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A RIGHT TO A CHILD OF ONE'S OWN? THE LEGAL JUSTIFICATION IN LIMITING ACCESS TO ASSISTED REPRODUCTIVE TREATMENT

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Abstract

The revolution in IVF treatment in recent years has resulted in the conception of over 4 million babies worldwide prompting stricter legal regulation and control of medical practice. This article explores the demand and availability for IVF, and how international and domestic legislation operates and applies in relation to the notion of 'a right to a child.' It considers whether there is, or should be, an established right to such treatment and the extent to which interferences by the state to prohibit or limit assisted reproductive treatments are legitimately justified.

Keywords: assisted reproductive treatment, IVF, right to a child, parental rights,

Introduction

On 25 July 1978, a baby named Louise Brown was born at Oldham General Hospital to British parents. Though childbirth occurs every day with an estimated 723,165 live births in England and Wales in 2010,² Louise Brown was the first child to be conceived and termed 'a test tube baby'. Born as a result of 'in vitro fertilisation' (IVF)- fertilisation 'in glass', the process involves the creation of an embryo outside of the body with the intention of implantation within the uterus for development. The significance of the birth of Louise is evidenced through the consequent 'revolution'³ of fertility services with 5,000 applicants

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² The Guardian, 'Call for more midwives as birth rate reaches 40 year high,' <http://www.guardian.co.uk/society/2011/jul/13/more-midwives-birth-rate-40-year-high> 15 December 2011

³ Woods, J., 'IVF: the birth that started a revolution,' *The Telegraph*,

seeking treatment subsequently.⁴ This 'revolution' in IVF has been estimated to have resulted in the births of 4 million babies⁵ worldwide calling for strict regulation and control of medical practice.⁶

As one of the most common techniques available to artificially conceive a child, this article aims to explore the demand and availability for IVF, and how international and domestic legislation operates in relation to the notion of 'a right to a child'. In the UK, the Human Fertilisation and Embryology Authority (HFEA) has estimated that 1 in 7 couples are infertile or subfertile⁷ with increased figures rationalised in relation to NHS available contraceptives and societal and environmental changes including increased parent ages.⁸ It must, however, be remembered that IVF is not available to all nor a cure to infertility, with Scott suggesting that IVF is merely the starting point for developing new techniques such as Pre-implantation Genetic Testing.⁹

In response to initial fears of potential 'eugenics' and scientific experimentation, the Human Embryology and Fertilisation Act 1990 as amended in 2008 (HFEA Act) serves to regulate and control assisted reproductive treatment (ART) services through imposing licensing requirements. The aim of the statute is clear in order to address the concerns of the Warnock Committee:

The development of science and medical technology in the field of human fertilisation opens up many new issues for the law. In vitro fertilisation, for example, has brought about situations not previously contemplated, in relation to which there is either no law at all, or such law as exists was designed for entirely different circumstances. We believe that new laws will be necessary to cope with the new techniques for alleviating infertility and their consequences and to deal with the developments in research in the field of embryology.¹⁰

http://www.telegraph.co.uk/health/women_shealth/3355633/IVF-The-birth-that-started-a-revolution.html 21 January 2012.

⁴ BBC News, '1978: First "test tube baby" born,' http://news.bbc.co.uk/onthisday/hi/dates/stories/july/25/newsid_2499000/2499411.stm 21 January 2012.

⁵ Mail Online, 'First test tube baby Louise Brown was grown in a JAR,' <http://www.dailymail.co.uk/health/article-1320175/First-test-tube-baby-Louise-Brown-actually-grown-jar.html> 21 January 2012.

⁶ Madden, D., 'Recent developments in assisted human reproduction', (2001) 7 *Medico-Legal Journal of Ireland* 53 at p. 61

⁷ Human Fertilisation and Embryology Authority, *The HFEA Guide to Infertility and Directory of Clinics*, (2005/2006).

⁸ Royal College of Midwives magazine, 'Birth after 35 – the older mother,' <http://www.rcm.org.uk/midwives/in-depth-papers/birth-after-35-the-older-mother/> 16 September 2011.

⁹ Scott, R., 'The uncertain scope of reproductive autonomy in preimplantation genetic testing and selective abortion', (2005) 13 *Medical Law Review* 291 at p.297.

¹⁰ Warnock Committee, *Report of the Committee of inquiry into Human Fertilisation and Embryology*, (1984) p.10.

It should be noted that concerns as to eugenics were arguably unfounded with Sheldon supporting a distinction between preference and eugenics which in any case only extends as far as genetic screening.¹¹ This article will therefore explore the domestic and international law in relation to ART. Of more focus will be whether there is an established right to treatment in this sense and whether interferences by the state are legitimately justified. Should this right extend to a right to a child of one's own, it would be difficult to justify state interference.

1 International Protection: The Right to Healthcare.

Though it is recognised that the right to healthcare is not a new concept, Sifris argues Article 25 of the Universal Declaration of Human Rights 1948¹² provides significant first legal recognition of an enforceable right to health.¹³ 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family.' Duties are placed on the Government by the European Social Charter 1961 Article 11¹⁴ to ensure enforcement so far as possible. The International Planned Parenthood Federation and the Right to Healthcare and Health Protection Charter 9.1 includes 'the right to healthcare extends to sexual and reproductive health'¹⁵ yet this would assume that infertility is an illness. This view was somewhat supported in the American case of *Magdalin v Commissioner of Internal Revenue*¹⁶ where it was speculated that infertility could be considered a defect/ underlying medical condition providing this is unavoidable and not simply an alternative to natural conception. As an aspirational rather than enforceable document, the Health Protection Charter cannot reasonably be relied upon in enforcement and thereby demonstrates the lack of clarity and uniformity surrounding the extent to healthcare protection and promotion.

Instead, it is necessary to consider further international legislation for clarification to the extent of the rights provided by the European Convention as directly enforced through the Human Rights Act 1998. Action can be brought against the state before the European Court of Human Rights where the state fails to protect rights. The Convention is also directly enforceable among all European Council signatories yet the scope of the Convention

¹¹ Sheldon, S., and Wilkinson, S., 'Hashmi and Whitaker: an unjustifiable and misguided distinction?', (2004) 12 *Medical Law Review* 137 at p.149.

¹² 217 A (III)

¹³ Sifris, R., 'Restrictive regulation of abortion and the right to health', (2010) 18 *Medical Law Review* 185 at p. 190-191.

¹⁴ Strasbourg, 3.V. 1996

¹⁵ International Planned Parenthood Federation, 'The right to Healthcare and Health Protection- Charter Right 9,'

<http://www.ippf.org/en/Resources/Statements/The+Right+to+Health+Care+and+Health+Protection.htm> 04 January 2012

¹⁶ *Magdalin v Commissioner of Internal Revenue* 130 S. Ct. 2388 (2010) (Sup Ct (US)).

extends to any national within those jurisdictions (some signatories have ratified the convention with exceptions). Therefore the scope may be vast in geographical terms yet can sometimes be viewed as superficial in terms of the extent of protection available in certain jurisdictions. Priaulx takes a similar view to this proposition in suggesting that the wording within the Convention is also superficial to an extent¹⁷ as using the word 'right' when the Convention is qualified in certain respects does not give full consideration to the 'parties' relative interests'¹⁸.

The right to life as governed by Article 2 is, however, limited including the rights of the unborn child and consequently the right to conceive. UK interpretation of the Article concludes that the right attaches only to human beings that have been born as defined in *AG Reference (No 3 of 1994)*¹⁹; a foetus only becomes a separate human being once the umbilical cord has been severed. This has been approved by the European Court of Human Rights in *Vo v France*²⁰ where it was held that criminal proceedings (enforcing Article 2) could not succeed as the foetus was merely an extension of the mother's body. This is reiterated in relation to reproduction stating that 'In our domestic law it has been repeatedly held that a foetus prior to the moment of birth does not have independent rights or interests'.²¹ This therefore also applies to embryos in storage and as Ford suggests, if an embryo does not have a right to life, they are not persons in law. They are 'things' but may not necessarily be capable of being 'owned as property',²² effectively meaning that applicants who store their material for future use could be in a vulnerable position. Madden speculates that Article 2 could incorporate 'the right to a child of one's own?',²³ though this would suggest that the Convention includes the right to be born, which in practice, would create further issues in relation to contraceptive medicine and abortion. Similarly, this would involve attaching rights to something that does not exist which LJ Wall noted would halt the whole IVF process in terms of production of surplus embryos.²⁴ In disallowing Article 2, this could be viewed as an attempt to promote the IVF industry and ensure full efficiency rather than limiting access.

¹⁷ Priaulx, N., 'Rethinking progenitive conflict: why reproductive autonomy matters', (2008) 16 *Medical Law Review* 169 at p.174.

¹⁸ *Ibid.*, p.192.

¹⁹ *Attorney General's Reference No. 3 of 1994* [1998] AC 245.

²⁰ *Vo v France* (2005) 46 EHRR 34.

²¹ *Natalie Evans v Amicus Healthcare Ltd & Others* [2004] EWCA (Civ) 727 at para.19.

²² Ford, M., 'A property model of pregnancy', (2005) 1(3) *International Journal of Law in Context* 261 at p.263.

²³ Madden, D., 'Is there a right to a child of one's own?', (1999) 5 *Medico-Legal Journal of Ireland* 8 at p.10.

²⁴ *Natalie Evans v Amicus Healthcare Ltd & Others* [2003] EWHC 2161 (Fam) at para.175.

Differences in culture and opinion are apparent through the interpretation and the application of the margin of appreciation when comparing the UK with, for example, The Republic of Ireland. Judicial discretion may impact the applicant adversely in comparison with decisions within a jurisdiction ensuring a higher level of protection to the rights of the unborn child. The Republic of Ireland arguably, through not permitting abortion and the impact of strict religion, allows for higher protection to the unborn child as 'the deliberate and intentional destruction of human life already formed is professional misconduct'.²⁵ The prohibition afforded by the Irish Constitution demonstrates the way in which each Member State is entitled to interpret the Article differently, though this could be viewed as contrary to the European Court decision of *Vo v France* in which the English notion of the unborn being an extension of the mother was considered the current legal position.

Article 8 of the ECHR is commonly relied upon for a wide range of purposes in relation to healthcare including patient confidentiality and in arguing a right to a family of one's own. *Evans*, in particular relied upon Article 8 in order to claim that disallowing the use of her embryos (the last way in which she could naturally bear a genetic child) denied her right to a family life under Article 8. The Article is a qualified right, and can be interfered with if in accordance with the law, necessary in a democratic society for the promotion of health among other reasons,²⁶ and to protect the rights of another. In denying this right, the court debated over which party should enjoy freedom. Miss Evans pursued the right to a child while the other party pleaded a freedom to not raise children with the party under the same Article. This therefore raises the issue of difficulties presented to the judiciary in balancing competing interests, a role which Da Silva likens to comparing the 'incommensurable'.²⁷ In this case, the judiciary did not deny the claimant a right to a family life as other socially recognised methods to become a mother in the social, legal and physical sense²⁸ existed such as that of adoption.²⁹ The decision appears to merely restrict the right to one of having a family life instead of the right to naturally bear a child.

The judgment does acknowledge that the right to become a genetic parent falls within the scope of Article 8 but the claim failed and was further rationalised in terms of fairness, where it was acknowledged genetic motherhood could not be forced on the applicant in the same

²⁵ The Republic of Ireland Medical Council, *A Guide to Ethical Conduct and Behaviour*, (1998, 5th edition) p.39.

²⁶ Ford, M., 'Evans v United Kingdom: what implications for the jurisprudence of pregnancy?' (2008) 8 *Human Rights Law Review* 171 at p.176.

²⁷ Da Silva, V., 'Comparing the incommensurable: constitutional principles, balancing and rational decision', (2011) 31 *Oxford Journal of Legal Studies* 273 at p.299.

²⁸ *Evans v United Kingdom* (2008) 46 EHR. 34 at para.72.

²⁹ Ford, 'Evans v United Kingdom: what implications for the jurisprudence of pregnancy?' at p.181.

way it would be unfair to impose genetic fatherhood on the other party.³⁰ The judgment however, appears to fail to take account of possible psychological needs in terms of motherhood such as issues in substituting a biological child for a child who is not genetically related which may not satisfy the applicant's 'desire for a child'. The view of the Grand Chamber in terms of satisfying social, legal and physical aspects of motherhood was rejected by Madden who suggests greater weight should be placed on having a biological child of one's own, 'The desire for a child can not only be pathological but biological'.³¹ Though a decision between the conflicting rights of autonomy was made, it was reiterated that the balance was primarily 'a matter for Parliament [and] a sensitive area of ethical judgement'.³² It was decided that the interference of this right was not *ultra vires* and is justifiable in situations of irreconcilable interests³³ demonstrating judicial discretion in defining the extent of a choice to treatment.

Article 12 could be described as somewhat redundant in the context of reproductive autonomy. Judicial attitude has appeared to favour claims in respect of Article 8 as shown in *Goodwin (Christine) v United Kingdom*³⁴ where it was noted in relation to Article 12: 'the inability of any couple to conceive or parent a child cannot be regarded as *per se* removing their right'.³⁵ Coupled with the claim within *Evans*, this seems to suggest that reproduction is more closely regarded as a part of family life rather than founding a family. However, the case of *RR v Poland*³⁶ illustrates the 'lesser importance' of Article 12 but suggests a practical approach potentially beneficial for all patients:

The Committee urges the State party to take concrete measures to enhance women's access to health care, in particular to sexual and reproductive health services, in accordance with article 12 of the Convention.

Academic discussion has suggested that Article 9 of the European Charter of Fundamental Rights³⁷ while read in conjunction with the Convention, somewhat extends the traditional scope for marriage/ fertility purposes.³⁸ Tobin suggests that dependent upon domestic law, the provision is able to confer rights on married partners, same sex couples and single individuals of both genders as the wording merely stipulates 'men and women'.³⁹ Article 9

³⁰ *Evans v United Kingdom* at para.2.

³¹ Madden, 'Is there a right to a child of one's own?', at p.13.

³² *Evans v United Kingdom* at para.26.

³³ *Ibid.*, at para. 70.

³⁴ *Goodwin (Christine) v United Kingdom* (2002) 35 EHRR 18.

³⁵ *Ibid* at p.452.

³⁶ *RR v Poland* (2011) 53 EHRR 31

³⁷ 2000/C 364/01

³⁸ *RR v Poland* at para.86.

³⁹ Tobin, B., 'Same-sex couples and the law: recent developments in the British Isles', (2009) 23 *International Journal of Law, Policy and the Family* 309 at p.316.

separates Article 12 into two separate and distinct rights to ensure modernisation to promote arrangements other than traditional marriage.⁴⁰ This means that providing domestic legislation allows for applicants outside of traditional marriage to seek fertility treatment, Article 12 should be read in the light of Article 9 of the Charter supporting applications outside of traditional marriage. This is apparent when looking at the HFEA Code of Practice 8th Edition in which Article 29A demonstrates nine protected characteristics which will not be used for discrimination purposes when seeking treatment, these include: age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/ belief, sex or sexual orientation,⁴¹ though it will soon become clear factors such as age and disability, though not expressed through statute, may impact upon applications in relation to clinic discretion. These principles are observed in accordance with the Equality Act 2010 and aim to facilitate a larger group of applicants to seek treatment without discrimination.

Prima facie, the ECHR appears to allow for further protection in seeking a choice to reproductive assistance; yet interpretation in accordance with the primary legislation could leave certain applicants in a vulnerable position exacerbated by the vast rights including consent facilitated by Article 8. Should the HFEA Act 1990 justifiably interfere with an applicant's choice; the Convention does little to support an appeal. Though there are established and international rights to healthcare, which are directly enforceable by citizens against the state, the notion of infertility being an illness is still relatively confused.

2 Eligibility Requirements

In the UK, the National Health Service spends roughly £2,771⁴² for every cycle of IVF treatment granted. It has been estimated that such treatment costs roughly £85 million a year, including costs of consequent treatment and care for privately treated patients.⁴³ Treatment is offered through one of the 151 Primary Care Trusts throughout the UK which control 80% of the overall NHS budget.⁴⁴ This budget is utilised in an arguably discretionary manner with many Primary Care Trusts including Surrey temporarily 'banning' access to treatment.⁴⁵ Though funding may now be available, NICE recommendations are still yet to be fully implemented meaning that each NHS eligible patient should be entitled to three

⁴⁰ McGlynn, C., 'Families and the European Union Charter of Fundamental Rights: progressive change or entrenching the status quo?' (2001) 26 *European Law Review* 582 at p.591.

⁴¹ Human Fertilisation and Embryology Authority, *Code of Practice* (2009 8th edition).

⁴² BBC News, 'NHS to offer one free cycle,' <http://news.bbc.co.uk/1/hi/3516941.stm?ls> 14 September 2011.

⁴³ *Ibid.*

⁴⁴ NHS Choices, 'NHS authorities and trusts', <http://www.nhs.uk/nhsengland/thenhs/about/pages/authoritiesandtrusts.aspx> 20 January 2012.

⁴⁵ Jones-Berry, S., 'IVF treatment reinstated by NHS Surrey', Get Surrey, http://www.getsurrey.co.uk/news/s/2103094_ivf_treatment_funding_reinstated_by_nhs_surrey

cycles of treatment.⁴⁶ This is arguably a result of resource allocation rather than unwillingness to provide services. Though limitation is necessary for resource allocation, eligibility requirements reiterate the exclusive nature of assisted reproduction treatment. The state has the right to interfere with certain individual's right to parenthood in ensuring the welfare of the child. Local authorities are permitted to remove children from their parents should there be a court order, a personal protection order, or a parent consents as shown in the case of *R v Nottingham City Council*.⁴⁷ This power is restricted and children should only be removed if they are likely to suffer 'Significant harm from the way they are being looked after by their parents or carers, or where the child is beyond the control of a parent'.⁴⁸ These powers are granted and explained through s31(2)(a) Children's Act 1989 and require the official to determine the likeliness of significant harm using a test on a balance of probabilities. The State has, in recent years, interfered with rights to actually conceive a child through assisted means though Zucca argues this is not primarily about interference but rather a method of regulating positive obligations.⁴⁹ In particular, it has been a matter of policy to refuse treatment to prisoners in accordance with s(2)(1) Prison Rules 1999⁵⁰ defined as 'a prisoner who has been convicted or found guilty of an offence or committed or attached for contempt of court or for failing to do or abstain from doing anything required to be done or left undone'.

*R (Mellor) v Secretary of State for the Home Department*⁵¹ illustrated a strict approach adopted by the UK government in denying certain rights in relation to prisoners. Sentencing aims to deprive a prisoner of his liberties in order for punishment and reparation principles, though such deprivation does not definitively exclude the right to reproductive treatment, the requests made by the applicant failed due to no exceptional circumstances present. The decision was justified on the basis of expert evidence showing that the advancing age of the patient was neither a significant ground nor reason to justify treatment and further factors impacted upon success such as the (arguable) disadvantage of a child brought up by a single parent. The notion of a single parent upbringing disadvantaging a child is a view not shared by LJ Arden who suggests more recognition should be afforded to single parents due

⁴⁶ National Institute for Clinical Excellence, *Fertility: assessment and treatment for people with fertility problems*, (February 2004, Clinical Guidance 11) p.41.

⁴⁷ *R v Nottingham City Council* [2008] EWHC 152 (Admin).

⁴⁸ Children and Family Court Advisory and Support Services, 'Care questions answered', http://www.cafcass.gov.uk/cafcass_and_you/info_for_families/care_questions_answered.aspx 2 February 2012.

⁴⁹ Zucca, L., 'Evans v United Kingdom: frozen embryos and conflicting rights', (2007) 11 *Edinburgh Law Review* 446 at p.448.

⁵⁰ 1999 No.728.

⁵¹ *R (Mellor) v Secretary of State for the Home Department* [2001] EWCA Civ 472.

to social changes.⁵² Similarly, the recent case of *Dickson v United Kingdom*⁵³ illustrates that a decision may not be justifiable if there is not a fair balance between the competing rights of the individual and the public as a whole: it was shown to be unfair for the claimants to evidence their case in terms of 'exceptional circumstances'. This decision does not necessarily override *Mellor*; *Dickson* is an example of how it is inappropriate to deny the right to all prisoners when adjudged through seriousness. *Mellor* was serving a life sentence for murder and therefore the interference was easily justifiable in terms of public outrage. Such refusal could be justified when viewing the treatment as a NHS provision with the costs already incurred by the taxpayer for the prisoner's detention. Such interference was judged proportionate in relation to Articles 8 and 12. Article 8 appeared not to apply to the right to procreate at all times: 'It would seem that the situation of a lawfully convicted person detained in prison in which the applicant finds himself falls under his own responsibility, and that his right to found a family has not otherwise been infringed.'⁵⁴ Justifying the denial of private treatment is, however, contrary to Mill's harm principle, the state should not interfere providing the autonomous actions of the individual do not harm the rights of another.⁵⁵

The average UK woman is fertile between the ages of 12 and 52, therefore it has been suggested that implementation of the Act limits applicants to assisted reproduction by using minimum and maximum age guidelines. Age guidelines exist for both success purposes (rates of success decreases at the age of 40⁵⁶) and resource allocation purposes (costs of age associated failure). The NHS generally states that treatment should be made available to applicants aged between 23 and 39 yet private clinics offer treatment to older patients at a cost. Similarly, the ban on IVF from certain PCTs as discussed above has also impacted upon the age requirements such as applicants in Surrey who were prevented from seeking treatment for 16 months. Though reinstating the treatment will not take effect until April 2012, there has been no mention of offering treatment to those now ineligible due to the time delay with appeals available only by way of judicial review. While previous decisions suggest the use of discretion in relation to IVF is justifiable, it has been suggested that 'in the absence of broader agreement, perhaps the best we can hope for is that individual PCTs will respond to such applicants fairly and consistently, even if practice differs from place to place'.⁵⁷ Using

⁵² *Natalie Evans v Amicus Healthcare Ltd & Others* [2004] EWCA Civ 727 at para.72.

⁵³ *Dickson v United Kingdom* (2008) 46 EHRR 41.

⁵⁴ *R (Mellor) v Secretary of State for the Home Department* [2001] EWCA Civ 472 para.24.

⁵⁵ Cowden, M., "No harm, no foul": a child's right to know their genetic parents,' (2012) 26 *International Journal of Law, Policy and the Family* 102 at p.111.

⁵⁶ Baby Centre Medical Advisory Board, 'Your age and fertility', <http://www.babycentre.co.uk/preconception/activelytrying/ageandfertility/> 28 March 2012

⁵⁷ Newdick, C., 'Judicial Review: Low-Priority Treatment and Exceptional Case Review', (2007) 15. *Medical Law Review* 236 at p.239.

the word discretionary has been argued by Eijkholt as a means to reinforce the idea of domestic legislation having power over reproductive rights. Newdick suggests that discretion may not be the issue and that the process of priority setting is often undermined by pressures and political influences from the Department of Health.⁵⁸

The discretionary nature of the age criteria is demonstrated in *R v Sheffield Health Authority, ex parte Seale*⁵⁹ in which the applicant was denied access to treatment on the basis of her age, at 37, 2 years older than the local maximum age limit. At judicial review it was decided that 'it is reasonable, or it is at least not Wednesbury unreasonable, of an authority to look at the matter in the context of the financial resources available.'⁶⁰ The case could not be argued on grounds of illegality as s3 National Health Service Act 1977 allows the Authority to act upon its own initiative should there be an absence of direction from the Secretary of State. Similarly, the decision to cap treatment could not be held irrational despite evidence suggesting there can be success up to the age of 42. The Authority stated treatment is 'generally less effective' in women over the age of 35, the absence of definitive language and the need to consider cases on an individual basis were justifiable in light of the financial restrictions. The direction of the Authority must be followed should provisions be rational and legal despite there being no age cap within the statutes.

It is incorrect to conclude that the intention of the policy is to deprive rights to certain applicants and refusals on the basis of age and location could be seen as an unfortunate consequence of implementing expensive and complicated treatment in an economically unsecure state. This is supported by reasoning from Murphy in relation to economic qualifications under Article 8(2),⁶¹ evidence of this in practice includes the requirement to show the applicant has been 'infertile' or 'subfertile' for three years prior to seeking treatment. This 'delay' is a reasonable requirement and has a practical effect of differentiating long term infertility from a temporary inability to conceive.

3 Welfare of the Child

All prospective parents opting for assisted reproductive treatment must meet selective criteria in order to ascertain suitability. A decision must be made as to whether the child to be conceived or any child already born will be likely to suffer any significant harm or

⁵⁸ Ibid at p.238

⁵⁹ *R v Sheffield Health Authority, ex parte Seale*, Queen Bench Division, 17 October 1994 (unreported)

⁶⁰ Ibid para.10.

⁶¹ Murphy, T., 'Works in progress: new technologies and the European Court of Human Rights', (2010) 10 *Human Rights Law Review* 601 at pp.632-3.

neglect.⁶² Ascertaining the 'welfare of the child' is the responsibility of those institutions providing services, though there is a presumption in favour of granting treatment, the HFEA have advised this can be rebutted if upon a reasoned judgement, it is found the child is likely to experience serious harm.⁶³ This guidance is largely identical to the framework used in relation to removing children from their parents under s31(2)(a) Children's Act 1989, it was unsuccessfully argued in *Evans* that adjudging using such criteria is discriminatory in relation to Article 14. Prialux suggests that the vast majority of those who naturally conceive act autonomously thereby asserting their so called right for respect to procreate,⁶⁴ yet the powers granted by the HFE Act 2008 legitimately impose restrictions against applicants seeking assisted treatment. Contrary to this view, LJ Arden rationalised the decision in *Evans*: 'It is the Act, which, conditionally, seeks to reverse nature's discrimination'.⁶⁵ While 'Separating a person from his parents must only happen as a last resort, and separation before birth is thoroughly unjustifiable',⁶⁶ the provision could be seen as necessary in order to monitor the standards of parenthood which in turn may suggest rights could in theory be attached to an unborn child.

Section 13(5) HFE Act 1990 itself lacks a certain definition of what the word 'welfare' includes yet guidance provided by the Authority seems to interpret this to range from protection from abuse to parent suitability in relation to disabilities. Factors such as previous convictions relating to the harming of children, child protection measures already issued against an existing child and previous violence within the family setting are used to adjudge the suitability of applicants. Further guidance from the Authority has suggested that cases are examined on an individual basis,⁶⁷ meaning such convictions may not be conclusive of an automatic refusal of treatment but a mere prompt into further research about the applicant and circumstances in order to make a reasoned welfare conclusion. Though this assessment process has been described by Jackson as irrelevant, largely artificial and so unworkable,⁶⁸ it could be viewed as a legitimate and realistic provision for protection purposes therefore justifying any refusal.

⁶² Human Fertilisation and Embryology Authority, *Code of Practice* (2009 8th edition) s8.10.

⁶³ Human Fertilisation and Embryology Authority, *Code of Practice* (2003 6th edition) p3.1.

⁶⁴ Prialux, N., 'Rethinking Progenitive Conflict: Why Reproductive Autonomy Matters?', (2008) 16 *Medical Law Review* 169 at pp.183-184.

⁶⁵ *Natalie Evans v Amicus Healthcare Ltd & Others* [2004] EWCA Civ 727 at para.72.

⁶⁶ Bainham, A., 'Arguments about parentage,' (2008) 67 *Cambridge Law Journal* 322 at p.322.

⁶⁷ Human Fertilisation and Embryology Authority, *What you need to know about the Welfare of the Child Assessment* (Dec. 2005).

⁶⁸ Jackson, E., 'Conception and the Irrelevance of the Welfare Principle', (2002) 65 *Modern Law Review* 176 at p. 176-203

Similarly, the needs of the child are also considered in relation to supportive parenting⁶⁹ and factors such as alcohol and substance abuse may hinder an application. Medical records are examined to ascertain the likelihood of any child being born with a physical or mental disability and how this could affect the standards of parenting expected or how the applicant's previous physical and mental conditions may have an impact.⁷⁰ This could be viewed as devaluing disability. Scott suggests that it is immoral to seek to avoid disability as this devalues the person who is to be born or is already disabled.⁷¹ Further guidance has illustrated that for a refusal to be made, the issue at hand must be significantly serious.⁷² The issue in this respect lies in what constitutes serious? This may be easy to address in terms of disability (as pre-implantation genetic testing has listed sufficiently serious disabilities), but it is likely that adjudging criteria such as substance abuse is subjective in the absence of definitive 'scales'. Similarly, Choudhry suggests that 'seriousness' is dependent upon a state's chosen margin of appreciation and welfare decisions thereby differentiate from other jurisdictions⁷³ again illustrating the overriding effect of domestic legislation.

The welfare provision has been somewhat extended to include the debate over a child's need for a father as stated in s13(5) of the 1990 Act. Though it already established that single applicants may seek ART, academics such as Daniel Sperling speculate that the notion of a child needing a father is rooted in sexist stereotyping. This effectively means that a male is required with their authoritative nature to counterbalance the mother's nurturing characteristics.⁷⁴ This seems to suggest that a child with only a female or male influence would not be as well rounded in character as a child with both influences. The significance of influence is relatively unknown yet the 'need for a father' was replaced by the 2008 amendments to the Act as 'a need for supportive parenting' suggesting the need for mixed gender influences to be relatively superficial. The House of Commons Science and Technology Committee recommended that this gender specific reference should be removed⁷⁵ in order to give full effect to the protection facilitated under the Human Rights Act

⁶⁹ Human Fertilisation and Embryology Authority, *Code of Practice* (2009 8th edition) s8.11.

⁷⁰ *Ibid* s8.10(b).

⁷¹ Scott, R., 'Choosing between possible lives: legal and ethical issues in preimplantation genetic diagnosis,' (2006) 26 *Oxford Journal of Legal Studies* 153 at p.172.

⁷² Human Fertilisation and Embryology Authority, *What you need to know about the Welfare of the Child Assessment* (Dec. 2005).

⁷³ Choudhry, S., and Fenwick, H., 'Taking the rights of parents and children seriously: confronting the welfare principle under the Human Rights Act', (2005) 25 *Oxford Journal of Legal Studies* 453 at p.474.

⁷⁴ Sperling, D., "'Male and female he created them": procreative liberty, its conceptual deficiencies and the legal right to access fertility care of males,' (2011) 7 *International Journal of Law in Context* 375 at p. 396

⁷⁵ House of Commons Science and Technology Committee, Fifth Report, *Human Reproductive Technologies and the Law*, (2004/2005) para. 101

1998. This resulted in the Government reasoning the amendment in terms of a 'Human rights enhancing measure'⁷⁶ seen to extend rather than limit access to reproductive treatment.

Though the Bill was enacted and amendments were made in 2008, the need for a father was discussed in relation to religion and ethics rather than the actual parental role. This is evident in the Commons debate: Iris Robinson states 'I am telling the House that the word of God says that procreation is through a man and a woman. We are moving mountains to facilitate immorality and to bring the rights of lesbians above all others in this country.'⁷⁷ Mr Edward Leigh, also a Christian, showed his dissent: 'My conscience tells me that an embryo is not a thing. It has been fertilised, and I believe that human life begins at conception.'⁷⁸ This then reintroduces the question; does ART have a stage of conception? With no definitive universal answer, this then suggests that the basis of the arguments lie not in the importance of the role of a father but in de-gendering reproduction⁷⁹ reiterating the notion of IVF being contrary to nature's wishes. The practical importance of the change in gender neutral language is arguably limited when read in conjunction with the rest of the provisions as further requirements such as the Welfare of the Child application can still hinder applicants despite being lawfully justified.

Decided before the gender neutral language was introduced, *Evans* offers detailed discussion of the role of a father in accordance with the provisions. Of more interest is the concept of 'treatment together' defined in schedule 3 in relation to the definition of 'father' under s28(3)(a). This effectively means that the 'man' in seeking 'treatment together' is the father of the child. Discussion within the case also suggests how a different male may be a substitute father under s28(3) (providing consent was given). Though the issue of consent will be discussed later, it is at this stage reasonable to suggest that the provision/need for a father is of little importance other than within the initial treatment stages.

Welfare requirements within the HFE Act 1990 seem *prima facie* to significantly limit an applicant's choice to treatment in effectively setting further eligibility requirements. Refusing applications on the basis of serious violence, substance abuse, and convictions relating to the welfare of the child are justified in relation to the duty of State to protect children from

⁷⁶ Joint Committee on Human Rights, Fifteenth Report, *Human Fertilisation and Embryology Bill*, (2007/2008) para.4.5.

⁷⁷ HC Deb. Vol 476. col. 213 20 May 2008.

⁷⁸ HC Deb. Vol 476. col 26. 19 May 2008

⁷⁹ Jackson, E., 'Degendering Reproduction?', (2008) 16 *Medical Law Review* 346 at p.347-348

neglect and abuse. Though argued to be somewhat discriminatory, similar provisions exist within the Children's Act 1989 and equally apply to those able to conceive naturally.

4 Consent Issues in Approving Treatment.

A strong deciding factor in addition to the criteria surrounding welfare relates to issues concerning 'supportive parenting,' though there is no express provision which requires two persons to seek treatment together, consent provisions exist in order to protect the parties involved. However, when looking at requests for ART it is apparent that strict interpretation of the consent provisions can deny the right to accessing treatment even if the patient wishes to assert her procreative right. Albeit this may seem to devalue the notion of reproductive autonomy,⁸⁰ interferences are justified in relation to protecting the rights of others and refusal on the basis of consent issues is neither unlawful nor unjustifiable.

Significantly *Evans* led to cementing the notion 'The Government has correctly identified that the use of genetic material to create an embryo without consent will engage the right to private life, as protected by Article 8 ECHR'.⁸¹ In looking at the decision of the Grand Chamber, it is clear that in the defendant withdrawing his consent, the judiciary were faced with a conflict of interests under Article 8. Mr Johnston was able to successfully withdraw his consent to usage of the embryos as paragraph 2(4) states consent extends to the use and storage of embryos created through gametes (which Mr Johnston provided). The issue in this case relates to the provision in paragraph 2(a) and section 4(1) commonly termed as treatment 'together' and when treatment occurs for the purpose of successfully withdrawing consent. Agreeing with the judgment in *Re R*⁸² the Act has been read so that 'the embryo must be placed in the mother at a time when treatment services are being provided for the woman and man together'. This effectively means that withdrawal of consent may be valid providing the embryos have not yet been implanted. This was further developed by Arden LJ where s28(3) was construed to mean that consent must be present at every stage of the joint enterprise⁸³ and the only way the claimant could succeed would be to show that the consent provisions are incompatible with her rights under the Convention.⁸⁴ Proving incompatibility is therefore unlikely as Article 8 is a qualified right and in this case, enshrined protected rights for the competing party.

⁸⁰ Eijkholt, M., 'The right to procreate is not aborted', (2008) 16 *Medical Law Review* 284 at p. 288

⁸¹ Joint Committee on Human Rights, Fifteenth Report, *Human Fertilisation and Embryology Bill*, (2007/2008) para.4.38.

⁸² *Re R* [2003] 2 ALL ER 131.

⁸³ *Natalie Evans v Amicus Healthcare Ltd & Others* [2004] EWCA Civ 727 at para.94.

⁸⁴ *Ibid* at para.96.

Murphy suggests that should *Evans* be able to conceive without assistance, there would have been no 'male veto' as decisions relating to reproductive decision could be made without reference to the genetic father.⁸⁵ This claim of discrimination under Article 14 failed as though 'the treatment is perhaps unpleasant, and certainly intrusive, but the result is to give a woman who is not fertile the chance of being on the same footing as one who is'.⁸⁶ Consent provisions cannot therefore be successfully argued as discriminatory, and the case was ultimately one of female self-determination vs consent. A further issue relating to consent is evident when viewing deceased father cases. Though various issues around ethics were raised in relation to these cases and the psychological impact this would have upon the children born, the real issue surrounded the fact that the women in extracting the sperm had acted without genuine consent from their partners, contrary to statute regulation.

In *Blood*, the claimant was eventually allowed to seek treatment outside of the UK, but the judiciary took a strict view. Section 4(1) HFE Act 1990 states that no one can store gametes except in the pursuance of a licence and this was construed to only being allowed providing consent provisions in schedule 3 were adhered to. As no written consent was obtained from the husband, storing his gametes was contrary to the Act so unlawful. This is reasoned on the basis of schedule 3 paragraph 5(1): 'A person's gametes must not be received for use for those purposes unless there is effective consent by that person to their being so used'. As the 'donor' was unconscious at the time of gamete extraction, initial consent was not ascertained nor were any specific directions as to the usage and storage present.

The reasoning behind the law in relation to deceased partners may be difficult to appreciate in relation to Article 2 of the Convention. Rights may only be attached to a living human being, so how does this then protect the rights of the deceased? This may be seen as a fault of the statute due to the impossibility of ascertaining effective consent, yet the reluctance to comprehensively legislate in the area demonstrates the significance of consent. Though the situation was perceived to be anomalous, a similar case followed in *L v The Human Fertilisation and Embryology Authority, Secretary of State for Health* applying the *Blood* rationale. This demonstrates though the Human Fertilisation and Embryology (Deceased Fathers) Bill recognised the issue of deceased fathers, access to treatment and legal recognition of the father cannot be granted if gametes were stored and extracted illegally.

⁸⁵ Murphy, T., 'Works in progress: new technologies and the European Court of Human Rights', (2010) 10 *Human Rights Law Review* 601 at p.622.

⁸⁶ *Natalie Evans v Amicus Healthcare Ltd & Others* [2004] EWCA Civ 727 at para.74.

The statute appears to offer a somewhat flexible approach to consent in allowing for modifications, withdrawals and for conditional use. It must be remembered that consent provisions only have this flexibility providing there has been initial effective consent. It is hoped the case of *Evans* will be confined to its facts despite provisions to remove consent before implantation still existing.

5 Competency of Treatment within the UK

With the heavy regulation placed upon reproductive treatment within the UK through statute, accessing treatment is not simple and is estimated to have a 22% success rate.⁸⁷ The method adopted for treatment is standardized as governed by the Act and the Authority. This effectively means that regardless of any underlying condition (i.e. why the patient is infertile and factors affecting fertility), the treatment is the same. The rationale behind this is clear when viewing treatment as a publicly funded service and though this is a practical approach, it has been argued in *R o/a Assisted Reproduction and Gynaecology Centre 'H' v HFEA*⁸⁸ that regulations imposed by the Authority preventing more than three embryos to be implanted during treatment is not necessarily the most effective method for all patients. The claimant was seeking to be implanted with five embryos due to previous failures. Despite the clinic suggesting that an exception to the rule be made on the basis of her increased age, and informing the Authority of practices in America (where the American Society for Reproductive Medicine recommend the use of more than three embryos where the patient is older and has a history of failed pregnancies⁸⁹), it was ruled that proceeding with treatment in this manner could result in the clinic having their licences revoked under s25(6) for failure to comply with the code of practice 5th edition.⁹⁰

The Authority's powers were further extended by s25(3) to grant decisions about techniques used including implantation. This decision, however, ruled that the guidance of the Authority should be subject to judicial review: 'The Authority is the body which is empowered by Parliament to regulate. Like any public authority, it is open to challenge by way of judicial review, if it exceeds or abuses the powers and responsibilities given to it.'⁹¹ This therefore means that as the guidance given by the Authority was considered carefully in relation to the facts; the fact the standardized treatment is not beneficial to the claimant does not give rise

⁸⁷ McHale, J., and Fox., M, *Health Care Law Text and Materials*, (2007), at p.779.

⁸⁸ *R (o/a Assisted Reproduction and Gynaecology Centre) v Human Fertilisation and Embryology Authority* [2002] EWCA Civ 20.

⁸⁹ *Ibid* at para.21.

⁹⁰ Human Fertilisation and Embryology Authority, *Code of Practice* (5th edition, 2001)

⁹¹ *R (o/a Assisted Reproduction and Gynaecology Centre) v Human Fertilisation and Embryology Authority* at para.65.

to judicial review. Stern argues that 'where clinical guidelines exist, studies show that providers' opinions about access to ARTs services are even more restrictive than clinical policies'.⁹² This can be observed to a degree within the Authority whereby the guidelines are often given further importance than definitive medical evidence suggesting new policy. However, standardized treatment is a legitimate means of regulating treatment within the UK in accordance with the licensing requirements.

Though the case was decided in 2002, the issue of using extra material has now come to light again with a recent scientific advancement. It is suggested the '3 person IVF technique'⁹³ should it be made a legal could provide a radical reform. The technique involves extracting 2 eggs (one from the mother and one from a donor), extracting 1 sperm and replacing the donor's nucleus within the egg with the mother's. This effectively means that gene characteristics such as hair and eye colour, appearance, height etc. will be transferred so that the child shares the same DNA but mitochondrial genetic disorders will not pass. Though this new method has been described by some as 'playing God', 1 in every 5,000 babies a year are born with a genetic disorder transferred through the mitochondrial DNA found within the mother's egg. 'This IVF revolution will allow families affected by mitochondrial diseases to have their own, healthy biological children'⁹⁴ suggesting that though the treatment will not be applicable to all, science is starting to acknowledge the importance of having biological children. However, it must be noted that there critics argue 'it is an essential parental virtue to accept one's child as it is'⁹⁵ and the debate surrounding the avoidance of disability further fuels ideas of eugenics.

Judicial Review is only available where the guidance is *ultra vires* and is likely to be met with increasing dissent by the judiciary as evidenced by Lord Woolfe in his Provost's Lecture:

As a result of scientific advances medical ethical problems of a new dimension are arising continuously. I have no doubt that those problems are not problems which are ideal for the courts to resolve. They are best tackled in the first instance by expert bodies such as the Human Fertilisation and Embryology Authority.⁹⁶

⁹² Stern., J et al., 'Access to Services at Assisted Reproductive Technology Clinics: A Survey of Policies and Practices', (2001) 184 *American Journal of Obstetrics and Gynaecology* pp.591-597.

⁹³ BBC News, "Three person IVF technique" moves closer', <http://www.bbc.co.uk/news/health-16627043> 11 February 2011.

⁹⁴ Johnson, A., 'Incredible IVF Advances Make 3 – Person IVF Technique Possible', Ezine Articles, <http://ezinearticles.com/?Incredible-IVF-Advances-Make-3-Person-IVF-Technique-Possible&id=6865444> 11 February 2011.

⁹⁵ Kahane, G., 'Choosing tomorrow's children: the ethics of selective reproduction', (2011) 19 *Medical Law Review* 334 at p.335.

⁹⁶ Woolf, L., 'Are the Courts Excessively Deferential to the Medical Profession?', (2001) 9 *Medical Law Review* 1 at p.16

Express representations such as these coupled with the previous decision evidence a lack of judicial willing to challenge the Authority on its guidance and policy. The Authority, therefore, can be shown to legitimately regulate the area of IVF which may affect patients in all stages of their treatment.

The 'objective' nature of treatment within the UK has led to a surge in what academics have termed 'procreative tourism', to seek ART abroad. This is not an option for most patients as the associated costs must be met by private finances. In recent years, countries such as Spain have become the destination of choice for British patients due to the loss of anonymity in the UK. In 2005 the Government passed a new non-retrospective law abolishing donor anonymity meaning the child born as a result may be able to contact the donor once they reach the legal adult age as well as adversely affecting UK waiting lists. Though Spain still retains donor anonymity, donors are sought from Eastern Europe including Britain in order to cope with the supposed 50-100% increase in demand that occurred once the law was enacted.⁹⁷ Contrary to this, speaking in 2007 Shirley Harrison the Chair of the HFEA stated

Many commentators continue to claim that the change in the law to remove anonymity for sperm and egg donors would lead to an immediate and steep fall in the number of donors. These new figures show that the predicted drop in sperm donor numbers is a myth.⁹⁸

Louise France suggests that strict donor rules such as the ability to stipulate the age of the recipient forces older patients especially to seek treatment abroad.⁹⁹ One patient interviewed claimed it was less expensive to use a donor egg in Spain than to use her own eggs in the UK suggesting that treatment within the UK is more expensive. The issue with procreative tourism is related to quality. Though some countries such as those in the European Union are subject to the European Union Tissue Directive¹⁰⁰ which implements a common standard of quality and safety, other countries offering 'IVF holidays' have no formal international restrictions or regulation. It is highly likely that any child born as a result of treatment abroad will become dependent upon the NHS.

⁹⁷ Tremlett, G., 'Spain becomes the destination of choice for fertility tourists from Britain', The Guardian, <http://www.guardian.co.uk/world/2006/may/12/spain.health1> 19 September 2011.

⁹⁸ Human Fertilisation and Embryology Authority, 'Number of sperm donors up following anonymity law changes', <http://www.hfea.gov.uk/465.html> 21 October 2011.

⁹⁹ *The Observer*, 'Passport, tickets, suncream, sperm...', <http://observer.guardian.co.uk/woman/story/0,1684149,00.html> 11 December 2011.

¹⁰⁰ Directive 2004/23/EC.

Though a success rate of 22% seems particularly low, it is not an indication of failure of infertility treatment. It would be unreasonable for the state to be obliged to provide a tailored service for each patient meaning adopting a standard procedure is not interfering with the right to infertility treatment; it is merely a method of regulating treatment in compliance with the NHS allotted budget and strict regulation imposed by the Authority. Though procreative tourism appears to be popular in terms of IVF holidays, it is doubtful there could be a successful claim by a patient to receive NHS funded treatment abroad as a means of avoiding the waiting lists as discussed in *R (Watts) v Bedford Primary Care Trust and Another*.¹⁰¹

Conclusion

Though some decisions within this area of law have seemed unsympathetic to the realities of infertility in almost labelling it a societal taboo¹⁰², and certain legislation could act as a barrier to treatment, it is submitted that while the state does limit the choice to seek reproductive treatment, this is lawfully justified in the light of an unrecognisable right to a child of one's own. The reasoning in this article is two-fold with first, there being no internationally recognised right to a child of one's own, and secondly, there being no enforceable right to access discretionary healthcare. Though it would be agreeable to take a sympathetic approach to infertility in labelling it an illness, in guaranteeing a 'remedy', and in viewing the social importance and psychological impact of motherhood,¹⁰³ these reasons could not justify treatment for all when considering the limitations of science, medicine and the financial capabilities of the state. Mason acknowledges the unsympathetic approach and suggests that despite 'decision by strict reference to the wording of the statute' enabling consistent law, this approach often fails to harmonise legal and medical approaches with the 'vague uneasiness' felt in decisions similar to *Evans*.¹⁰⁴ The 'unsympathetic approach' does however have merits in viewing the current state of the law surrounding treatment. Decisions have been consistent and the combination of the HFE Acts with the Authority have enabled for transparent viewing of the current state of the law surrounding infertility.

It is submitted that the right to a child of one's own is neither an established nor enforceable right within the UK. Though the ECHR has been commonly relied upon to assert rights to biological children through Article 8 in particular, arguments have been frequently denied

¹⁰¹ *R (Watts) v Bedford Primary Care Trust and Another* [2006] QB 667.

¹⁰² Laing, J., and Oderberg, D., 'Artificial reproduction, the "welfare principle", and the common good', (2005) 13 *Medical Law Review* 328 at pp. 332–333.

¹⁰³ Enright, M., 'Dispositional contracts and frozen embryos: right for women?', (2006) 12 *Medico-Legal Journal of Ireland* 31 at pp.31-32.

¹⁰⁴ Mason, J., 'Discord and disposal of embryos', (2004) 8 *Edinburgh Law Review* 84 at p.90.

with decisions reiterating how the right is both qualified and could not extend to a child of one's own. The right has been interpreted to allow for a wider right to motherhood recognising the legal, social and psychological importance of having children¹⁰⁵ and has in some respects suggested alternatives such as surrogacy and adoption. In making these suggestions, it is proposed that decisions have acted to limit the significance of biological parenthood. Similarly, in viewing the refusal in *Evans*, it is agreed with Madden that 'The desire for a child of one's own may sometimes become almost too strong or even pathological in some cases, particularly as a consequence of its repression or non-fulfilment'.¹⁰⁶ Providing alternatives to biological motherhood could be seen as a failing of infertility policy in the UK which acts to further iterate there being no positive right to a child of one's own.

Similarly, it is asserted there is no established right to access for infertility treatment. Though the state is under a duty to provide healthcare, this does not necessarily extend to discretionary treatment including access to IVF treatment. Though discretion in relation to IVF and reproductive health care has in many situations been justified due to expenses of the state, stringent criteria effectively barring the aged, the disabled and the convicted, suggest other contributory factors to the decision process. This has led many commentators such as McHale to argue that infertility treatment largely remains an area only accessible by the rich.¹⁰⁷ It is of course not only initial refusal by patients seeking private treatment, but also patients eligible to receive treatment on the NHS, which may prove to be ineffective due to the limited cycles on offer. This limited aspect of treatment has led critics to suggest that the associated low success rate for one cycle of treatment fails to take infertility treatment seriously¹⁰⁸ which could act to further demonstrate how little a duty to provide treatment the state is expected to extend. Though new suggestions to treatment are frequently made, it is unlikely that this area of the law will be subjected to rigorous reform due to changes previously made by amendment.

It is this exclusive nature surrounding IVF that suggests the state, through limiting access, is effectively able to limit who has a choice to have a child. Restrictions in relation to access for infertility treatment in terms of the HFE Acts and the Authority are lawful. Though it is observed that limitations are necessary in relation to financial capabilities, in setting down stringent criteria as to the welfare of the child and rigid practices in regulating the method of

¹⁰⁵ *Evans v United Kingdom* (2008) 46 EHRR 34 at para.72.

¹⁰⁶ Madden, D., 'Is there a right to a child of one's own?', (1999) 5 *Medico-Legal Journal of Ireland* 8 at p.13.

¹⁰⁷ McHale, F., *Health Care Law: Text and Materials*, (2007), ch.11.

¹⁰⁸ *Ibid* p.813.

treatment, these state mechanisms impact upon the scope of private treatment also. It would be unfair to suggest that welfare criteria were an unnecessary method of controlling reproductive treatment and simply a method of asserting control. Though the choice to treatment may be limited in some respects, it is undeniable that the state has recognised the increase in demand and calls for a fairer and more equal system.¹⁰⁹ It is therefore suggested that the discretion of Primary Care Trusts, and caps to age in relation to the amendments allowing for single and same sex couples to seek treatment, need to be viewed through the removal of the need for a father. Though the law in this area is arguably strict and clearly adversely impacts some applicants, it is evidenced that the state has made real attempts to 'open up' the area of IVF in breaking with tradition.¹¹⁰ In viewing the law through this method, it is submitted that the limitations imposed by the state are necessary, proportionate and lawful.

¹⁰⁹ Madden, D., 'Recent developments in assisted reproduction: legal and ethical issues', (2001) 7 *Medico Legal Journal* 53 at pp.60-61.

¹¹⁰ Gomez, D., 'The special status of the human embryo in the regulation of assisted conception and research in the United Kingdom,' (2011) 17 *Medico-Legal Journal of Ireland* 6 at 7-8.