HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY

HFEA UPDATE

Welcome to the September issue of HFEA Update.

This issue focuses on the legal status of male donors in embryo donation in order to highlight some of the difficulties which may arise in practice.

**Please distribute copies of the Update to members of staff working at your clinic or organisation. Additional copies can be obtained from the HFEA. The Update is also available on the HFEA website: www.hfea.gov.uk/HFEAPublications**

INSIDE

**Legal status of Male donors in embryo donation**

**Review of the Welfare of the Child Assessment.**

**Correcting data for the next Patients Guide**

## The Legal status of male donor in embryo donation

Following a number of examples arising from recent court proceedings relating to the use of embryos by single women which were created using the sperm of their estranged partners, the HFEA highlights possible issues surrounding the legal position of the male donor in embryo donation arrangements.

### The Human Fertilisation and Embryology Act 1990

- A woman who carries and gives birth to a child will always be the legal mother of that child at birth, although legal parenthood may subsequently be transferred to others, for example through adoption or through the granting of a parental order in surrogacy cases – HFE Act 1990, s.27.
- Where a man has consented to the use of his sperm for the treatment of others (a donor), and that sperm is used for that purpose, that man is not to be treated as the legal father of any resulting child – HFE Act 1990, s.28(6).
- Where a woman who receives treatment with donated gametes or embryos is either married to, or receiving treatment together with, a man, that man and no one else will be the legal father of any resulting child *unless*, where she is married, it can be shown that her husband did not consent to the treatment – HFE Act 1990, s.28(2)-(4).

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## Advising patients

Given the complexity of these issues (with some sample scenarios below), the HFEA would like to draw your attention to the guidance contained in paragraph 6.32 of the HFEA *Code of Practice* (6th edition) "In all cases of any doubt, couples are expected to be advised to seek their own legal guidance on this matter."

# Considerations relating specifically to embryo donation

The following examples relates to situations in which embryos that were created using the sperm of a man for the treatment of himself and his wife or partner are subsequently donated for the treatment of others. It does *not* apply where embryos were created with donor sperm and donor eggs specifically for the treatment of a third party.

## Embryo donation to single women

In rare cases a single woman may be offered treatment with spare embryos donated by a couple following their own fertility treatment.

**Example**: A couple have successful IVF treatment and have completed their family with surplus embryos remaining in storage. Those embryos are then donated to a single, infertile woman, who is known to the original couple, and a child is born. Will the child have no legal father or is the man who provided the sperm when the embryos were created capable of being treated as the child's legal father?

If the woman has no partner while she is receiving treatment then there will be no man to be treated as the father by virtue of s.28 (2) & (3).

However it is not clear from the legislation whether if a couple donate an embryo that was originally created for their own treatment, the man could be treated as the legal father.

This may be of particular of concern in 'known donation' arrangements where the identity of the donor couple is known to the recipient. If the donor is, and remains, anonymous it will of course be impossible to cite him as the father. In this case the donor may be in a similar position as pre-Act sperm donors.

## Subsequent use of embryos created in the course of treatment together by estranged partners

A recent case before the high court has highlighted this issue in relation to couples who create embryos using their own gametes in the context of treatment together but who subsequently become estranged before those embryos are transferred.

**Example:** An unmarried couple undergo IVF treatment together. Their fresh embryo transfer cycle is unsuccessful but a number of embryos are placed in storage. Before these can be transferred, however, the couple's relationship breaks down albeit on amicable terms. The woman still wishes to use the frozen embryos for treatment as a single woman and the man agrees as long as he is not to be treated in law as the father of any resulting child – in other words the couple would no longer be receiving 'treatment together' and the man wishes to be treated simply as a 'known donor'. All consent forms are altered to reflect these new circumstances. If the treatment goes ahead and a child is born, will the child have no legal father? Alternatively must the man be treated as the father of child?

These concerns do not apply in the case of a separated couple who are still married at the time at which the treatment is to take place: if the treatment is to go ahead at all, the man will not be able to show that he did not

consent to the treatment (since, as a gamete provider, his effective consent is a necessary condition for treatment to take place), and he must therefore, by s.28(2), be treated as the father of any resulting child.

The case is slightly different if the couple are not married or are divorced at the time at which treatment is to take place: in this case the man could consent to the use of his embryos, allowing the treatment to go ahead, without, however, the treatment taking place within the context of 'treatment together'. However, in this case, too, it is arguable that owing to the circumstances in which the embryos were originally created the man will not be prevented from being treated as the legal father by s.28(6) and, as no other man is to be treated as the father by s.28(2) or (3), he is therefore capable of being treated in law as the father of any resulting child.

## Reviewing the 'welfare of the child' guidance

Earlier this year, the HFEA launched a review of the welfare of the child requirements under the Human Fertilisation and Embryology Act.

The Authority recognises the importance of closely involving clinics and other stakeholders in the welfare of the child review. With this in mind, questionnaires were sent out to clinics in June, inviting clinic staff to describe their experience of conducting welfare of the child assessments, to give their views on current practice and to offer suggestions for improvements to the current system. Clinics were also asked to display a notice in waiting areas, asking patients to give their experiences and views of the welfare of the child assessment.

The feedback received from clinics and patients - coupled with reviews of the psychosocial, legal and ethical literature, experience in other child-related areas of practice and welfare of the child policies in other countries - will inform the Authority's thinking on this issue. A consultation, outlining a number of policy options, will be sent to clinics and other stakeholders towards the end of the year. The consultation will be complemented with a series of meetings in the new year, designed to gauge opinion on the welfare of the child and to develop a new policy in partnership with clinics and stakeholders. The principle outcome of the review will be revised guidance to clinics, which is expected in spring 2005.

Experiences and opinions are welcomed throughout the review. To submit your views or for further information about the review, please contact Juliet Tizzard, Policy Manager, on 020 7291 8232 or at juliet.tizzard@hfea.gov.uk.

## Correcting data for the next Patients Guide

Over the next few weeks you should receive a CDROM containing the errors which we have identified on specific forms submitted to the HFEA that relate to treatments during the period January 2002 – March 2003. Please could you report the necessary corrections to these errors using standard HFEA form templates to us by the end of November 2004. Some Centres may already have received a CDROM which contained invalid data for which we apologise.

Towards the end of September, you will receive a draft document representing your Centres entry in the next Patients Guide which is to be published in March 2005. When you receive this information, you will be asked to check it for accuracy. It will list, amongst other data, total treatments and outcomes for the period for your Centre. The timescales for verifying your entry will be notified in due course.

If you have any queries, please contact a member of the Quality Assurance Team on: 020 7291 8294

## Member Focus

**David Barlow**

### David Barlow

**Nuffield Professor and Head of the Nuffield Department of Obstetrics & Gynaecology, John Radcliff Maternity Hospital**

As a practicing clinician David Barlow plays a vital role at the HFEA – an authority which, by law, must have a majority of non-practicing, non-scientific members. "The HFEA has a diverse membership," says David, "but it is important to have involvement from professionals who can balance the demands of regulation with the need to encourage clinical practice."

David has studied and practiced medicine all his adult life. Having obtained degrees in both biochemistry and medicine at Glasgow University in the 1970s, he has been involved in many areas of reproductive medicine. He was appointed Nuffield Professor and Head of the Nuffield Department of Obstetrics and Gynaecology in 1990, based at the John Radcliffe Hospital.

Although very much immersed in the field of reproductive medicine, the term *fertility industry* is not part of David's vocabulary. Whilst he accepts the field has a significant private sector involvement, he argues that the majority of people working in assisted conception units do so on standard health service or university pay scales. David explains: "We do not talk about the cardiology or cancer industry. Using the term *fertility industry* conjures up an image in the minds of the public and the media, which is unfair to the motivation and commitment of the majority of people working in the field."

Since joining the HFEA in 1998, David has served on many HFEA committees. One of the most challenging is the current Clinical and Information Working Group which looks at ways of providing outcome data and success rates in assisted reproduction. It is an area David is particularly interested in. He explains that patients naturally want to know success rates in order to compare clinics, but rates vary widely depending on the types of patients treated at individual clinics. Multiple births are still a major problem in assisted conception and it is important that the success rate data does not hamper the efforts being made to reduce multiple births. "At the HFEA we are working to achieve a system of providing outcome data that is meaningful for patients and clinics, and that also promotes good practice," says David.

HFEA PROFILE

The HFEA appreciates any comments on the content of the HFEA Update.

Please contact Helena Hird, Head of Public Relations: helena.hird@hfea.gov.uk

DIARY DATES

**HFEA Open Authority Meetings**
*Wednesday 20 October 2004 (Edinburgh)*
**HFEA Research Conference 2004**
*Thursday 25 November 2004 (London)*

To reserve a place at an HFEA Open Authority Meeting please e-mail: openmeeting@hfea.gov.uk or telephone: 020 7291 8221.