottish Council on Human Bioethics

The SCHB regrets many of the provisions adopted in both the Human Fertilisation and Embryology Act of 1990 and of 2008. More specifically, it regrets the very existence of stored human embryos - many of which will eventually be destroyed. This is a problem which should be addressed as a matter of urgency (so that the situation become similar to the one in Germany where no spare embryos are created).

Moreover, the HFEA should publish the total number of embryos presently being stored in the UK and what eventually happens to them. Otherwise, the respondents to this consultation cannot be seen as being informed in preparing their replies. In other words, this lack of information invalidates this consultation.

Question 7

If yes, what should the new limit be for **embryos** created using third-party donated gametes? Please select from the list below.

- ~~• 10 years~~
- ~~• 20 years~~
- ~~• 30 years~~
- ~~• 40 years~~
- ~~• 50 years~~

Please go to Question 8 next.

Response from the Scottish Council on Human Bioethics

Embryos which already exist should be held as long as possible until they are implanted in a woman for gestation rather than being allowed to die. Moreover, in a similar way as to what happens in Germany, the SCHB agrees that no spare embryos should ever be created.

Question 8

The Government intends that in cases where a couple use their own gametes, and one or both individuals previously stored their gametes, to create an embryo that is then also entered into storage, the embryo's 55 year limit will start from the date when the last person gave consent. For example, person A had eggs in storage for 10 years and person B had sperm in storage for 6 years and subsequently they create embryos which also enter storage. The embryos have 49 years of storage time remaining because person B was the latest person to give consent. If person

B provided fresh gametes that were not in storage, the embryo would have 55 years storage time as their consent would be considered the latest.

Taking the above in account, please consider the below options in the case of third-party donated materials and select either option a) or b).

~~a) two different periods, such as a set number of years for donor gametes and then an additional set number of years for any embryos created using the donated gametes~~

~~b) a single period, such as a set number of years for donor gametes and any subsequently created embryos, that starts when the donor gamete is first put into storage.~~

Question 9

Please explain the reasoning behind your answers in this section of questions.

9.1. Relationships between children resulting from donor gametes and their parents

9.1.1. In addressing the issues raised by the regulation of donor-assisted conception, the SCHB believes that it is very important to examine the deep bonds that exist between parents and their offspring. For example, many parents, as the responsible partners in the creation of life, know that in some way they belong to the child and the child in receiving life belongs to them. In other words, a sort of mutual belonging exists.

The deep sense of loss or incompleteness felt by parents, unable to be directly responsible for the creation of life in their child, may be the essential reason for their interest in assisted reproduction as opposed to, for example, adoption. In other words, the costly and sensitive procedures considered by all families seeking artificial conception are a pointer to the importance they attach to the biology of creation. They may apprehend the possibility of their own inability to feel a sense of belonging with the child and the difficulties the child itself may experience in feeling that it did not belong to them.

9.1.2. This apprehension is also reflected in published reports which suggest, for example, that when Assisted Insemination by Donor (AID) has been used, the commissioning (non-genetic) father is significantly more reticent than the commissioning (genetic) mother of informing the child of its biological origins. Moreover, it has been indicated that only 21% of AID parents, in the Netherlands, have decided to inform their child of the way in which they were conceived. This is compared to 94% of the parents who have not used AID.⁵

Researchers have also found that in 46 families in England with a child up to age of 8 who had been conceived through sperm donation only 13% had already told their child and 26 % said they intended to. But 43 % had decided against it and 17 % were still unsure what they would do.^{6,7}

And one European study of donor insemination families in the UK, Italy, the Netherlands and Spain found that only 12% of the mothers had planned to tell the child about his or her conception procedure, while 75% had decided not to do so. By the time the children reached 11-12 years old, only 8.6% of parents had told their children about their conception procedure.⁸

⁵ Brewaeys, A., Golombok, S., Naaktgeboren, N., de Bruyn, J.K., Van Hall, E.V., Dutch parent's opinion about confidentiality and donor anonymity and the emotional adjustment of their children, *Human Reproduction*, Vol.12, No.7, (1997)

⁶ Sperm donation — should you tell your child?, Reuters, <http://www.msnbc.msn.com/id/6866305/>

⁷ Poor couples 'want IVF anonymity', BBC News, 26 January 2005, <http://news.bbc.co.uk/1/hi/health/4205661.stm>

⁸ Golombok *et al*, The European Study of Assisted Reproduction Families: The transition to adolescence, *Human Reproduction*, Vol. 17(3): 840-40 (2002)

This is all the more worrying since 50% of donor insemination children suspect, when growing up, that their social father may not be their genetic one before being told.⁹

Thus, the question remains: WHY so few parents inform their children of the manner in which they were conceived?

Moreover, even in the present consultation it is indicated that “*donor-conceived individuals have a reasonable opportunity to make contact with their donors and donor conceived siblings when they reach 18, should they wish to*”.¹⁰ However, it does not explain WHY these donor-conceived individuals would want to make contact with their donors and donor conceived siblings.

The consultation also indicated that “*couples or individuals using the same donor for their own family should be able to have siblings using the same donor*”.¹¹ However, it does not explain WHY these individuals may want to use the same donor.

The consultation further states that: “*In some cases, family donations of gametes or embryos might provide the only option for individuals or couples to have a genetically related child. For example, if a woman is unable to use her own eggs, those of her sister, mother, or aunt might be used. This would provide a degree of genetic relatedness and would allow her to carry the child and experience pregnancy.*”¹² But again it does not explain WHY couples may want a genetically related child.

An answer to some of these questions may be found if the deep and important bonds which exist between the parents and their children are considered. But these have not yet been sufficiently or appropriately developed.

Other examples of the importance of the biological parent-child bonds:

Other perspectives of the strength of the parent-child bond can be noted in the following examples:

9.1.3. The dilemma faced by the two women Natallie Evans and Lorraine Hadley who lost their High Court battle, in 2003, to use the frozen embryos created with the help of their former but now estranged partners against their will.¹³ It was, indeed, very clear to all that one of the main reasons why both men had refused to give permission was that they felt that some kind of bond would exist between them and the child which they did not want.

⁹ Mary Braid, Your daddy was a donor, The Observer, 20 January 2002, <http://observer.guardian.co.uk/review/story/0%2C6903%2C636020%2C00.html>

¹⁰ UK Department of Health and Social Care, Technical Consultation - Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts, 2021, p. 5-6.

¹¹ UK Department of Health and Social Care, Technical Consultation - Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts, 2021, p. 6.

¹² UK Department of Health and Social Care, Technical Consultation - Gamete (Egg and Sperm) and Embryo Storage Limits: Consequential Impacts, 2021, p. 10.

¹³ Women lose embryo battle - BBC - 1 October 2003, <http://news.bbc.co.uk/1/hi/health/3151762.stm>

9.1.4. The assumed strength of the biological parent-child bonds which is reflected in the fears that many gamete donors have concerning the lifting of anonymity. For example, 90 % of UK clinics have reported in the past a shortage of donors.¹⁴

9.1.5. Recent research results which show that more than four out of five US children conceived using donor insemination with an identifiable sperm donor would be likely to ask the identity of their donor and try to contact him. This would happen either when that information was available to them at the age of 18 or sometime later in their lives. Many said that they would also like to contact any other children of the donor¹⁵. But WHY do they want this contact?

9.1.6. The fact that UK clinics are expected to strive, as far as possible, to match the ethnic background and physical characteristics of gamete donors to those of an infertile partner; thus, in a way, making sure that the possible child is seen (in a visual sense) to ‘belong’ to its parents.¹⁶ In this regard, Olivia Montuschi from the Donor Conception Network, which represents families of children conceived after sperm or egg donations, insisted that it was vital for children to share physical characteristics with their parents. She also indicated that *“If a child is significantly different in any way, either in physical characteristics or intellectual attainment, then it can make it harder for them to feel part of that family”*.¹⁷ But WHY is it so important that children feel part of the family? Does this not reflect a deep sense of bonding or communality which should exist between the biological parents and the child?

9.1.7. The extremes to which some persons, such as past UK Home Secretary, Mr. David Blunkett, will go in order to prove their paternity over a child. But what, exactly, do these people feel towards the child they claim is ‘theirs’ and why do they go to such lengths?

Moreover, it is interesting to note that, in Mr. Blunkett’s case, the judge indicated that it was in the child’s best interests to have his parentage determined at the earliest opportunity by a court ordering scientific tests.¹⁸

9.1.8. The more than 116,000 frozen human embryos that are presently stored in UK clinics resulting from IVF. This has arisen because parents may:^{19,20}

- (1) want to implant these embryos at a later date into the biological mother,
- (2) be unsure of the moral status of these human embryos and therefore not want to see them destroyed either outright or in research,

¹⁴ A. Frean, Couples may get chance to design the ‘ideal’ IVF baby, TIMESONLINE, 12 November 2004: <http://www.timesonline.co.uk/article/0,,2-1355182,00.html>

¹⁵ Children Positive about Sperm donors, BioNews No. 284, 15 November 2004

¹⁶ This is also reflected in paragraph 18 of the HFEA consultation which states that: Clinics usually offer recipients gametes or embryos from donors who are a close physical match to the people receiving treatment. This is thought to be in the interests of the family concerned so that donor-conceived members of that family do not ‘stand out’ and risk becoming socially stigmatised as a result. Additionally, some recipients want donors with a certain background for non-genetic reasons, for example because they want a donor who shares their religion.

¹⁷ A. Frean, Couples may get chance to design the ‘ideal’ IVF baby, TIMESONLINE, 12 November 2004: <http://www.timesonline.co.uk/article/0,,2-1355182,00.html>

¹⁸ Blunkett wins right to seek access, BBC NEWS, 3 December 2004: http://news.bbc.co.uk/1/hi/uk_politics/4065177.stm

¹⁹ Sarah-Kate Templeton, Spare embryos ‘should be donated to infertile couples’, The Sunday Herald, 21 September 2003: <http://www.sundayherald.com/36912>

²⁰ Couples’ feelings mixed about extra embryos, 14 October 2003 (Reuters Health): <http://www.stjudemedicalcenter.org/healthnews/reuters/20031014elin022.htm>

(3) not want to give these embryos up for adoption because of the ‘bonds’ that exists between them and the embryos. In the UK, despite the high number of left-over embryos, only around a few hundred embryos/year are donated to infertile couples who cannot create their own.²¹

In this respect, Professor Ian Craft, past director of the London Fertility Centre, said: *“It surprises me that so few couples agree to donate spare embryos if you consider the desperation of infertile couples to have children.”* Adding that *“there are very few babies to adopt and so I would have thought these couples, who have been through infertility treatment themselves and who have completed their families, would be more sympathetic to others”*. He also indicated that society should be making people more aware of the benefits that these supernumerary embryos may represent to childless couples.²²

9.2. Concerns of the SCHB relating to Donor-Assisted Conception

9.2.1. The SCHB notes that Donor-Assisted Conception is not risk free for the woman giving the eggs since many eggs must be retrieved from female patients and this is not without the risks of ovarian hyperstimulation syndrome following aggressive hormonal treatments.²³

9.2.2. It remains the SCHB’s concern that some media-highlighted cases of obvious gamete insemination and embryo implantation errors have taken place. This has arisen when obvious racial differences were noticed. It is not known how often other true mistakes have occurred when racial characteristics were not present.

9.2.3. The SCHB notes that parents who use donor insemination are often bringing a child into the world in order for him or her to relate to themselves while often ignoring the relationship the child may want to have with his or her genetic parents. Though the parents may concede to tell their child the truth when they are older, they would then have to understand that the child may wish to see and know his or her genetic parents and express a sort of a ‘love’ which he or she may already experience. The child may also experience difficulties towards his or her genetic or social parents with the possibility of feeling a sense of rejection.

9.2.4. The SCHB is, therefore, of the opinion that until the above questions are answered satisfactorily concerning:

- (1) the important bonds that exist between the biological parents and the child, and
- (2) the unease the general population has concerning donor insemination,

²¹ G Fuscaldo, J Savulescu, *Spare embryos: 3000 reasons to rethink the significance of genetic relatedness*, *Reproductive BioMedicine Online*, Volume 10, No 2 February 2005, <http://www.rbmonline.com/4DCGI/Article/Detail?38%091%09=%201550%09> Studies reviewing the fate of surplus human embryos reveal that close to 90% of couples choose to discard their excess embryos and that hundreds of embryos are disposed of annually. It has been argued that human embryos are a valuable resource and that there is a need to consider educational programmes to encourage couples to donate spare embryos to other infertile couples, rather than discard them. Surveys show that one reason why so few embryos are donated is that couples attach great significance to genetic parenthood. Advances in reproductive technology may necessitate a review of biological definitions of family and the importance of genetic relatedness. It can be argued that it is unreasonable to conclude that genetic ties are so significant that embryos should be discarded rather than donated and raised by non-genetically related parents. It is suggested that education programmes should encourage reflection on people’s beliefs about the importance of genetic relatedness with regard to what makes a family. Open embryo donation or directed embryo donation programmes might cause couples to change their minds, or alleviate their anxiety about donating embryos to others.

²² Sarah-Kate Templeton, *Spare embryos ‘should be donated to infertile couples’*, *The Sunday Herald*, 21 September 2003: <http://www.sundayherald.com/36912>

²³ Delbaere, A., G. Smits, O. Olatunbosun, R. Pierson, G. Vassart, and S. Costagliola. 2004. New insights into the pathophysiology of ovarian hyperstimulation syndrome. What makes the difference between spontaneous and iatrogenic syndrome? *Human Reproduction* 19: 486-489.

then the possibility of accepting donated gametes in order to address infertility should not be envisaged. Accordingly, the SCHB cannot reply to the other questions posed in this consultation without undermining its stance that such procedures should not proceed until further investigations are undertaken and the serious doubts concerning these procedures are addressed.

9.3. Criteria for embryo adoption

9.3.1. Concerning the creation of human embryos *in vitro*, the SCHB notes that in countries such as Germany, Austria, Italy and Ireland it is considered unethical to create human embryos *in vitro* if they are not immediately implanted into the mother. This happens in order to avoid the difficult problem, which exists in the UK, of having an ever increasing stock of frozen, unwanted and supernumerary embryos generally destined for destruction.

9.3.2. The SCHB also notes that patients should be asked to think about what they want to do with their potential left-over embryos before they are created. This is in agreement with Dr Richard Kennedy, past secretary of the British Fertility Society and consultant gynaecologist at the Centre for Reproductive Medicine in Coventry, who indicated that “*it would be helpful to raise the issue of ‘what will you do with these embryos?’ before they are created.*”²⁴

9.3.3. The SCHB believes that it would be preferable if parents were better counselled as to the implications of a donation. They may initially have been motivated by a very vague idea of doing some good with something that was left over, without any real cost to themselves.

9.3.4. The SCHB recognises that even though an unacceptable large number of stored embryos does unfortunately exist in the UK, it would be preferable for these embryos to be given for adoption instead of being destroyed. Though some of the problems relating to the important biological ‘bonds’ that should exist between parents and children (see previous section) do not exist in this case, the adoption of embryos, in a similar way as the adoption of children, is a very positive solution to an already existing difficult situation. This is in contrast to *creating* difficulties in kinship identities and the related biological ‘bonds’ which is what is happening in the use of donor gametes. The SCHB would thus like to encourage the adoption by infertile couples of supernumerary embryos²⁵.

9.3.5. The SCHB is of the view that embryo adoption should be considered in the same light as the adoption of children born after birth. In other words, children born through embryo adoption should have the same right to know their genetic parents as children adopted after birth.

9.3.6. The SCHB believes that, if a child has been brought up knowing the truth about his or her adopted origins, he or she may find it beneficial to be enlightened about the fact that he or she was rescued from the frozen state. As well as wanting to meet his or her true live siblings the person may also need to be counselled because of the effect of being a survivor compared to many of the other embryos who perished when defrosted.

Section 2: Known or Family Donations

Background

²⁴ Sarah-Kate Templeton, Spare embryos ‘should be donated to infertile couples’, The Sunday Herald, 21 September 2003: <http://www.sundayherald.com/36912>

²⁵ This should take account of the risk of incest if many embryos are adopted in a common location.

In some cases, family donations of gametes or embryos might provide the only option for individuals or couples to have a genetically related child. For example, if a woman is unable to use her own eggs, those of her sister, mother, or aunt might be used. This would provide a degree of genetic relatedness and would allow her to carry the child and experience pregnancy. Similarly, if the man is infertile, his brother, father, or uncle might be able to donate sperm.

In other cases, individuals or couples may be provided by a direct donation from a friend. This might be particularly relevant to female same-sex couples and single women, who require donated sperm to conceive.

Existing Legislation

The *HFE Act* does not differentiate between third-party, known and family donations of gametes and embryos, and so currently there are no legal or regulatory differences between the two. However, through the HFEA's [Code of Practice](#), licenced UK clinics are prohibited from performing treatment that involves the mixing of gametes for close relatives who are genetically related; *i.e.* grandfather and granddaughter, grandmother and grandson, father and daughter, mother and son, brother and sister, half-brother and half-sister, uncle and niece, aunt and nephew, uncle and half-niece, and aunt and half-nephew. These restrictions are explicit and are in line with UK law, which prohibits consanguineous relationships.^{26,27} In addition, clinics may provide tailored implications counselling to ensure everyone understands the implications of donating to a family member.

Key Issues

Known or family donations may contain inter-generational donations, for example a mother donating her eggs to her daughter, or a father to his son. Known family donations therefore might need to take place over longer time frames, *i.e.* over two generations, as opposed to third-party donations. As a result, the Government considers that it may be appropriate to keep the maximum limit for known or family donations of gametes and embryos at 55 years, with 10-year renewable storage periods requiring explicit written consent. In order to lessen the administrative burden on clinics and the regulator, we suggest that all known or family donations, not just inter-generational donations, could benefit from the same maximum storage limit of 55-years. The questions below seek your views on this specific subject.

Question 10

Should the new approach of 10-year renewable storage periods with a maximum time-limit of 55 years, be applied to known family donations of gametes and embryos?

- Yes
- No

Question 11

If not, what should the new limit be? Please select from the list below.

- 10 years
- 20 years
- 30 years
- 40 years

²⁶ Sexual Offences Act 2003

²⁷ Marriage (Prohibited Degrees of Relationship) Act 1986

•50 years

Question 12

Please explain the reasoning behind your answers in this section of questions.

The SCHB has agreed that until the unanswered questions relating to donor insemination and kinship identity are addressed satisfactorily, the possibility of accepting donated gametes in order to address infertility should not be envisaged.

Section 3: Surrogacy

Background

Under some circumstances, individuals or couples may rely on surrogacy arrangements to have biologically related children. It may be that due to health conditions, the woman is unable to carry the child, or for male same-sex couples it may be the only option to have a biologically related child. The couples or individuals entering into an agreement that they will be the parents of a child born to a surrogate through assisted conception are known as the intended parents.

In cases of surrogacy, there are a number of options as to who the gamete providers may be:

- i Both gametes are provided by the intended parents *i.e.* in the case of an opposite-sex couple, in which case the surrogacy arrangement will be undertaken using the gametes of the intended parents and therefore any embryo created will be with their own materials.
- ii Only the male gamete is provided by the intended parent(s) *i.e.* in the case of a male same-sex couple, an opposite sex couple where the female gamete provider is infertile, or in the case of a single male. In these cases, the female gamete is likely to come from a donor and so any embryo created will contain donor material.
- iii Only the female gamete is provided by the intended parent(s) *i.e.* in the case of an opposite sex couple where the male gamete provider is infertile, in the case of a single female, or in the case of a female same-sex couples. In these cases, the male gamete is likely to come from a donor and so any embryo created will contain donor material.

There is an increased interest in surrogacy arrangements in the UK as an option for family formation and so it is important to consider how the proposed legislative change for storage might impact on intended parents and the surrogate.

Existing Legislation

Legislation governing surrogacy in the UK dates to the *Surrogacy Arrangements Act 1985*, with occasional updates around legal parenthood now consolidated in the *Human Fertilisation & Embryology Act 2008*. A review of this legislation is currently being undertaken by the Law Commissions of England & Wales and Scotland. The existing legislation is silent on how embryos destined for surrogacy should be treated in relation to storage. It is however worth noting that one

of the intended parents must be genetically related to the resulting child; therefore at least one of the gametes must come from the intended parents.

Key Issues

As highlighted above, in surrogacy arrangements the gametes may come from the intended parents or from one of the intended parents and from a donor. However, any fertility treatment processes that takes place will always include an additional person – the surrogate. In most cases, a surrogate will undergo IVF using embryos created from the gametes of other people such as gamete donors. This is different from the traditional definition of ‘own use’ in which case both gametes would come from the couple undergoing treatment and the woman would carry the pregnancy herself.

This raises a question about whether surrogacy arrangements and materials stored for surrogacy arrangements should be in a different category.

Question 13

Should the definition of ‘own use’ be extended to embryos destined for surrogacy created using both the intended parents’ gametes, even though the person undergoing fertility treatment will be the surrogate?

- ~~• Yes~~
- No - X

Question 14

Embryos that enter storage and that were created using third-party donor gametes destined for surrogacy should be treated the same way as embryos created using a third-party donor in a non-surrogacy arrangement. Do you agree?

- ~~• Yes~~
- No

Question 15

Please explain the reasoning behind your answers in this section of questions or offer any other views you may have on this issue.

Interestingly, no real and extensive discussion and attitudinal research amongst members of society in the UK relating to surrogacy has taken place.²⁸ This is surprising since any investigation should normally be carried out before any legislation is proposed or amended. Moreover, an enquiry would be very useful since, even for the most informed of commentators, many of the questions relating to surrogacy are complex, such as:

- Should a woman ever be encouraged to detach herself, psychologically, from her gestating child?
- What do the intended parents mean when they say that they want a child ‘of their own’?
- Can the ethical and relational identity challenges arising from the use of donor eggs and/or sperm ever be resolved for the donor, the intended parents, and the resulting child?
- Can persons ever own (or rent) their bodies, as such, in a civilised society?

²⁸ Law Commission & Scottish Law Commission, Building families through surrogacy: a new law, 2019, p. 3.

- Is there a risk of commodification of children born from commercial surrogacy both in the UK and abroad? How will the children resulting from commercial surrogacy understand, or consider, the manner in which they were brought into existence, when they become more mature?
- Should procedures, which are prohibited in the UK, be legalised just because some individuals are going abroad to bypass the law?
- What kinds of psychological risks would exist for the surrogate or the child if the latter is immediately taken away after birth?
- Why is there no requirement for discussion and agreement concerning the detection of disability and its management (such as a termination of the pregnancy)? What would the rights and interests be of a disabled fetus or those of the surrogate if she disagrees with the intended couple on the definition of acceptable risks of disability?

Until such questions are seriously considered (and answered) it is difficult to accept this consultation as being adequate or reliable since it does not really address, or give any information about, the core ethical challenges. Again, if the principle of providing appropriate information in the consent procedure is seen as important for patients, then it is also important for democratic societies and parliaments before they make decisions, such as in considering different forms of surrogacy.

Moreover, a number of the proposals being present to the surrogacy problems are unproven, disturbing and even scandal-prone solutions. Proposals which may undermine the very basis of civilised society. There is no real evidence that the alarming solutions being suggested are what the general public really wants. This is because the consultation seems to limit the possible ways forward in a manner which, to be honest, may be considered as a form of undue constraining and even coercion of the responder.

The SCHB notes that many elements in the present consultation relate to the wishes of the intended parents or the surrogate, but the possible views of the children being brought into existence through surrogacy seem to be overlooked. The 'Right to have a child' by intended parents seem to have priority over any rights of children born through surrogacy. In other words, the proposals seem to have been driven by, and largely serve the interests of, those who wish to benefit from surrogacy, but with little concern for surrogate women or the children who are born. This differential would be further widened if surrogacy became a commercial relationship.

The purpose of any law is not merely to licence activities that some autonomous individuals within society seek to access. Rather the law must protect those who may be harmed by others. In this regard, the SCHB would like to consider the following serious ethical concerns:

1. Concerns relating to the surrogate woman

The use of a surrogate woman to gestate the child for someone else is one of the main concerns relating to the whole procedure. These include the reality that she is expected to psychologically detach herself from her gestating child and give it up at birth. Risks also exist that the surrogate mother may just be seen as the means to an end with the resulting possibility of exploitation. Indeed, there is an instrumental logic that persists in surrogacy, among other reproductive technologies, which needs to be developed.

1.1. The psychological risk of detachment towards the gestating child

Generally, a woman who knows that a child is growing inside her feels very strong bonds of mutual belonging with it. This is because she enters into a kind of relationship with the child she is gestating at a

time when it is growing from its most vulnerable and smallest size into a fully-grown baby. It is also one of the most important times in the life of this child - one where he or she is entirely dependent on others and most in need of protection and unconditional acceptance. In this regard, one of the central objections to surrogacy is that it involves an expectation of deliberate detachment between the surrogate mother and the child she is carrying.²⁹

Furthermore, it may be suggested that the relationship between mother and child is itself undermined by surrogacy since, in the procedure, a woman deliberately becomes pregnant with the aim of giving up the child after birth which is a very detrimental way of considering pregnancy.³⁰ Questions can be asked relating to the kinds of relationships surrogates are expected to have with the gestating child. This is because, with the procedure, a woman's detachment from her child in the womb is accepted and even encouraged - a situation which would very much be discouraged in any traditional pregnancy.³¹

In this respect, the New Zealand neuroscientist and bioethicist, D. Gareth Jones, comments:

“However numerous our objections to surrogacy, a central one is the deliberate breaking of that intimate relationship between the biological or carrying mother and the child. Relationships are critical to what we are as human persons. Surrogacy therefore places the development of a crucial relationship in jeopardy, and it does this intentionally ... This is a very high price to pay for providing an infertile couple with a child.”³²

Thus, a pregnancy cannot be seen as being unimportant for both the mother and the child. Instead, it represents a very significant natural relationship of dependency on the mother by the prenatal child for his or her survival and protection.³³

1.2. The psychological risk of relinquishing the child at birth

Concerns also exist as to what is actually happening when the surrogate mother relinquishes the child at birth. This is because she may feel a very strong bond of mutual belonging with the child arising from the gestational experience. But even if it was possible for a surrogate to relinquish the child to whom she has given birth, it is not a psychological feature that society should ever encourage even on the basis of altruism. As Jones explains:

“The welfare of the surrogate mother also needs to be considered from another angle, and this is her own reaction to the loss of ‘her’ baby. Far too little attention has been paid to this, or to the guilt and despair she may experience in later years. While the reactions of surrogates will undoubtedly vary, the loss of the child is as real for her as for the woman whose child has been adopted or the woman who has had a still-birth.”³⁴

²⁹ D. Gareth Jones, *Manufacturing Humans*, Leicester: Inter-Varsity Press, 1987, p. 204-205.

³⁰ Department of Health & Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology*, 1984, London: Her Majesty's Stationery Office, p.44-45.

³¹ Scott B. Rae and D. Joy Riley, *Outside the Womb: Moral Guidance for Assisted Reproduction*, Chicago: Moody Publishers, 2011, p. 183.

³² D. Gareth Jones, *Manufacturing Humans*, Leicester: Inter-Varsity Press, 1987, p. 204.

³³ Normam M. Ford, *The Prenatal Person: Ethics from Conception to Birth*, Blackwell, Oxford, 2002, p. 115.

³⁴ D. Gareth Jones, *Manufacturing Humans*, Leicester: Inter-Varsity Press, 1987, p. 2004-206.

Of course, it may be suggested that surrogacy is similar to adoption in that the surrogate mother relinquishes the child at birth to the commissioning parents. But this may not, in fact, be true since in adoption the adoptive legal parents are not deliberately bringing into existence a child to be relinquished. In this regard, the American bioethicists, Gilbert Meilaender, explains that when a child is relinquished for adoption, the woman who rears that child is rightly described as his or her mother, adding:

*“But this, again, only indicates that adoption is not analogous to surrogacy. The child adopted is not conceived in order to be given up. The child is already on the scene presenting in his person a need for care. Adoption is a procedure designed to answer that need already present. By contrast, perhaps the greatest moral difficulty with surrogacy is that the surrogate is being invited to conceive a human being as a means to satisfying someone else’s desire to have a child.”*³⁵

Some courts, in the USA, have already compared gestational surrogacy to a form of baby-sitting lasting nine months. But this very much underplays and overlooks the deep psychological relationship a surrogate may develop with her gestating child. Indeed, very deep emotional bonds may develop between the surrogate and her child which the woman would have to break when giving over the child to the intended parents. Moreover, the genetic element cannot be seen as having priority over all other aspects. The moral philosopher, Norman Ford, indicates:

*“Where donor gametes are legally permitted in [artificial reproductive technology] ... with the consent of one’s partner, common law has usually, and rightly, been changed by statute law to determine that the birth mother is the legal mother of the child rather than the genetic mother. Even the legal sanctioning of altruistic surrogacy would weaken the importance of motherhood.”*³⁶

This means that a woman should never legally be forced to relinquish a child after birth against her will.³⁷ For example, in the UK at present, legislation always recognises the birth mother as the legal parent including for surrogates. It is only in follow-up legal proceedings that the child may be relinquished to the commissioning parents (but this is not automatic).

Even when surrogacy is undertaken for altruistic aims in a spirit of compassion, the dangers of psychological harm are substantial. For instance, when surrogacy takes place within an extended family setting between sisters, surrogate arrangements are fraught with unforeseen complications for all involved and should never be encouraged.³⁸

1.3. Risks of dispute between the surrogate and commissioning parents

When a number of participants are involved in a surrogacy procedure, a risk exists that real difficulties may arise after the initial arrangements. For example, when the child is born disabled and the intended parents then refuse to accept the child which they had ‘commissioned’.

In 2010, it was reported that a couple in Canada had engaged a surrogate to carry their child but then discovered, during an ultrasound examination in the first trimester of the pregnancy, that the foetus was

³⁵ Gilbert Meilaender, *Bioethics: A Primer for Christians* (Third Edition), Grand Rapids: Eedermans Publishing Co. 2013. p. 23.

³⁶ Norman M. Ford, *The Prenatal Person: Ethics from Conception to Birth*, Blackwell, Oxford, 2002, p. 115.

³⁷ Department of Health & Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology*, 1984, London: Her Majesty’s Stationery Office, p.44-45.

³⁸ D. Gareth Jones, *Manufacturing Humans*, Leicester: Inter-Varsity Press, 1987, pp. 205-206.

likely to have Down's syndrome.³⁹ The couple then asked the surrogate to have an abortion for which she expressed some concerns. But the couple had entered into a contract with the surrogate before the gestation began stating that if she refused the eventual request for an abortion, then the couple would be absolved of all further responsibility towards the child. In the end, the surrogate agreed to the abortion but this case demonstrates the potential complications and significant ethical difficulties that may arise from surrogate arrangements.⁴⁰

One of the most famous surrogacy disputes, which exemplifies the risks of bringing a child into existence outside the exclusive embodied loving relationship of a married couple, took place in 1997 in California. This arose when an infertile couple, Luanne and John Buzzanca, contracted three separate adults, a sperm donor, an egg donor and a surrogate woman, to bring 'their' child into existence through *in vitro* fertilisation. A baby girl was subsequently born in 1995 called Jaycee. But before the birth took place and after the Buzzancas signed a contract with the surrogate, John decided to leave his wife and filed for divorce. At the divorce hearing, it was ruled that John should pay child support which he later appealed since he considered that the baby was not a child of the marriage. In the meantime, the surrogate filed for custody of the child which she later dropped, and Luanne took responsibility of the baby girl while continuing to sue her estranged husband for child support.

In 1997, a superior court ruled that the child had no legal parents responsible for her care and that John Buzzanca was not obliged to pay child support. This was because the baby girl had two gametes, two commissioning non-biological parents and a surrogate mother who had relinquished her parental rights through the surrogacy agreement.

The case, as a result, went to an appeal court in 1998⁴¹ whereby a panel of three-judges ruled unanimously that both John and Luanne were to be considered the legal parents of the baby girl because she would never have been born had not Luanne and John both agreed to have a fertilised egg implanted into a surrogate mother. Thus, the judges found that the child's conception was every bit as much the responsibility of the Buzzancas as if things had been done the old-fashioned way.

1.4. The risk of Commodification and Objectification of the Surrogate

A number of other ethical questions relating to surrogacy exist, including that surrogate women are allowing themselves to be used as a kind of human incubator for someone else's child. Indeed, it may still be very difficult, in practice, to ensure that such a relationship does not reflect some exploitative connotations.⁴² Thus a real risk of commodification of the women's body exists which describes the treatment of a human being as an interchangeable marketable commodity which can give rise to commerce. A commodity has a price and only an instrumental value. But with surrogacy there is also a risk of 'objectification' which describes the treatment of a human being as a thing or an object, disregarding his or her personality and inherent dignity.

It is because of such risks that Article 3 of the **EU Charter of Fundamental Rights** indicates that: "*In the fields of medicine and biology, the following must be respected in particular ... the prohibition on making the human body and its parts as such a source of financial gain*".

Similarly, the **Council of Europe Convention on Human Rights and Biomedicine** indicates in Article 21 that: "*The human body and its parts shall not, as such, give rise to financial gain.*"

³⁹ Hyder, N. (2010). 'Couple request surrogate mum to abort over disability'. *BioNews*, 579.

⁴⁰ Andrea Braverman, Polly Casey and Vasanti Jadva, *Reproduction through surrogacy: the UK and US experience*, in *Reproductive Donation*, Martin Richards, Guido Pennings and John B. Appleby (eds.) Cambridge: Cambridge University Press, 2012, p. 294.

⁴¹ *Buzzanca v. Buzzanca* (1998 Cal. App. Lexis 180), 10 March 1998.

⁴² D. Gareth Jones, *Manufacturing Humans*, Leicester: Inter-Varsity Press, 1987, p. 203.

Risks of commodification and objectification are very real when it is the women most needing money who become surrogates. Society could then be faced with the unacceptable situation where the use of human bodies, as such, could have a price with the possibility of contracts being written up. Gilbert Meilaender explains: “*Clearly, the child then becomes an object, and, if money is paid [to] the surrogate, a commodity. She makes of the child’s person and of her body and its procreative powers instruments in service of others’ purposes.*”⁴³

Christina Weis also argues with respect to the biological stratifications and the commodification of reproductive capital in Russia that:

“... *surrogacy workers and client parents are socially stratified. Client parents possess more economic, social and cultural capital than their surrogacy workers, and have access to resources that the latter do not. Further, I have shown that surrogacy in Russia is framed as an economic transaction and that consequently, surrogacy workers perceive carrying a contracted and commissioned pregnancy as a form of work/temporary employment.*”⁴⁴

Moreover, it is argued that the inherent human dignity of a woman is assaulted when she uses her uterus for financial profit and that she is merely being considered as an incubator for someone else’s child. But, since real risks exist in gestating a child, no woman should ever be asked to undertake a pregnancy for another woman in exchange of money.⁴⁵

In addition, even when there is no commercial transaction in the surrogacy arrangement, there is still a risk that the woman may merely be considered as a kind of ‘container’ or ‘incubator’ divorced of any natural maternal relationships with her child.⁴⁶

1.5. Risk of Exploitation

Because most European countries have prohibited all forms of surrogacy for ethical reasons, an international market has developed in which wealthy commissioning parents pay poor surrogate women to gestate their child for them in countries where surrogacy regulations are weak or not really enforced. Because of this, a real risk of exploitation exists. The Swedish journalist, Kajsa Ekman, asks “*how can we justify a situation in which wealthy people use poor people as breeders, inject them full of hormones, take children away from them and leave pocket money in exchange?*”⁴⁷ This is a very real question and cannot be ignored in the countries in which the relatively wealthy commissioning parents originate.

In this respect, India has sought to end its reputation as being a centre for fertility tourism and enacted its Surrogacy (Regulation) Bill 2016 banning all international applications. It did this to protect vulnerable women from unscrupulous agents representing wealthy clients.⁴⁸

⁴³ Gilbert Meilaender, *Bioethics: A Primer for Christians* (Third Edition), Grand Rapids: Eedermans Publishing Co. 2013. p. 23.

⁴⁴ Christina Weis, ‘Reproductive Migrations Surrogacy workers and stratified reproduction in St Petersburg’, PhD thesis De Montfort University September 2017 Section 6.2. (p. 187).
See also <https://www.opendemocracy.net/en/beyond-trafficking-and-slavery/workers-or-mothers-business-of-surrogacy-in-russia/>

⁴⁵ Department of Health & Social Security, Report of the Committee of Inquiry into Human Fertilisation and Embryology, 1984, London: Her Majesty’s Stationery Office, p.44-45.

⁴⁶ Normam M. Ford, *The Prenatal Person: Ethics from Conception to Birth*, Blackwell, Oxford, 2002, p. 115.

⁴⁷ Ekman, K. E. 2014. *Being and being bought: Prostitution, surrogacy and the split self*. Victoria: Spinifex Press. p. 150. Mentioned in: Clara Watson, *Womb Rentals and Baby-Selling: Does Surrogacy Undermine the Human Dignity and Rights of the Surrogate Mother and Child?* *Journal, The New Bioethics*, Volume 22, 2016 - Issue 3, pp. 212-228 (p. 220).

⁴⁸ <https://www.telegraph.co.uk/news/2018/12/20/india-bans-commercial-surrogacy-stop-rent-womb-exploitation/>

2. Concerns for the resulting child

Questions may also exist relating to the way the resulting child may consider his or her commissioning, surrogate or other parents. For example, the child may want to know and even have a relationship with the surrogate mother when he or she grows up since he or she knows that without her, he or she would not even have existed. But this also means that the resulting children may struggle, psychologically, when finding out about the manner in which they were brought into existence and that this seems to have come about by prioritising the intended parent's personal autonomy over all other factors. Norman Ford indicates:

“An individualistic notion of personal autonomy opens the way to overlook the personal identity and dignity of the child who may be treated as an object. As a result, the notion of harm can be so narrowed as to exclude the psychological damage to the child's sense of personal identity. It is not a question of it being better to be than not to be. Accepting this line of argument could lead to justifying the conception of children from adulterous affairs. Adultery is immoral and ought not to be committed even if it gives rise to children who may live happy lives.”⁴⁹

In addition, because of all the different kinds of parents a child born from surrogacy may have, new regulations may be required to determine who the legal parents of a child really are while ensuring that other possible parents cannot legally challenge this decision. Indeed, such challenges may have detrimental consequences for the child. If a dispute does arise because of legal ambiguity between the gametal, gestational and commissioning parents, the child may eventually become parentless which may also mean that he or she does not have a nationality. The American bioethicist, Ben Mitchell explains: *“For the sake of the children we should resist the temptation to create the conditions that cause a child to ask, ‘who are my parents?’”⁵⁰*

Thus, surrogacy may also be damaging to the child, whose relational bonds with the surrogate are considered to be significant and whose wellbeing should be seen as having paramount importance. Moreover, it may be suggested that a surrogacy agreement may be degrading to the resulting child since, for all practical purposes, he or she would have been brought into the world through a legal and/or monetary transaction.⁵¹ This means that, in the case of commercial surrogacy, children may be asking themselves if they only actually exist because a certain amount of money was exchanged to the surrogate and that their very existence has a price.⁵²

In this regard, and in agreement with a number of other countries in Europe, the SCHB is of the opinion that surrogacy should be prohibited because of the grave psychological and social risks that may be created by such a procedure. These include psychological and social risks for (1) the commissioning parents, (2) the surrogate mother, her possible partner and existing children in addition to (3) the child created.

Section 4: Posthumous Use

⁴⁹ Norman M. Ford, *The Prenatal Person: Ethics from Conception to Birth*, Blackwell, Oxford, 2002, p. 115-116.

⁵⁰ Ben Mitchell, *Shouldn't Children Want Parents of Their Own?*, *Ethics & Medicine*, Vol. 30:2 Summer 2014, p. 69.

⁵¹ Department of Health & Social Security, *Report of the Committee of Inquiry into Human Fertilisation and Embryology*, 1984, London: Her Majesty's Stationery Office, p.44-45.

⁵² Clara Watson, *Womb Rentals and Baby-Selling: Does Surrogacy Undermine the Human Dignity and Rights of the Surrogate Mother and Child?* *Journal, The New Bioethics*, Volume 22, 2016 - Issue 3, pp. 212-228.

Background

Since its introduction in 1990, the *HFE Act* contained provisions for the storage and use of gametes and embryos after death. The *HFE Act* requires written consent from the person who provided the material for the ongoing storage and use of gametes and embryos by their partner following their death. If there is no specific written consent for posthumous use, treatment cannot take place. This provision will remain in the *HFE Act* and written consent will remain a key requirement for posthumous storage and use of gametes and embryos.

Existing Legislation

There are currently no additional arrangements in the legislation to alter the storage period after someone storing material has died. There must be effective consent under Schedule 3 of the *HFE Act*. While a patient can give consent to the posthumous storage and use of their gametes or embryos, storage and use is only possible for the duration of their consent. This cannot be for longer than the statutory maximum, which is currently 10 years.

Key Issues

The new settlement will provide individuals with 10-year renewable storage periods up to a maximum of 55 years, with new written consent required every 10 years. This means that, in the absence of any additional provisions, consent for posthumous storage and use of gametes and embryos must also be renewed every 10 years and therefore the maximum period that storage and use can take place following death could only be up to 10 years, depending on when the individual has died.

The 2020 consultation feedback identified cases where a partner has died at a time approaching the end of the 10-year storage limit. It was recognised how stressful it can be making decisions about using stored material to start a family, directly after such a bereavement. Suggestions were made that an additional period of consent for use could be allowed in these very specific circumstances.

The Government is therefore considering whether to include additional provisions in relation to posthumous use. In the event of a gamete or embryo provider's death within any 10-year consent period, provided that consent has already been given for the ongoing storage and use of their gametes or embryos posthumously, an extension could be given so that their partner has sufficient time to decide whether they wish to use the gametes or embryos for fertility treatment.

Question 16

Should there be an additional period applied to cases when, having consented to their gamete or embryo being used posthumously, a person then dies, before being able to renew their storage period for another 10 years?

- Yes
- No - X

Question 17

If yes, how long should the extension be? Please select from the list below.

- 2 years
- 5 years
- 10 years

Question 18

Please explain the reasoning behind your answers in this section of questions.

The SCHB is opposed to the posthumous use of sperm and eggs in generating embryos. This is because children could be psychologically challenged in knowing that they were brought into existence through the means of gametes from a dead person.

Section 5: Research Use

Background

Research using human embryos is used to study both normal and abnormal differentiation and development. These studies can help understand certain genetic disorders, birth defects, how organs and tissues develop, and why some pregnancies fail.

The Human Fertilisation and Embryology Authority monitors all embryo research in the UK. The Human Fertilisation and Embryology Authority uses a panel of experts, as part of their Licence Committee, to peer review all research applications. The Licence Committee decide whether the research project is sufficiently novel and important in the field, and whether the use of human embryos is justified - *i.e.* that it cannot be completed using other cell types or embryos from other animals. As a result, there are only a small number of carefully monitored research projects using human embryos in the UK.

Existing Legislation

The special status of the embryo is recognised in the *HFE Act*. Under Paragraph 2 of Schedule 3 to the HFE Act, consent for the storage and use of an embryo must specify its purpose; whether it is to be used in providing treatment only to the person(s) giving consent, whether it is to be donated for treatment to someone else, or whether it is to be used in research. As with all the above scenarios, when an embryo (or gamete) is donated to research, the person(s) giving consent can specify any additional conditions under which the embryo may be used. At the end of the 10-year storage period, the gametes and embryos must be allowed to perish.

Key Issues

Currently if gametes or embryos are donated for use in research, they must be used within the statutory storage period for the activities consented to. In practice, patients donate their gametes and embryos for use in research towards the end of their statutory storage period, at which point there is little time remaining for the use in research. Therefore, the samples are not allowed to be used and must be allowed to perish without the embryo or gamete provider's consent being acted upon. There is also a risk that samples will be used in research which might be rushed by the impending storage expiry, or that samples may not even be considered for research because the remaining time in storage is extremely limited.

The 2020 consultation feedback included suggestions that if consent to donation for research has been given within the last year of the statutory storage period, then there should be provisions put in place so that embryo or gamete providers are able to consent to storage for an additional period. This would allow the gametes or embryos to leave the treatment pathway and be stored for a short period beyond the statutory storage period to be used in research projects. It will be clear that once

the patient has consented to their samples being used for research, the samples can no longer be used for treatment purposes. It is worth noting that patient who donated the embryos or gametes can vary or withdraw their consent to research up until the samples are used in a research project.

In this scenario, the Government proposes that a specific extension to the storage period for use of embryo or gametes in research would be appropriate.

Question 19

When consent has been given, should there be an extension to the 10-year consent period, following completion, to allow gametes and embryos to be kept for research purposes?

- Yes
- No

Question 20

If yes, how long should the extension be?

- 2 years
- 5 years
- 10 years

Question 21

Please explain the reasoning behind your answers in this section of questions.

The SCHB notes that UK legislation concerning embryo research is generally a lot more liberal than elsewhere in the world and that it would be highly desirable for UK legislation to encompass relevant international declarations and conventions.

In this regard, the SCHB is of the opinion that possible new regulations in the UK relating to Human Fertilisation and Embryology should be amended so that it becomes compliant with the following provisions of international declarations, legislation and regulation:

United Nations Educational, Scientific and Cultural Organization:

- *The Universal Declaration on Bioethics*
- *The Universal Declaration on the Human Genome and Human Rights*⁵³
- *The International Declaration on Human Genetic Data*⁵⁴

Council of Europe

- *Convention on Human Rights and Biomedicine (European Treaty Series - No. 164)*⁵⁵ : Article 18 (2) (*Research on embryos in vitro*) which states that:

“The creation of human embryos for research purposes is prohibited.”

- *Additional Protocol on the Prohibition of Cloning Human Beings (European*

⁵³ http://portal.unesco.org/en/ev.php@URL_ID=13177&URL_DO=DO_TOPIC&URL_SECTION=201.html

⁵⁴ http://portal.unesco.org/shs/en/file_download.php/6016a4bea4c293a23e913de638045ea9Declaration_en.pdf

⁵⁵ Signed by 31 of the 45 Council of Europe Members States, <http://conventions.coe.int/Treaty/en/Treaties/Word/164.doc>

Treaty Series – No. 168)⁵⁶ : Article 1 which states that :

- (1) "Any intervention seeking to create a human being genetically identical to another human being, whether living or dead, is prohibited."
- (2) "For the purpose of this article, the term human being "genetically identical" to another human being means a human being sharing with another the same nuclear gene set."

European Union

- Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells

The SCHB notes that the process of human development is a continuous one in which any demarcation would be arbitrary and merely conventional, as exemplified by the different upper time limits for abortions and embryological destructive research across Europe. Within the development process it is indeed impossible to indicate a non-arbitrary point of transition from human non-person to human person.

For this reason, the SCHB concurs that the precautionary principal should be applied concerning the status of the human embryo. In other words, until unambiguous scientific proof to the contrary can be provided, a human embryo, as soon as it is created, should be considered as having the same moral status as an adult human person.

Next Steps

The Government will also seek advice from the [Moral and Ethical Advisory Group \(MEAG\)](#)⁵⁷ on any ethical aspects, as part of the formulation of its final policy.

The Government plans to take steps to change the legislation to allow for 10-year renewable storage periods for gametes and embryos up to a maximum of 55 years, when parliamentary time allows. The draft legislation will include provisions to take account of consequential changes needed in these specialist areas subject to final feedback from this consultation.

The Government will work with the regulator, the Human Fertilisation and Embryology Authority, to ensure that, when the recommended changes are made, the changes are communicated to clinics and patients in an appropriate manner and regulatory oversight is provided for the safe implementation of the changes.

The consultation questions without the narrative are listed in Annex A and should be returned to storagelimit@dhsc.gov.uk by **31 October 2021**

⁵⁶ Signed by 29 of the 45 Council of Europe Members States, <http://conventions.coe.int/Treaty/en/Treaties/Word/168.doc>

⁵⁷ <https://www.gov.uk/government/groups/moral-and-ethical-advisory-group>