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Introduction

In previous work I have discussed the inception of the requirement to take account of the welfare of children to be born as a result of assisted reproductive technology (ART) in the United Kingdom and related policy developments up to 2006 (Blyth, 2007). This chapter continues that account, providing a critical review of policy debates and regulatory and legislative shifts up to the present time. The principal sources of review and reform emanate from temporally overlapping and, at times, antagonistic, parliamentary, government and regulatory body initiatives – as outlined in Table 2.1:

Table 2.1 Welfare of the Child: UK legislative and policy review 2004–2009

June 2004	House of Commons Science and Technology Select Committee <i>Inquiry into Human Reproductive Technologies and the Law</i> launched
January 2005	HFEA <i>Tomorrow’s Children</i> (welfare of the child) <i>consultation</i> launched
March 2005	House of Commons Science and Technology Select Committee <i>Inquiry into Human Reproductive Technologies and the Law</i> report published
April 2005	Commencement of Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004 requiring all new gamete and embryo donors to agree to their identity being disclosed to any donor-conceived individual aged at least 18 years requesting this information from the HFEA
August 2005	Department of Health <i>Review of the Human Fertilisation and Embryology Act: A Public Consultation</i> launched
November 2005	HFEA <i>Tomorrow’s Children</i> (report following welfare of the child consultation) published
November 2005	Department of Health <i>Review of the Human Fertilisation and Embryology Act: A public consultation</i> – end of consultation
December 2006	<i>White Paper Review of the Human Fertilisation and Embryology Act: Proposals for revised legislation</i> (including establishment of the Regulatory Authority for Tissue and Embryos) published
May 2007	Draft Human Tissue and Embryology Bill published for pre-legislative scrutiny by Joint Parliamentary Scrutiny Committee
August 2007	Joint Parliamentary Scrutiny Committee report on Draft Human Tissue and Embryology Bill published
October 2007	Government response to Joint Parliamentary Scrutiny Committee report published
December 2007	Human Fertilisation and Embryology Bill introduced in House of Lords
November 2008	Human Fertilisation and Embryology Act 2008 received Royal Assent
November 2009	Eighth edition of HFEA <i>Code of Practice</i> published (further revisions April 2010, April 2011, October 2011, April 2012, October 2012)

- A Department of Health consultation on whether genetic and biographical information should be made available to a donor-conceived person (Department of Health, 2001, 2003), resulting in: (1) standardisation of collection of nonidentifying donor information by the regulatory body, the Human Fertilisation and Embryology Authority (HFEA); (2) a requirement that from April 2005 all donors had to agree to disclosure of their identity to adult donor offspring (Human Fertilisation and Embryology Authority [Disclosure of Donor Information] Regulations 2004); (3) creation of a voluntary contact register for individuals conceived by donor conception prior to implementation of the 1990 Human Fertilisation and Embryology Act (hereafter ‘the 1990 Act’), their donors and other genetic relatives;

- A consultation by the HFEA on the operation of the welfare of the child requirement (Human Fertilisation and Embryology Authority, 2005a), resulting in: (1) liberalisation of the child welfare provisions (Human Fertilisation and Embryology Authority, 2007); (2) advocacy of early parental disclosure of donor conception to their donor-conceived children (Human Fertilisation and Embryology Authority, 2005b);
- An *Inquiry into Human Reproductive Technologies and the Law* undertaken by the House of Commons Science and Technology Select Committee between 2004 and 2005 that advocated abolition of the welfare of the child provision ‘in its current form’ (House of Commons Science and Technology Committee, 2005a: 107) and criticised the removal of donor anonymity (House of Commons Science and Technology Committee, 2005a: 158);
- A Department of Health review of the 1990 Act, resulting in the replacement of the obligation on fertility clinics to take account of the child’s need for ‘a father’ with that for ‘supportive parenting’ (a complex process taking place between November 2005 and November 2009 involving: (1) a public consultation (Department of Health, 2005); (2) a White Paper (Department of Health, 2006); (3) a draft Human Tissue and Embryology Bill that was subject to pre-legislative scrutiny by a Committee from both Houses of Parliament that itself involved further extra-parliamentary consultation (House of Lords/House of Commons, 2007a, 2007b); (4) a revised Human Fertilisation and Embryology Bill, which became the Human Fertilisation and Embryology Act 2008 (hereafter ‘the 2008 Act’). Parliamentary debate provided further opportunity for discussion of legislative provisions regarding the welfare of children born following ARTs. Indeed, this single topic accounted for 10 per cent of the time legislators debated the Bill, before it completed its parliamentary passage in November 2008 to take effect from 1 October 2009 (McCandless and Sheldon, 2010). This was remarkable in the light of, first, the serendipitous manner in which the requirement to take account of the welfare of the child found its way into the legislation in the first place (Blyth, 2007); second, Baroness Warnock’s (2007) perceptive and accurate comment (in the view of this writer) that ‘it has always been a pretty ineffective bit of legislation’, and third, the eventual outcome – the removal of two words, ‘a father’, from Section 13(5) of the 1990 Act, and their replacement by two more, ‘supportive parenting’, as indicated below:

A woman shall not be provided with [infertility] treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for *a father*), and of any other child who may be affected by the birth. (Human Fertilisation and Embryology Act, 1990 S 13(5) – my emphasis)

A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for *supportive parenting*), and of any other child who may be affected by the birth. (Human Fertilisation and Embryology Act 1990 S 13(5) (as amended) – my emphasis)

In addition, as an eventual compromise regarding divergent views on how best to promote disclosure of their genetic and biographical history to donor-conceived people, the 2008 Act gave statutory backing to the HFEA’s existing guidance on early parental disclosure (Human

Fertilisation and Embryology Act 1990 (13 (6C)) – as amended) (see also Blyth and Frith, this volume).

The welfare of the child in ART: 1991–2005

Legislation regulating the fast-moving world of medical technology is always going to have difficulty keeping up with the pace of change. Thus future reform of the 1990 Act was inevitable from the outset and in at least one respect review was inherent as regards the welfare of children born as a result of donor conception. The 1990 Act endorsed contemporaneous practice in donor conception in which anonymity between donor and recipient was accepted as a given. Section 31 of the Act made provision for a donor-conceived individual reaching the age of 18 years to request information about his or her donor held by the HFEA.

This information was to be specified in subsequent regulations, but explicitly excluded the donor's identity. The management of requests for this information was seen as especially sensitive and pertinent to 'child welfare'; arguably, the 1990 Act militated against the welfare of donor-conceived individuals who considered knowledge of their donor to be integral to their sense of their own welfare. Following implementation of the Act, interested stakeholders who had campaigned for the abolition of donor anonymity from the outset lobbied the government to ensure a timely clarification of this information and suitable systems for its disclosure to young donor-conceived people, the first of whom to become eligible to take advantage of this provision would come of age in 2010 (Wincott and Crawshaw, 2006).

The government eventually acceded to these requests in 2001–2002 and in January 2003, the then Minister of Health, Hazel Blears MP, stated the government's position, while also making her own opinion clear:

I think there is a strong argument in principle that donor conceived children are able to find out the identity of their donor. (Blears, 2003)

However, mindful of opposition to such a move, especially from fertility clinics, primarily concerned about the possible adverse impact on donor supply and potential conflict between the interests of different parties involved in donor conception, she proposed a 'wider debate' to elicit more information from clinics and donors, and draw on the experiences of jurisdictions that had already prohibited donor anonymity, and indicated that she intended making a final decision within six months. Meanwhile, two specific measures were agreed. First, the standardisation of non-identifying donor information collected by the HFEA to be made available to a donor-conceived person and second, funding for a pilot voluntary contact register to enable individuals conceived before implementation of the 1990 Act, their donors, and any half siblings to establish their donor links through DNA testing and to make contact by mutual consent. (This subsequently became UK Donorlink (Crawshaw and Marshall, 2008; Crawshaw et al., 2013).)

There was, indeed, extensive and impassioned debate regarding the removal of donor anonymity and its presumed consequences. Opposition was largely presented in terms of anticipated *practical* consequences rather than as a matter of *principle*, although some critics contended that any measure likely to reduce the number of children born as a result of donor conception could hardly advance the cause of child welfare (Cohen, 2012; Harris, 2004;

Jackson, 2002; Savulescu, 2004; Wilkinson, 2003). Two key adverse outcomes were anticipated – a reduction in the number of donors and a reduced likelihood of parents telling their donor-conceived children about their conception because of fears they might contact their donor. The major professional medical bodies representing physicians working in ART voiced opposition to the proposed policy change on the grounds of its anticipated adverse impact on donor recruitment (British Fertility Society, 2004; British Medical Association, 2004; Royal College of Obstetricians and Gynaecologists, 2004). However, the British Medical Association highlighted conflicts of opinion between the organisation’s Medical Ethics Committee, which supported the abolition of anonymity, and its Representative Body. Some critics forecast a cataclysmic effect on donor conception, including the emasculation of egg sharing and oocyte donation (Henderson, 2004), while Pennings (2001: 617) predicted a loss of ‘about 80%’ of donors.

In the event, Blears’ proposed timescale fell victim to political exigencies and it was left to her successor, Melanie Johnson, to take forward this work. Virtually one year later, Johnson announced that, despite the overwhelming opposition of clinics and mixed responses from donors whose views had been secured, the government would seek parliamentary approval for the abolition of donor anonymity with effect from 1 April 2005. The principles on which this decision was based were unambiguous:

I believe that in an increasingly-open society, donor-conceived people born in the coming years will want as much information as possible [...] I believe they have a strong case. Is it reasonable for information about genetic origins that is held on a national database to be withheld from them? [...] It has not been an easy decision to make. We have concluded that the interests of the child are paramount [...] We believe that it is right that people conceived by future donations should be able to obtain identifying information about their donor. (Johnson, 2004)

Subsequently, two overlapping processes involving exploration and debate on child welfare issues took place during 2004 and 2005. In June 2004, the House of Commons Science and Technology Select Committee launched its *Inquiry into Human Reproductive Technologies and the Law*, reporting in March 2005 (House of Commons Science and Technology Committee, 2005a, 2005b). During 2005, the HFEA undertook consultations on the 1990 Act’s welfare of the child provisions (HFEA, 2005a, 2005b). Both exercises evinced divergent views held by various interested parties who were sufficiently motivated to make known their opinions.

House of Commons Science and Technology Select Committee Inquiry into Human Reproductive Technologies and the Law

The 1990 Act’s welfare of the child provisions, the government’s continuing support for these and the abolition of donor anonymity were severely criticised by the Committee, although half of its members formally distanced themselves from the libertarian partisanship evident in its report, which was approved only with the chair’s casting vote (House of Commons Science and Technology Committee, 2005c). The Committee proposed abolition of the child welfare provision ‘in its current form’ because it

‘discriminat[es] against the infertile and some sections of society, [is] impossible to implement and [...] of questionable practical value in protecting the interests of

children born as a result of assisted reproduction’ (House of Commons Science and Technology Committee, 2005a: 107).

The Committee specifically slated articulation of the ‘need for a father’ for being ‘too open to interpretation and unjustifiably offensive to many’ (House of Commons Science and Technology Committee, 2005a: 101). Nevertheless, acknowledging that there might be occasions when valid child welfare issues might be raised as a result of providing ART services to particular individuals, the Committee’s proposed solution implausibly advocated increasing the workloads of already overstretched child safeguarding agencies:

The State employs social services to protect children from harm. If it has reason to believe that children born as a result of assisted reproduction are at increased risk then healthcare professionals can alert social services at an early stage. (House of Commons Science and Technology Committee, 2005a: 103)

The Committee voiced its objection to the removal of donor anonymity not only on the anticipated adverse impact on donor supply,¹ but also because of the possibility that parents would be less inclined to tell their donor-conceived children about their conception in the first place, a proposition initially floated by the British Medical Association (2004: 228). In her evidence to the Committee, Professor Susan Golombok (2004: 136) asserted that empirical evidence on this matter was largely anecdotal. Despite the manifestly thin evidence base, the Committee nevertheless concluded:

there is a *powerful* argument that the ending of such anonymity would result in a greater likelihood of parents not telling the child because the fear (rational or not) of rejection in favour of an identifiable biological parent outweighs the advantage of having identifying information to transmit. (House of Commons Science and Technology Committee, 2005a: 157 – my emphasis)

A more circumspect conclusion would suggest that while the jury is still out, there is some emerging evidence to contradict the Committee’s conclusion, in which encouragement and facilitation of increased transparency, whether through regulation, legislation or professional practice appear to contribute to a climate of increased parental disclosure. Further, as official HFEA data illustrate (Table 2.2), the impact of the legislative change to remove donor anonymity on donor recruitment has been significantly less draconian than feared by opponents. The number of new semen donor registrations dropped to an all-time low in 2004, coinciding with the removal of donor anonymity. Subsequently, modest increases were recorded each year until 2012. However, a slight fall-back was recorded in 2013 and about one-third of new sperm donor registrations are of foreign imports that fulfil UK regulatory requirements (the most recent available data) (HFEA, 2014). HFEA data show a steady increase in new oocyte donor registrations between 1992 and 2001, followed by reductions

¹ Continuing criticism of the removal of donor anonymity from other interested parties followed implementation of the legislation, augmented by legendary fertility specialist Lord Winston (2006), and two former chairs of the HFEA, Sir Colin Campbell (2006) and Baroness Deech (2006). Dr Evan Harris MP, a member of the House of Commons Science and Technology Committee, described the abandonment of anonymity as ‘stupid and misguided’ (cited in Woolf, 2006) and in June 2008 claimed: ‘There was no good reason for removing anonymity, which has led to a catastrophic drop in the number of patients treated by donor insemination. There was always a huge risk that this would happen, diminishing the capacity of both the NHS and private clinics to treat infertility. There are probably now thousands of untreated couples who may be forced abroad, or into the unregulated sector’ (cited in Henderson, 2008).

until 2006 (where a significant fall was recorded). In the years since 2006, however, modest continuous increases have been sustained.

Table 2.2 All new donors registered 1992-2013

<i>Year</i>	<i>Semen donors</i>	<i>Oocyte donors</i>
1992	375	451
1993	426	528
1994	417	732
1995	414	749
1996	419	806
1997	343	910
1998	256	943
1999	302	1,120
2000	323	1,241
2001	327	1,302
2002	288	1,174
2003	257	1,032
2004	237	1,106
2005	285	1,025
2006	307	812
2007	355	1,016
2008	403	1,157
2009	438	1,191
2010	492	1,261
2011	541	1,523
2012	631	1,634
2013	586	1,636

Source: 1992–2003 (Human Fertilisation and Embryology Authority, 2013); 2004–2013 (Human Fertilisation and Embryology Authority, 2014).

HFEA Review: Tomorrow’s Children

In January 2005, the HFEA initiated a public consultation on the operation of Section 13(5) (Human Fertilisation and Embryology Authority, 2005a). Unlike the House of Commons Science and Technology Select Committee inquiry, the HFEA review focused merely on the welfare of the child requirement within the terms of the 1990 Act and therefore could neither invite nor consider proposals for legislative change nor advocate itself for this, although the consultation provided further evidence of the controversial nature of Section 13(5) (Human Fertilisation and Embryology Authority, 2005b; Jackson, 2002). Following the consultation, several key changes were made to the guidance given to clinics (HFEA, 2005c), which took effect from 1 January 2006 and which was later incorporated into the seventh edition of the *HFEA Code of Practice* (HFEA, 2007).

The new guidance was designed to: focus [...] more clearly on the risk factors that could lead to serious harm, [provide] ... a system that is fairer for patients and more proportionate for doctors whilst still protecting children’s interests, which should be predicated in a presumption to provide services to an individual or couple except where there was evidence of a risk of serious medical, physical or psychological harm to any child born (or any existing child of their family). (HFEA, 2005d)

The new focus on risk of serious harm represented further liberalisation of provisions relating to the child’s ‘need for a father’ that the HFEA had initiated in its sixth edition of the Code of

Practice (HFEA, 2004a). Where the child will have no legal father, the fifth edition of the Code of Practice

‘required: centres [...] to have regard to the child’s need for a father and [to] pay particular attention to the prospective mother’s ability to meet the child’s needs *throughout their childhood*. Where appropriate, centres should consider particularly whether there is anyone else within the prospective mother’s family and social circle willing and able to share the responsibility for meeting those needs, *and for bringing up, maintaining and caring for the child*. (HFEA, 2001: 3.15 – my emphasis)

In the sixth edition, centres were ‘expected’: to assess the prospective mother’s ability to meet the child’s/children’s needs and the ability of other persons within the family or social circle willing to share responsibility for those needs. (HFEA, 2004a: 3.14)

While the wording of this obligation remained substantially the same in the seventh edition, save for substituting the phrase ‘is expected to assess’ with ‘should assess’ (HFEA, 2007: G.3.3.3), the ability of a clinic to use it to justify withholding treatment was significantly reduced. Henceforth it was to be considered only in determining the child’s potential exposure to risk of ‘serious harm’. The guidance further warned against ‘unfair discrimination on grounds of gender, race, disability, sexual orientation, religious belief or age’ (HFEA, 2007: G.3.3.2), replacing a more generalised requirement to undertake a ‘fair assessment’, which should be conducted ‘with skill and care’ and with due regard ‘to the wishes and sensitivities of all involved’ (HFEA, 2004a: 3.12).

In response to criticism regarding the HFEA’s previous requirement for a patient’s GP to be contacted as a matter of routine, the new guidance specified that enquiries of

‘any individuals, agencies or authorities for [...] further factual information’ should be undertaken only where the clinic suspected a risk of serious harm to the child, or where the information gathered was incomplete, inconsistent or deception was suspected (HFEA, 2007).

Once further information was obtained, treatment should be refused only if this indicated that either the child to be born or any existing child of the family is likely to experience ‘serious harm’ or where the clinic *still had insufficient information ‘to conclude that there is no significant risk’* (HFEA, 2007: G.3.4.5 – my emphasis). This replaced previous guidance that a clinic ‘may refuse treatment where it is unable to obtain sufficient information or advice on which to make a proper assessment’ (HFEA, 2004a: 3.23(iii)).

As had been the case previously, further enquiries should not be undertaken without the individual’s consent and the clinic should still take account of a refusal to consent. However, in a departure from previous policy, the HFEA stated that this ‘should not itself be grounds for refusing treatment’ (HFEA, 2007: G.3.4.4).

Parental disclosure of donor conception

Prior to the *Tomorrow’s Children* review, the HFEA had required centres to take account of ‘a child’s potential need to know about their origins and whether or not the prospective

parents are prepared for the questions which may arise while the child is growing up' (HFEA, 2001: 3.14a). Following the review, however, the HFEA adopted a radically proactive stance:

'There is evidence that finding out suddenly, later in life, about donor origins can be emotionally damaging to children and to family relations. Therefore, it should be made clear to individuals seeking treatment with donor gametes or embryos that telling their child/children about their origins early in childhood is in their welfare interests. Clinics should encourage and prepare patients to be open with their children from an early age about the circumstances of their conception' (HFEA, 2005c: 5.6; 2007: G.5.4.6)²

Promotion of increased transparency was part of a new approach pursued by the HFEA, which had – separately – seen the encouragement of clinics to 'respond as fully as possible to patients' requests for non-identifying information about the donor or donors used in their treatment' (Human Fertilisation and Embryology Authority, 2004b) – later encapsulated in the eighth edition of the *Code of Practice* (HFEA, 2009: 30.16(d)) – and what transpired to be a short-term measure, to provide parents of donor-conceived children with details of their children's donor codes (Blyth, 2012).

Department of Health Review of the 1990 Act

As part of its review of the 1990 Act, the government initiated a further round of public consultation (Department of Health, 2005). Notwithstanding the Science and Technology Committee's criticism of the removal of donor anonymity, the government made clear that this decision would not be revisited. Indeed, views on the question: 'what measures would be appropriate, if any, to *ensure* that parents tell children conceived through gamete or embryo donation that they are donor conceived?' were specifically invited (Department of Health, 2005: 6.31 – my emphasis), as were comments on the welfare of the child provisions. Respondents to the consultation proposed a range of possible options regarding parental disclosure, from parent-directed approaches as to whether and when to tell child(ren), to a legal obligation to do so. Some of those favouring a legal mandate suggested using birth certificates to indicate the individual's donor conception status, although this was rejected by others (People Science & Policy, 2006: 48–49). In the event, neither the White Paper (Department of Health, 2006: 2.58) nor the Human Tissue and Embryos (Draft) Bill 2007 made any reference either to parental obligations to tell their donor-conceived children about their conception or to the potential role of birth certificates in facilitating disclosure, although it was intended that provisions would be made to help donor-conceived people to ascertain if they had half-siblings as a result of donor conception.

As regards the welfare of the child provisions, members of the public who responded to the consultation generally favoured retention of a reference to the child's 'need for a father', with some recommending that reference be made to a need 'for both a mother and a father' (Department of Health, 2006: 2.25). The government, however, announced its intention to remove reference to the 'need for a father', taking into consideration recent legislation relating to civil partnerships, and its failure to be 'convinced that the retention of this provision could be justified in terms of evidence of harm, particularly when weighed against the potential harms arising from the consequences of encouraging some women who wish to

² However, the HFEA did not specifically cite the source of this evidence.

conceive to make private arrangements for insemination rather than use licensed treatment services' (Department of Health, 2006: 2.26) (see also Emily Jackson in this volume). The Human Tissue and Embryos (Draft) Bill 2007 (Department of Health, 2007a: 21(2)(b)) proposed the streamlined requirement that:

A woman shall not be provided with treatment services, unless account has been taken of the welfare of any child who may be born as a result of the treatment, and of any other child who may be affected by the birth.

In line with new provisions regarding the introduction of proposed legislation, the draft Bill was sent for review by a joint parliamentary committee comprising members of the House of Lords and the House of Commons, in which the Committee called for both oral and written evidence (House of Lords/House of Commons, 2007a, 2007b). The Committee received evidence that largely replicated that obtained previously by the Department of Health, although it reached somewhat different conclusions. As regards disclosure of donor-conception status, the Committee was concerned that the benefit of removing donor anonymity was 'illusory if the fact of donor conception is not known' (House of Lords/House of Commons, 2007b: 272), and:

[r]ecognise[d] the force of the argument that the fact of donor conception should be registered on a person's birth certificate. This would create the incentive for the parent(s) to tell the child of the fact of his or her donor conception and would go some way to address the value of knowledge of genetic history for medical purposes... [A]ssisted conception by its nature involves the authorities and we are deeply concerned about the idea that the authorities may be colluding in a deception. However, we also recognise that this is a complicated area involving the important issue of privacy, as well as issues of human rights and data protection. We therefore recommend that, as a matter of urgency, the Government should give this matter further consideration. (House of Lords/House of Commons, 2007a: Recommendation 28)

The Committee was also perturbed by the government's proposals to remove all reference to a child's parenting needs and the potential adverse implications of single parenting that eradication of the 'need for a father' requirement would presage. It observed that:

a loving, supportive family network is more important for a child's development than the gender of the second parent and we note the provisions on parenthood in the draft Bill [...] in which a reference to a 'father' would no longer simply refer to a child's male parent, but would also refer to a woman who is a child's parent [...] In an area such as this, the law has symbolic value. Ultimately, however, the issue is one of what is in the best interests of the child. (House of Lords/House of Commons, 2007b: 242)

And went on to recommend that:

the current provision ... including the 'need of that child for a father' should be retained but in an amended form in a way that makes clear it is capable of being interpreted as the 'need for a second parent'. (House of Lords/House of Commons, 2007b: 243)

In responding to the Committee's recommendations, the Department of Health acknowledged the sensitivity of birth certificate annotation but indicated its preference for educational rather than legislative measures to promote parental disclosure (Department of Health, 2007b: 69). However, it did promise to 'keep the matter under review' and to engage in 'constructive dialogue with stakeholders' (Department of Health, 2007b: 70). It also rejected the Committee's proposition to include reference to a 'second parent', even if this could be done without compromising single women's access to ART services, on the grounds that this would contribute nothing of significance to the existing proposal (Department of Health, 2007b: 57).

The government subsequently withdrew the draft Bill and a new Bill, the Human Fertilisation and Embryology Bill 2007, was introduced to the House of Lords in November 2007. As expected, this contained no specific measures regarding parental disclosure of donor conception and no reference to birth certificates, but included a revised child welfare requirement, that:

a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of treatment (*including the need of that child for supportive parenting*), and of any other child who may be affected by the birth. (Human Fertilisation and Embryology Act, 1990 (13(5)) as amended – my emphasis)

During debate on the Bill in both the House of Lords and the House of Commons, further attempts were made to instate into the legislation provisions to use birth certification to record donor conception (Earl Howe, 2007; Baronesses Barker and Warnock and Earl Howe, 2007; Lord Jenkin, 2008; Robert Key, 2008). While none of these was supported, parliament did agree to statutory backing of the HFEA's existing guidance regarding:

- (a) the importance of informing any resulting child at an early age that the child results from the gametes of a person who is not a parent of the child, and
- (b) suitable methods of informing such a child of that fact. (Human Fertilisation and Embryology Act 1990 (13 (6C)) – as amended)

In addition, government ministers highlighted a previously announced agreement to work with Donor Conception Network to explore 'ways in which current and potential parents of donor-conceived children can be encouraged to tell the children about their origins' (Royall, 2007) and gave a 'firm commitment' to 'carry out a review of practices in informing donor-conceived children of the fact of their donor conception and whether there is a need for a change in the law to best ensure that donor-conceived children are informed of their donor conception' within four years of the Act coming into force (Primarolo, 2008a, 2008b, 2008c, 2008d; Royall, 2008)³. Similarly, members of both Houses sought to amend the welfare of the child requirement (see McCandless and Sheldon (2010) for a detailed review and discussion, especially the removal of the 'need for a father' requirements), although the government's original formulation prevailed.

³ This commitment fell victim to the change of government following the general election of 2010 – since which time there has been no evidence that the government considers any such review to be sufficiently pressing.

Subsequent to the enactment of the Human Fertilisation and Embryology Act 2008 in 2009, the HFEA revised its *Code of Practice* that provides a definition of ‘supportive parenting’ as follows, extending the liberalising trend regarding the welfare clause evident in previous editions of the *Code*:

Supportive parenting is a commitment to the health, well-being and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised. (HFEA, 2009: 8.11)

Conclusions

Just over five years following implementation of the 2008 Act, it might be pertinent to ask whether it has made any difference either to professional or parental behaviour. An absence of evidence militates against a conclusive response at this point in time. As regards parental disclosure, contrary to the fears of the Science and Technology Select Committee and others, such evidence as there is (from studies undertaken in the UK, Finland and Sweden) suggests increasing levels of parental disclosure over time. In 2008, Crawshaw published the results of a survey of counsellors in UK fertility clinics that was undertaken after the law on donor anonymity was changed in 2005. Counsellors reported that, compared with past experiences, more patients who were planning to build their family by means of donor conception were indicating their intention to tell their child about the nature of his or her conception. Whether or not such intentions translated to actual practice remain, of course, open to speculation in the absence of follow-up studies. Although no research has yet been published involving donor-conceived children born since anonymity was removed, a study of parents of children born following oocyte donation in 2000 who were interviewed when the children were one year old (Golombok *et al.*, 2004) and again when the children were aged seven years (Readings *et al.*, 2011) indicates increased levels of parental disclosure, albeit ‘reflected more in [...] intentions than in actual disclosure patterns’ (Readings *et al.*, 2011: 492), as well as illustrating parental discrimination in what to reveal (such as divulging recourse to IVF but not to oocyte donation). In the first phase of the study, in which 51 families participated, 29 (56%) parents stated their intention to tell their child about the circumstances of her or his conception, 11 (22%) were uncertain and 11 (22%) had decided not to tell. By the time of the second phase, 19 families had dropped out. Of the 32 families remaining in the study when their child was aged seven years (62.8% of the original group), 13 (40.6%) reported that they had already told their child, 10 (31.3%) were intending to tell, four (12.5%) were uncertain and five (15.6%) had decided not to tell. Unfortunately, the authors neither enumerate the dropout rates from each of the three initial disclosure groups nor pair participants’ initial and later disclosure plans; this would have made it possible to generate specific decision-making trajectories for these parents and provide more helpful information to guide future policy and professional practice. Similar trends regarding increased parental inclinations have been observed in Sweden, where donor anonymity was removed in 1985 (Gottlieb *et al.*, 2000; Isaksson *et al.*, 2012; Lalos *et al.*, 2007; Milsom and Bergman, 1982) and in Finland, where donor anonymity was removed in 2007 (Söderström-Anttila *et al.*, 2010). Lee, Macvarish and Sheldon (2012, 2014) have undertaken the first – and so far only – empirical study of practice in fertility clinics since implementation of the 2008 Act. The study highlighted a strong presumption by clinics to provide treatment in the absence of serious concerns about the welfare of the child, virtually universal support for taking account of children’s welfare,

concerns to avoid discriminating against potential patients, especially lesbian couples, and clinics' limited experiences of actually refusing to provide treatment on welfare grounds, although where such 'extreme cases' occurred they were usually 'complex and idiosyncratic'. At the same time, however, research participants reported their underlying awareness that, despite appearances, 'you can never know':

the spectre of the paedophile shapes perceptions, as a person hardly ever encountered but whose threat nevertheless creates a powerful rationale for pre-emptive action. (Lee *et al.*, 2012)

Ironically, given the history of Section 13(5), lesbian couples were often perceived within clinics as 'ideal parents' – although this was not especially surprising, given similar findings reported nearly two decades previously (Blyth, 1995). Concerns were, however, evident regarding the motivations of single women and their ability to be effective 'supportive' parents. As family form *per se* seemed to have retreated as a source of potential welfare concerns, these were found to be more directed towards the quality of future parent–child relationships, emotional and psychological issues, and disclosure to children where a family had been built using donor conception. The study provided evidence of confusion among at least some respondents about the meaning of 'supportive parenting'; some interpreted it as just a new way of referring to 'need for a father' especially in relation to treating single women, while others misinterpreted it as '*supported* parenting'. However, what is perhaps the most revealing of the study's findings, given the time, energy and expense surrounding the legislative and regulatory changes, is that 'the new law appears to have had a relatively limited impact on clinics' previous practice' (Lee *et al.*, 2012), echoing a conclusion drawn by Douglas almost two decades previously following analysis of the impact of the then new Human Fertilisation and Embryology Act 1990:

'On the basis of this study s13(5) does not appear to have forced or even encouraged clinics to alter their approach to whom they will treat'. (Douglas, 1993: 68)

This invites the hopefully not-too-flippant question 'What was the point?' In this case it was hardly to demonstrate the instrumental role of law or its impact in actual practice or on people's behaviour. Rather, if it serves any purpose at all, it is a symbolic one:

whether or not legislation is implemented may be less important than the fact that the legislation has been introduced. (Stolz, 2007: 313)

The original formulation of the welfare requirement, especially including the reference to a child's 'need for a father' can be seen in this light, as an indication of concerns about the path taken by reproductive technology and the potential implications for family life as we know it or would like it to be (McCandless and Sheldon, 2010).

The past two decades have brought us increasing familiarity with ARTs – and perhaps some measure of desensitisation regarding their more radical manifestations. The contribution of the revised welfare provisions requiring ART providers to take account of the needs of children born following ART for 'supportive parenting' towards 'ensur[ing] that the law is both effective and fit for purpose in the early 21st century' may be seen as little more than a symbolic gesture reflecting rather than shaping contemporary practice. A more rounded assessment of UK law affecting the interests of children born following ART may be made by taking account of provisions enabling donor-conceived adults to learn about their

biographical and genetic heritage. Here – as Blyth and Frith (this volume) show – although there is scope for further development, the UK has emerged as a world leader.

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