INCAPACITOUS PATIENTS, ASSISTED REPRODUCTIVE TECHNOLOGY, AND THE IMPORTANCE OF INFORMED CONSENT

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Abstract: The principle of self-determination has gained significant judicial support over the last three decades, and the choice to procreate using assisted reproductive technology is a clear example of our right to choose a treatment that enhances our personal lives. The Human Fertilisation and Embryology Act 1990 (as amended in 2008) stipulates that each party must give written, informed consent to ensure that our reproductive materials are used within strict parameters. However, the growing number of posthumous conception cases in several jurisdictions has raised concerns, particularly in situations where gametes are extracted from incapacitous patients without their consent, leading to posthumous parenthood. The landmark case of *Y v A Healthcare NHS Trust* [2018] EWCOP 18 caused significant concern when it authorised the retrieval, storage and use of sperm from a suspected brain-stem dead man for procreative purposes under the Mental Capacity Act 2005. It has never been known to be in the 'best interests' of a patient who lacks capacity to procreate in English law, and the consequences of this decision could be highly significant, raising questions about the exploitation of incapacitous patients and the misuse of genetic material. The decision has since been confirmed as the correct approach by the Court of Protection in *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48. This article examines the rigorous consent regime of the 1990 Act and the ethical complexities of retrieving gametes from incapacitous patients for procreative purposes. It will be determined that the 1990 Act's preference for a rigorous consent regime for public policy reasons is appropriate, and any alternative forms of consent could open a slippery slope to the unethical use of vulnerable individuals for their reproductive materials.

Key words: *Consent, fertility treatment, best interests, incapacitous patients.*

1. INTRODUCTION

The United Kingdom has one of the most rigorous fertility legal frameworks in the world. The Human Fertilisation and Embryology Act 1990 ('the 1990 Act') was the first attempt to regulate what quickly became a global race to create babies *in vitro* after the birth of Louise Brown in 1978. It was composed after the publication of the Warnock Report,[1] a detailed narrative on assisted reproductive technology and how it should be regulated in light of its unique social and ethical complexities. The 1990 Act was strict by design, and the principle of informed consent was woven into a comprehensive licencing framework to ensure that the practice of fertility treatment operated within agreed social boundaries. To quote Lord Bingham in *R (Quintavalle) v Secretary of State for Health*,[2] '[Parliament] opted for a strict regime of control. No activity within this field was left unregulated. There was to be no free for all'.[3] The statute was amended in 2008, but the strict consent regime remained firm. A handful of appeal cases over the years have challenged the decisions of the Human Fertilisation and Embryology Authority (established under section 5 of the 1990 Act), in which patients have argued that the requirement for informed consent has scuppered their procreative liberty. These include the notable cases of *R v Human Fertilisation and Embryology Authority ex parte Blood*,[4] in which a deceased husband could not consent to the use of his sperm, and *Evans v United Kingdom*,[5] in which an ex-fiancé withdrew his consent to the storage of his and his ex-fiancé's embryos. The appeal courts adhered to the strict regime of the 1990 Act and refused to authorise fertility treatment in both cases, sending a clear message to practitioners and patients that the informed consent of *both* gamete providers was the key to unlocking fertility treatment in the United Kingdom. This has since been confirmed in more recent times by *ARB v IVF Hammersmith*,[6] holding that a man has a cause of action against a clinic if it provides fertility treatment to a woman (his ex-partner) without his informed consent. The principle of self-determination, particularly when it comes to our own genetic destiny, appears to have the full support of both statute law and the courts.

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[1] Warnock Report: 'Report of the Committee of Enquiry into Human Fertilisation and Embryology', Department of Health and Social Security (July 1984, Cmnd: 9314, London: HMSO).

[2] *R (Quintavalle) v Secretary of State for Health* [2003] UKHL 13.

[3] Ibid, [13].

[4] *R v Human Fertilisation and Embryology Authority ex parte Blood* [1999] Fam 151.

[5] *Evans v United Kingdom* (6339/05) (2008) 46 EHRR 34.

[6] *ARB v IVF Hammersmith* [2018] EWCA Civ 2803.

However, a highly unusual judgment in the Court of Protection case of *Y v A Healthcare NHS Trust*[7] called into question the core principles of the 1990 Act by authorising fertility treatment without statutory consent. Knowles J, in the first case of its kind in the United Kingdom, held that it was in the 'best interests' of a suspected brain-dead man to have his sperm retrieved, stored and used by his wife to posthumously conceive a sibling for their existing child. The result of this decision has been a unique statutory 'crossover' between the best interests test under section 4(6) of the Mental Capacity Act 2005 and the requirement for informed consent under Schedule 3(1) of the Human Fertilisation and Embryology Act 1990. Fertility treatment has never been offered in the 'best interests' of patients who lack capacity in the United Kingdom because it is a lifestyle decision connected to personal choice, identity and personal sovereignty, aptly described by Sperling as 'one of the primeval and most elementary interests a person may have'.[8] It involves the sharing of genetic material, and brings with it what are generally perceived to be adult responsibilities. To authorise fertility treatment in the 'best interests' of a suspected brain-stem dead patient, who has no capacity or understanding of the procedure or its consequences, could not only be viewed as illogical, but runs the risk of 'plundering' vulnerable patients for their reproductive materials in a highly invasive and arguably sexual way (electro-ejaculation, e.g., requires rectal penetration).[9] It could also bring the law and the medical profession into disrepute by performing medical procedures upon incapacitous patients on the request of third parties with no clear benefit to the patient.

There is evidence in other countries that consent to fertility treatment can be disposed of in cases where one party can no longer consent. In *Cresswell*,[10] a Queensland judge held that a young woman could possess the frozen sperm of her late fiancé who committed suicide on

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[7] *Y v A Healthcare NHS Trust* [2018] EWCOP 18.

[8] D Sperling, 'Male and Female He Created Them: Procreative Liberty, its Conceptual Deficiencies and the Legal Right to Access Fertility Care of Males' (2011) 7(3) Int J of L in Context 375-400, 375.

[9] For more on this tricky area of law, see: DA Ohl, 'Electroejaculation' (1993) 20 Urology Clinics of North America 181-88; PH Chung, 'Assisted Fertility Using Electroejaculation In Men With Spinal Cord Injury - A Review of Literature' (1995) 64 Fert & Steril 1-9; SM Kerr, 'Postmortem Sperm Procurement' (1997) 157 J of Urol 2154-58; C Miles Rothman, 'Live Sperm, Dead Bodies' (1999) 20 J of Androl 456-457; G Bahadur, 'Death and Conception' (2002) 17 Hum Reprod 2769-2775; RV Desai, M Krishnamurthy, H Patel, et al., 'Post-Mortem Sperm Retrieval: An Ethical Dilemma' (2004) 116 Am J of Med 858-858; S Shefi, G Raviv, ML Eisenberg, et al., 'Posthumous Sperm Retrieval: Analysis of Time Interval to Harvest Sperm' (2006) 21(11) Hum Reprod 2890-3; JD Hans, 'Attitudes Toward Posthumous Harvesting and Reproduction' (2008) 32 Death Stud 837-869; AC Kramer, 'Sperm Retrieval from Terminally Ill or Recently Deceased Patients: A Review' 16(3) (2009) Can J of Urology 4627-31, and D Williams, 'Over My Dead Body: The Legal Nightmare and Medical Phenomenon of Posthumous Conception Through Portmortem Sperm Retrieval' (2011) 34 Camp L Rev 181.

[10] *Re Cresswell* [2018] QSC 142.

the premise that they were one day 'intending to have children'.[11] In *The Matter of Zhu*[12] in 2019, a New York judge awarded grieving parents the legal right to retrieve, store and use their son's sperm to create a grandchild on the basis that he owned a donor card.[13] Back in the UK, in a more unique development in 2020, mother Louise Anderson asked Scotland's Court of Session to award her possession of the frozen sperm of her deceased trans-gender daughter Ellie in order to create her own grandchild.[14] Most recently in 2022, grieving widower Ted Jennings won his landmark case in the High Court to use his deceased wife's remaining embryo in a surrogacy arrangement despite her lack of consent to posthumous use. Theis J stated that consent would be 'inferred' in this case due to the wording of the consent form.[15] This decision was quickly followed by *Re X (Catastrophic Injury: Collection and Storage of Sperm)*,[16] in which Mr Justice Poole suggested that the presumed consent of an incapacitated patient to gamete retrieval was enough for court authorisation, and he also supported the approaches taken in *Y v A Healthcare NHS Trust* and *Jennings*. The 1990 Act does not allow for an 'inferred' or a 'presumed' consent to fertility treatment; it requires written consent to the posthumous use of embryos under Schedule 3.[17] Yet these cases show a judicial trend towards authorising fertility treatment without the consent of one gamete provider where they can no longer consent for themselves.[18] The landmark case of *Y v A Healthcare NHS Trust* may not have made the greatest leap in being one of the first cases to authorise the retrieval, storage and use of sperm from an incapacitous man if posthumous conception without consent is already accepted in several jurisdictions. However, incapacitous patients require a different legal framework for decisions regarding their care - the Mental Capacity Act 2005 -

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[11] Ibid, [161], [164], [166], [183] and [189] (Brown J).

[12] *The Matter of Zhu*, 64 Misc. 3d 280 (2019).

[13] Ibid, at 283 (John P Colangelo, J). See: Liam Stack, 'Parents of West Point Cadet Fatally Injured In Accident Obtain Order To Preserve His Sperm' *The New York Times* 5th March 2019.

[14] We still await the judgment – Covid caused a delay in the case. See: Simon Johnson, 'Mother of Deceased Transgender Teenager Launches Landmark Legal Bid to Preserve Sperm' *The Telegraph*, 25th August 2020, and David McCann, 'Transgender Girl's Sperm to be Stored Pending Case' *The Times*, 11th September 2020. This author has covered Louise Anderson's case, and the case of *Zhu*, in more detail elsewhere: [anonymous].

[15] *Jennings v Human Fertilisation and Embryology Authority* [2022] EWHC 1619, [92], [102] (Theis J). See also: H. Devlin, 'Widower Wins Right To Have Baby Using Embryo Created With His Late Wife' *The Guardian*, 22nd June 2022.

[16] *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48.

[17] Additionally, news broke in 2020 that a British woman had given birth to posthumous twins after her husband died of throat cancer three years previously: Arthi Nachiappan, 'Woman Gives Birth to IVF Twins Three Years After Her Husband Died' *The Times*, 13th August 2020. See also (separately): 'Woman Makes Scottish Legal Bid to Use Late Husband's Sperm' *The Guardian*, 15th September 2020.

[18] This list is not exhaustive, but other notable cases include: *Re Denman* [2004] 2 Qd R 595; *L v Human Fertilisation and Embryology Authority* [2008] EWHC 2149; *Re the Estate of the late Mark Edwards* [2011] NSWSC 478; *Re Leith Dorene Patterson* [2016] QSC 104; *Mr and Mrs M v Human Fertilisation and Embryology Authority* [2016] EWCA Civ 611; and *LT v DT Estate* [2020] BCCA 328.

and this differs significantly from the informed consent framework governing fertility treatment under the Human Fertilisation and Embryology Act 1990. It gives rise to the interesting question of whether gamete retrieval (an invasive procedure) and the subsequent use of assisted reproductive technology is in the ‘best interests’ of the patient, or whether we are trespassing upon vulnerable individuals for others’ (selfish) desires. In light of the recent upsurge of cases in numerous jurisdictions in which women seek court authorisation to use the sperm of their incapacitous or deceased boyfriends, fiancés and husbands, this article will undertake a timely critical examination of the importance of informed consent under the Human Fertilisation and Embryology Act 1990 (as amended in 2008) and the reasons why it should remain the ‘benchmark’ for lawful fertility treatment in the United Kingdom. To achieve this, it will first outline the origins of the consent regime under the 1990 Act and its supporting case law, and then it will investigate the legal and ethical complexities of bringing patients who lack capacity into the realm of assisted reproductive technology with a particular emphasis on the retrieval of their gametes. It will be concluded that when constructing the 1990 Act, Parliament preferred informed consent for social, ethical and public policy reasons, and the application of a best interests test to an incapacitous patient to use his reproductive materials is suspected to have weakened the rigorous consent regime of the 1990 Act. This opens the very real possibility of involving vulnerable individuals in fertility treatment without their knowledge or consent, which raises significant ethical concerns.

2. THE HUMAN FERTILISATION AND EMBRYOLOGY ACT 1990 AND ITS STRICT CONSENT REGIME

The Warnock Report was published in July 1984 to examine the social, ethical and legal implications of recent developments in the field of human assisted reproduction.[19] Experts from many disciplines, including religious leaders, were invited to contribute their views on the creation of life outside the realms of nature. Shadows of ‘unscrupulous scientists’, ‘hybrid half-human creatures’ and ‘eugenic selection’ loomed large in the public consciousness.[20] It

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[19] Warnock Report: ‘Report of the Committee of Enquiry into Human Fertilisation and Embryology’, Department of Health and Social Security (July 1984, Cmnd: 9314, London: HMSO).

[20] Warnock, ibid, 62 and 70.

was made clear by the Warnock Committee that fertility treatment was to be a public service governed by widely accepted moral principles:

> What is common is that people generally want some principles or other to govern the development and use of the new techniques. There must be some barriers that are not to be crossed, some limits fixed, beyond which people must not be allowed to go. The very existence of morality depends on it. A society which had no inhibiting limits, would be a society without moral scruples. And this nobody wants.[21]

The question of consent was uncomplicated. The controversial nature of fertility treatment and the possibility for harmful mistakes meant that a strict policy for consent was thought to be necessary:

> We recommend that in the case of more specialised forms of infertility treatment (IVF) the consent in writing of both partners should be obtained, wherever possible, before treatment is begun as a matter of good practice. Any written consent should be obtained on an appropriate consent form.[22]

Interestingly, the Warnock Committee did not recommend to banning posthumous conception as was suggested for other practices (such as trans-species fertilisation, growing an embryo *in vitro* beyond fourteen days, and sex selection for social reasons), but it had 'grave misgivings' about the practice, which was a clear sign that from a public policy perspective at least, it was not supported.[23]

The Human Fertilisation and Embryology Act 1990 was given Royal Assent on 1st November 1990 and the majority of the Warnock Report recommendations made it into law, including that consent be fully informed and in writing (Schedule 3); the creation of a statutory authority (section 5); a welfare test for the prospective child (section 13), and a raft of criminal offences (section 41). Posthumous conception was not banned, but to show

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[21] Warnock Report, (n 19) at 2 and 5.

[22] Warnock Report, (n 19) at 16. This consent recommendation was also applied to spare embryos used in research at 66-67, suggesting that no embryos, not even embryos that were destined to be destroyed before implantation, were to be used without the informed consent of the gamete providers.

[23] Warnock Report, (n 19) at 18, 55 and 57.

disapproval for the procedure, section 28(6) prohibited a mother from registering the father on a birth certificate if his sperm was used after his death.[24]

It is fair to conclude that the provisions of the Human Fertilisation and Embryology Act 1990 were grounded in public policy. A strict consent regime was a good way of ensuring that personal autonomy was respected in a highly contentious area of medicine within socially accepted limits (e.g., excluding sex selection for social reasons). Parliament passed the amending Human Fertilisation and Embryology Act in 2008 which addressed cloning, sex selection, tissue-typing (saviour siblings), the status of legal parents and parentage (gay couples), child welfare (removal of father), data management, embryonic research, interspecies embryos, donor anonymity, and the selection of disabled embryos. The need for informed, written consent from both gamete providers stayed firm under Schedule 3. No alternative forms of consent were presented, and no exceptions to consent were carved out.[25] Exportation directions were published in October 2009 (General Directive Ref: 0006) which require the written consent of both gamete providers before gametes/embryos can be sent abroad for fertility treatment. In conclusion, whilst some social standards have evolved since the 1990 Act was first passed into law, the need for informed consent to undertake fertility treatment has not only stayed firm but has garnered significant support from the courts, to which we now turn.

3. THE COMMON LAW ON THE IMPORTANCE OF INFORMED CONSENT

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[24] This was to ensure the timely winding-up of estates after death. It was later overturned by the Human Fertilisation and Embryology (Deceased Fathers) Act 2003, but the issue of probate remains.

[25] For commentary on the 2008 reforms, see: C Gavaghan, ‘Disability, Identity and Choice: Embryo Testing and the Human Fertilisation and Embryology Act 2008’ (2007) 9(3) Contemp Issues L 133-152; M Fox, ‘The Human Fertilisation and Embryology Act 2008: Tinkering at the Margins’ (2009) 17(3) Fem L Stud 333-344; N Gamble and L Ghevaert, ‘Human Fertilisation and Embryology Act 2008: Revolution or Evolution?’ (2009) 39 Fam Law 730-733; D McGrattan, ‘No Need for a Father: The Human Fertilisation and Embryology Act 2008’ (2009) 2 Irish J of Fam L 33-39; J McCandless and S Sheldon, ‘The Human Fertilisation and Embryology Act 2008 and the Tenacity of the Sexual Family Form’ (2010) 73(2) Mod L R 175-207; L Smith, ‘Clashing Symbols? Reconciling Support for Fathers and Fatherless Families after the Human Fertilisation and Embryology Act 2008’ (2010) 22(1) Child & Fam L Q 46-70, and M Eijkholt, ‘Procreative Autonomy and the Human Fertilisation and Embryology Act 2008: Does a Coherent Conception Underpin the Law?’ (2011) 11(2) Med L Int 93-126. See also: S McLean, ‘Consent and the Law: Review of the Current Provisions in the Human Fertilisation and Embryology Act 1990 for the UK Health Ministers’ (1997) 3(6) Hum Reprod Update 593-621.

Judicial decisions over recent decades have confirmed the importance of informed consent for the storage and use of gametes under Schedule 3 of the Human Fertilisation and Embryology Act 1990. The Human Rights Act 1998, in tandem, has inspired case law that grounds consent to treatment in patient self-determination.[26] The legal result, when both strands of jurisprudence are entwined together, is that a competent patient has the right to govern their own procreative destiny.[27] This is particularly evident in the jurisprudence emanating specifically from the 1990 Act.

The first case to require a judicial review of the 1990 Act was *R v Human Fertilisation and Embryology Authority ex parte Blood.*[28] A widow was refused fertility treatment under the 1990 Act because her deceased husband had not provided an informed and written consent to the storage and use of his sperm, which had been retrieved without court approval before his brain stem death was pronounced. It was too late for the court to comment on its unlawful retrieval, but its storage and use under the 1990 Act was up for scrutiny. Sir Stephen Brown P. noted the importance of informed consent and its intrinsic connection to public policy:

> This is a very hard case. It stirs emotions and evokes universal sympathy for the applicant … It is clear that the requirement for the written consent of the donor for the purposes both of storage and the use of gametes was considered to be a matter of fundamental importance.[29]

Mrs Blood lost her case in the High Court on the simple (but central) ground of consent. The Court of Appeal later overturned the High Court decision in part: the Human Fertilisation and Embryology Authority ('the HFE Authority') was to reconsider any EC Treaty rights

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[26] In a medical context, see the ground-breaking cases of *Chester v Afshar* [2004] UKHL 41 and *Montgomery and Lanarkshire Health Board* [2015] UKSC 11. For interesting commentaries on *Chester* and *Montgomery*, see: J Stapleton, 'Occam's Razor Reveals an Orthodox Basis for Chester v Afshar' (2006) 122 LQR 426-48; C Foster, 'It Should Be, Therefore It Is' (2004) 154 New LJ 7151; JK Mason and D Brodie, 'Bolam, Bolam - Wherefore Are Thou Bolam?' (2005) 9 Edin LR 298-305; T Clark and D Nolan, 'A Critique of Chester v Afshar' (2014) 34 OJLS 659-92; R Bagshaw, 'Modernising the Doctor's Duty to Disclose Risks of Treatment' (2016) 132 LQR 182-186; C Hobson, 'No More Bolam Please: Montgomery v Lanarkshire Health Board' (2016) 79(3) Mod LR 488-503; L Sutherland, 'Montgomery: Myths, Misconceptions and Misunderstanding' (2019) 3 JPIL 157-167; G Turton, 'Informed Consent to Medical Treatment Post-Montgomery: Causation and Coincidence' (2019) 27(1) Med LR 108-134, and TT Arvind and AM McMahon, 'Responsiveness and the Role of Rights in Medical Law: Lessons from Montgomery' (2020) 28(3) Med LR 445-477.

[27] In agreement, see: MM Shultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95 Yale LJ 219, and M Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7 LS 172.

[28] *R v Human Fertilisation and Embryology Authority ex parte Blood* [1996] 3 WLR 1176.

[29] Ibid, 1188-1190.

applicable to Mrs Blood to seek treatment abroad, but the decision regarding consent stood firm. Lord Woolf MR in fact admitted that a criminal offence had occurred: 'Mr Blood's sperm should not in fact have been preserved and stored. Technically an offence was committed by the licence holder as a result of the storage'.[30] He also confirmed that the only role of the court was to apply the provisions of the 1990 Act to the facts:

> The absence of the necessary written consent means that both the treatment of Mrs Blood and the storage of Mr Blood's sperm would be prohibited by the Act of 1990. The Authority has no discretion to authorise treatment in the United Kingdom … all the courts and the Authority can do is give effect to the clear language of the Act.[31]

The next case of *L v Human Fertilisation and Embryology Authority*[32] mirrored the facts of *Blood,* and Charles J reiterated that 'the 1990 Act set an absolute, clear and bright line which prevents storage in the UK, and use in the UK, without effective consent'.[33] In *Centre for Reproductive Medicine v U,*[34] it was thought that Parliament had placed a heavy emphasis on informed consent to strike a fair balance between all parties:

> The whole scheme of the 1990 Act lays great emphasis upon consent. The new scientific techniques … bring with them huge practical and ethical difficulties. These have to be balanced against the strength and depth of the feelings of people who desperately long for the children … as well as the natural desire of clinicians and scientists to use their skills. Parliament has devised a legislative scheme in a way which tries to strike a fair balance between the various interests and concerns.[35]

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[30] *R v Human Fertilisation and Embryology Authority ex parte Blood* [1999] Fam. 151, 178.

[31] Ibid, 179-180. For interesting commentaries on the *Blood* case, see: C Dyer, 'Whose Sperm is it Anyway?' (1996) 313 BMJ 837; H Biggs, 'Madonna Minus Child. Or – Wanted: Dead or Alive! The Right to Have a Dead Partner's Child' (1997) 5 (2) Fem LS 225; S McLean, 'Consent and the Law: Review of the Current Provisions in the Human Fertilisation and Embryology Act 1990 for the UK Health Ministers' (1997) 3(6) Hum Reprod Update, 593-621; L Delaney and K Doyle, 'Fathers – Who Needs Them – HFEA v Blood' [1997] Fam Law 261; D Morgan and RG Lee, 'In the Name of the Father? Ex Parte Blood: Dealing with Novelty and Anomaly' (1997) 60 (6) Mod LR 840-856, and from Mrs Blood herself: D Blood, 'Response to the Consultation Document of Professor McLean' (1998) 13 Hum Reprod 2654-56.

[32] *L v Human Fertilisation and Embryology Authority* [2008] EWHC 2149.

[33] Ibid, [77]. The gametes were exported abroad at [33].

[34] *Centre for Reproductive Medicine v U* [2002] EWCA Civ 565.

[35] Ibid, [24] (Hale LJ).

The most significant case in this area, which perfectly combined the principle of self-determination with the need for informed consent under the Human Fertilisation and Embryology Act 1990, was *Evans v United Kingdom.*[36] In an extraordinary trail of appeal judgments, Ms Evans was told that because her ex-fiancé Mr Johnston had revoked his consent to store their embryos, she could no longer use them despite since being rendered infertile by chemotherapy. She was also told that state legislation requiring the consent of both parties for lawful fertility treatment (the 1990 Act) was not in contravention of her right to a private life under Article 8 because the 'bright line of consent' served an important role in public policy. The European Court of Human Rights stated:

> The Court finds that strong policy considerations underlay the decision of [the 1990 Act] to favour a clear or 'bright-line' rule which would serve both to produce legal certainty and to maintain public confidence in the law in a highly sensitive field … the Court does not accept that the Article 8 rights of the male donor would necessarily be less worthy of protection than those of the female.[37]

The *Evans* case confirms that there is not a positive obligation upon the State to provide fertility treatment to a patient regardless of her personal circumstances.[38] Writers have argued that women have a 'presumption of control' over embryos as a result of their 'unique contribution to reproduction',[39] but the outcome of *Evans* suggests that control over embryos should not be assumed to slide towards one particular party (e.g. the female). If it did, it could render the principles of self-determination and informed consent meaningless for half of the population.[40]

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[36] *Evans v United Kingdom* (6339/05) (2008) 46 EHRR 34.

[37] *Evans v United Kingdom* (6339/05) (2006) 43 EHRR 21, [63], [65]-[66]. Ms Evans later appealed to the Grand Chamber (n 36) and was met with the same response. The recent decision in *Jennings v HFEA* [2022] EWHC 1619 contradicts *Evans* by concluding that Mr Jennings had a human right to use his deceased wife's embryo despite her lack of consent, [102] (Theis J).

[38] In the UK, the case of *R v Ethical Committee of St Mary's Hospital (Manchester) ex parte Harriott* [1988] 1 FLR 512 confirmed that there is no 'right' to access to fertility services. See also: J Montgomery, 'Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990' (1991) 54 Mod LR 524.

[39] TC Shevory, 'Through a Glass Darkly: Law, Politics and Embryos' in H Bequaert Holmes (ed.), *Issues in Reproductive Technology* (New York University Press, New York, 1992), 232.

[40] For commentaries on *Evans* see: S Collier, 'Assisted Reproduction – Statutory Overhaul Overdue' (2004) 154 (7140) New LJ 1201; J Miola, 'Mix-ups, Mistake and Moral Judgment: Recent Developments in UK Law on Assisted Conception' (2004) 12 (1) Fem LS 67, 76; S Sheldon, 'Gender Equality and Reproductive Decision-Making' (2004) 12 Fem LS 303, and 'Evans v Amicus Healthcare; Hadley v Midland Fertility Services – Revealing Cracks in the Twin Pillars?' (2004) 16 (4) Camb Fam LQ 437; A Alghrani, 'Deciding the Fate of Frozen Embryos' (2005) 13 (2) Med LR 244, and C Lind, 'Evans v United Kingdom – Judgments of Solomon: Power, Gender and Procreation' (2006) 18 Child & Fam LQ 576.

The recent case of *ARB v Hammersmith*[41] continued to support the statutory requirement for informed, written consent under the Human Fertilisation and Embryology Act 1990 (as amended in 2008) by criticising a fertility clinic for allowing a woman to forge the signature of her husband, resulting in a live birth from a frozen embryo:

> The need for the obtaining of written consent is more acute in an area of medicine where it is acknowledged that individuals will embark upon these procedures desperate for conception and the birth of a child … Consent is a cornerstone of the 1990 Act. A procedure which permits delegation for the obtaining of consent to a person who is not employed by the clinic is not only illogical, it makes a mockery of a process, the purpose of which is to obtain valid written consent.[42]

To conclude this section outlining the legal position, it appears to be settled law that in order to pursue fertility treatment under the 1990 Act, the informed, written consent of *both* gamete providers must be provided in support of their right to determine their own genetic destiny (in addition to the other public policy reasons, such as public confidence and clarity, listed by the appeal courts in *Evans*, *U* and *Hammersmith*, above). No other forms of consent, such as a presumed consent or a substituted judgment, appear to suffice, so as to avoid making 'a mockery of the consent process' (*Hammersmith*) or committing a statutory criminal offence (*Blood*), and this is regardless of complicating factors such as sympathy, infertility or gender (*Evans*). The jurisprudence emanating from the 1990 Act, therefore, supports its strict consent regime and has left no room for manoeuvre.

4. THE LEGALITY OF GAMETE RETREIVAL FROM PATIENTS WHO LACK CAPACITY

Fertility treatment happens in three legal stages and consent is required for each one: gametes are retrieved, stored, and then used. The 'use' of gametes includes the implantation of sperm into the uterus, the creation of an embryo, export abroad, long-term storage, or research. The

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[41] *ARB v Hammersmith* [2018] EWCA Civ 2803.

[42] Ibid, [45], [49], [53] and [59] (Nicola Davies LJ). Writers have welcomed the decision in *Hammersmith*. See: C Auckland and I Goold, 'Claiming in Contract for Wrongful Conception' (2020) 136 LQR 45-51.

retrieval of gametes is covered by the common law (to which we now turn), and everything else is governed by the rigorous consent regime of the Human Fertilisation and Embryology Act (as amended in 2008) – this will be explored briefly later in the context of incapacitous patients.

The procurement of gametes tends to be a competent act, either through sexual intercourse for natural conception, or in a fertility clinic. Patients will provide their common law consent to this act. If a man is rendered incapacitous and *then* his partner wishes to retrieve his sperm for procreative purposes (or the other way around), the legal and ethical landscape is convoluted. Sperm is retrieved from an incapacitous man via electro-ejaculation. This requires rectal penetration with an electrical probe to stimulate the prostate. A catheter is inserted into the bladder to drain it of urine (because it is acidic) and sperm is then released into the bladder when the electrical currents cause the body to ejaculate. The catheter then retrieves the sperm from the bladder. The body is thus penetrated twice. It is just as invasive for a woman to retrieve her eggs; she must self-inject hormones for two weeks to mature several eggs at once and then, when under sedation and with her legs in stirrups, a vaginal ultrasound is performed with a probe. A needle is pushed through the vaginal wall into the ovary follicles to gently suck out the fluid and up to 20 eggs. She is also penetrated twice. This brings us to the landmark case of *Y v A Healthcare NHS Trust.*[43] Knowles J was confronted with a desperate wife (Y) whose husband (Z) was suspected to be brain stem dead. The couple had enquired about fertility treatment to conceive a second child, but Z had not had the chance to sign the consent forms before his unexpected motorbike accident. Y requested permission from the Court of Protection to retrieve, store and use his sperm (the retrieval request being new to English law). Knowles J set out the best interests test under section 4(6) of the Mental Capacity Act 2005, even though this provision had never been used to authorise gamete retrieval for procreative purposes before, which states as follows:

> **Mental Capacity Act 2005**
>
> Section 4: Best interests
>
> > (6) [The person making the determination] must consider, so far as is reasonably ascertainable–

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[43] *Y v A Healthcare NHS Trust* [2018] EWCOP 18.

> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
> (c) the other factors that he would be likely to consider if he were able to do so.

Knowles J considered the testimony of Y, which described initial fertility tests and a joint clinic appointment to discuss their case, and determined that it was in Z's best interests under section 4(6) of the 2005 Act to father a second child:

> It seems to me that Z would have chosen to allow clinicians to retrieve his sperm so that it might be stored and then used after his death so that his little boy might be able to have a brother or sister … I am in no doubt that the decisions I have taken on Z's behalf were in his best interests even though his death was imminent.[44]

Z had not expressly or impliedly consented to the retrieval of his sperm via electro-ejaculation, but Knowles J was clearly of the opinion that despite his 'imminent death' it was in his best interests to undergo the rather invasive and, some would say, sexual procedure (discussed further below). This rationale of Knowles J's judgment has since been confirmed as the correct approach by Poole J in Re *X (Catastrophic Injury: Collection and Storage of Sperm)*.[45] It is submitted by this writer that there are legal and ethical difficulties with these decisions that could have far-reaching consequences for patients who lack capacity, their genetic material, and the use (or misuse) of assisted reproductive technology.[46]

(a) The lack of 'best interests' supporting retrieval.

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[44] Ibid, [24]. There has been an identical case in Australia but with the opposite outcome. In *MAW v Western Sydney Area Health Service* [2000] NSWSC 358, O'Keefe J refused to use the jurisdiction of *parens patriae* to grant the request of a wife to retrieve her incapacitated husband's sperm for procreative purposes (explored more below).

[45] *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48. Poole J refused to authorise the retrieval and storage of sperm in this case because, unlike *Y v A*, the incapacitated patient had not discussed the idea of posthumous conception during his lifetime and his girlfriend did not testify to such a conversation in court.

[46] This writer published the initial case note on *Y v A Healthcare NHS Trust* which examines the decision of Knowles J in more detail. See: L. Cherkassky, 'Y v A Healthcare Trust [2018] EWCOP 18 and the Mental Capacity Act 2005: Taking Gamete Retrieval to the Bank' (2019) 135 *Law Quarterly Review* 209-214.

First, it is submitted that an electro-ejaculation for procreative purposes on a man who is suspected to be brain-stem dead is not clinically indicated but emotionally desired, and not by the patient himself, but by a third party. The old common law on best interests, *Re F (Mental Patient: Sterilisation)*,[47] made it clear that for a medical treatment to be in the best interests of a patient who lacks capacity it must be 'to save their lives or to ensure improvement or prevent deterioration in their physical or mental condition'.[48] Modern cases (applying s.4(6) of the Mental Capacity Act 2005) have added that 'best interests' include physical, emotional, social and psychological interests too.[49] In addition, the treatment must not be 'futile'[50] and it is also important to consider the patient's wishes even if he has a limited understanding of the circumstances.[51] Therefore, it may well be in accordance with the 'wishes and feelings, beliefs and values' of a man lacking capacity to a limited degree to undergo an electro-ejaculation under the 2005 Act if he understood what it was for and had expressed a desire to have children. However, a patient who is suspected to be brain-stem dead would glean no physical, emotional, social or psychological benefit from such an invasive procedure upon his person. The benefit is solely for the third party who made the request (e.g., his wife) which is not enough; the 2005 Act expressly states under s.5(1)(b)(ii) that it must be 'in P's best interests for the act to be done'. In support of this, in the Australian case of *MAW v Western Sydney Area Health Service*,[52] O'Keefe J rejected a comatose gamete retrieval request from a wife because the patient (her husband) would not glean an interest from it in his incapacitated state:

> At the time of the application it was apparent that the patient was, and would remain, unaware of the fact that a surgical procedure to remove semen from him was being or had been undertaken. His condition was inconsistent with his ever knowing the possible purpose of use of any such semen. His wellbeing in the psychological or general sense could not therefore be said to be promoted by the proposed surgical procedure. The possibility of [complications] and the absence of any necessity to

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[47] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

[48] Ibid, 55.

[49] *Aintree University Hospitals Foundation Trust v James* [2013] UKSC 67 and *An NHS Trust v Y* [2018] UKSC 46.

[50] *Re A (Mental Patient: Sterilisation)* [2000] 1 FLR 549, and *Re F* [2015] EWCA Civ 882.

[51] *Wye Valley NHS Trust v B* [2015] EWCOP 60, and *B v D* [2017] EWCOP 15. Although in contrast, see: *W Healthcare NHS Trust v H* [2004] EWCA Civ 1324.

[52] *MAW v Western Sydney Area Health Service* [2000] NSWSC 358.

> undertake the proposed procedure militate against consent being given for it to be undertaken.[53]

The decision in *MAW* suggests that despite the desperate circumstances of a petitioning wife, the interests to be *properly* considered by the courts are those of the patient. The decision in *Y v A Healthcare NHS Trust* conflicts with this approach, and could therefore be viewed as condoning the harvesting of almost-dead bodies for reproductive materials 'upon request'.[54]

(b) The courts on best interests, incapacitous patients and sterilisation.

The 2005 Act has previously been applied to incapacitous patients for the purposes of *sterilisation*, not procreation.[55] This is because a patient who lacks capacity may not understand the nature of contraception, pregnancy, childbirth or rearing due to their mental disorder. A pregnancy may be incredibly stressful and disconcerting for an incapacitous patient, and the birth could be traumatising and violating if they are not aware of its purpose. In addition, the pain they are experiencing, and the interventions they are given (e.g., an epidural), could be interpreted as torture or abuse. A sterilisation can prevent this experience from happening to an incapacitous patient, and it also prevents a new-born baby from being taken from its biological mother and placed into the care system for rearing. It would therefore seem illogical to 'revert' the application of the best interests test and hold that *procreation*, rather than sterilisation, was in the best interests of such a patient. To use a recent example of how dangerous an incapacitous pregnancy could be, Mr Justice Cobb in *BC v DD*[56] ruled in favour of a sterilisation on a 36-year old woman ('DD') who suffered from Autistic Spectrum Disorder. DD faced uterine rupture; placenta accreta (haemorrhage); intra-cerebral embolism (epilepsy); premature birth; mental distress with delusional disorder, and a risk of death if she were to conceive a seventh time. She had a history of hiding her pregnancies from medical professionals, and of delivering her babies at home in dangerous

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[53] Ibid, [68].

[54] In line with *Y v A*, Poole J in *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48 noted that had the incapacitated patient discussed posthumous conception during his lifetime, his consent would have been presumed for the retrieval and storage of his sperm, therefore allowing his *parents* to make the order.

[55] See: *Re D (Wardship: Sterilisation)* [1976] 2 WLR 279; *Re B (Wardship: Sterilisation)* [1988] AC 199; *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1; *Re GF* [1992] 1 FLR 293; *Re W* [1993] 1 FLR 381; *Re HG* [1993] 1 FLR 587; *Re X* [1998] 2 FLR 1124; *Re A (Mental Patient: Sterilisation)* [2000] 1 FLR 549; *Re ZM and OS* [2000] 1 FLR 523; *Re S* [2001] Fam 15, and *BC v DD* [2015] EWCOP 4.

[56] *BC v DD* [2015] EWCOP 4.

and ‘grossly unhygienic circumstances’.[57] Mr Justice Cobb was satisfied that, due to DD stating that ‘there was no father to her baby…she took a tablet from a health food shop which affected her hormones and led to her pregnancy’ and that she was ‘unable to consider the overriding medical reason for contraception in terms of her own physical health’, that DD did ‘not have sufficient understanding, by reason of her condition, to make the relevant decision about contraception or sterilisation’.[58] It is submitted by this writer, therefore, that the best interests test under the 2005 Act is there to prevent physical and psychological harm to incapacitated patients, not to authorise the retrieval or use of their reproductive materials. No other jurisdiction has yet ruled that it would be in the best interests of an incapacitous patient to receive fertility treatment (except for the UK Court of Protection in *Y v A Healthcare NHS Trust* and *Re X (Catastrophic Injury: Collection and Storage of Sperm)*).

(c) The subjectivity of the petitioner.

The Mental Capacity Act 2005 takes into account the views of ‘anyone engaged with caring for the patient’ under s.4(7). However, it is submitted by this writer that as sole beneficiary of the court order, who stands to gain a direct benefit from the act of gamete retrieval, a partner is not a reliable witness to attest to the ‘wishes and feelings, beliefs and values’ of the incapacitous patient in the context of parenthood. There is every chance, for instance, that a wife (or girlfriend) could embellish or fabricate conversations shared at home before her husband (or boyfriend) was rendered incapacitous in order to obtain his sperm to create a pregnancy. It *is* known for relatives to be consulted by doctors in certain areas of medicine, for example in organ donation, but organ donation can be distinguished from a petition to retrieve gametes on the grounds of the recipient of the benefit. A partner petitioning for gametes is the sole beneficiary of the retrieval, hoping to establish her own pregnancy and give birth to her own baby.[59] This could serve as a reminder of her husband, and as a possible coping mechanism for her grief or loneliness. Organ donation, on the other hand, sees any benefit go to strangers. Organ donation also does not result in a new life, a child who may, one day, wish to connect to a deceased father. Parenthood is a decision to be made by the individual alone, usually as part of a living (not deceased) relationship, involving genetic

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[57] Ibid, at [9], [10], and [66].

[58] Ibid, at [67]-[69].

[59] Or in the recent case of *Re X (Catastrophic Injury: Collection and Storage of Sperm)*, the grandparents create their only grandchild.

destiny and lifelong financial/emotional responsibility. It should also not be assumed that, should one party in a relationship die without expressing wishes regarding posthumous fertility treatment, that they would have expected the surviving party to take on board the full responsibility of child-rearing. This could lead to financial hardship and emotional stress (including post-natal depression on top of grief). The deceased may not wish for his widow to endure this without him. It might be more appropriate to leave the significant decision of procreation solely to the adult with capacity himself, as opposed to his grieving relatives after he has become incapacitous.

(d) Gamete retrieval could constitute a trespass to the person and a criminal battery.

It is not appropriate to touch a patient without their consent, and a third party benefit is not enough to justify non-consensual touching. This results in a civil trespass to the person and a criminal battery if no ‘interest’ to the patient can be proven under the Mental Capacity Act 2005. A raft of consent cases has established this over several decades, and it is submitted that this is what occurs in a scenario where an electro-ejaculation is performed upon a patient who is suspected to be brain-stem dead, where he has not provided written consent to the procedure.[60]

(e) Gamete retrieval could be a sexual offence under the Sexual Offences Act 2003.

This is a novel argument which needs further exploration in subsequent work, but it is tentatively suggested here that to perform an electro-ejaculation upon a man who lacks capacity, without his consent, could amount to one of several sexual offences under the Sexual Offences Act 2003. These include section 2: assault by penetration; section 3: sexual assault; section 4: causing a person to engage in sexual activity without consent, and section 30: sexual activity with a person with a mental disorder impeding choice. The *actus reus* of these crimes require ‘penetration’, ‘touching’ or ‘activity’, and the *mens rea* is intention.

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[60] See: *Collins v Wilcock* [1984] 1 WLR 1172, 1177 (Lord Goff). In a medical context, see: *Pacific Railway Co. v Botsford* 141 US 250 (1891); *Schloendorff v Society of New York Hospital* 105 NE 92 (NY, 1914); *T v T and Another* [1988] 1 All ER 613; *Airedale NHS Trust v Bland* [1993] 2 WLR 316 (Lord Goff at 365); *Re T* [1993] Fam 95; *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290; *Re MB* [1997] EWCA Civ 3093; *St George’s Healthcare NHS Trust v S* [1998] 3 All ER 673; *R v Tabassum* [2000] Crim LR 686, and *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 F.C.R. 1. However, see: *Re Y (Mental Patient: Bone Marrow Donation)* [1997] Fam. 110 where it was ruled that it was in the best interests of an incapacitous woman to donate her bone marrow (an invasive procedure) to her competent sister, who she barely knew, in order to maintain care home visits from their mother (per Connell J).

These criteria could easily be met by inserting an electrical probe into the rectum of an incapacitous man to cause him to ejaculate for procreative purposes. The fact that the *actus reus* must be 'sexual in nature' for all four crimes does not necessarily impede prosecution, as s.78(a) of the 2003 Act defines an act as 'sexual' if a 'reasonable person would consider that, whatever its circumstances or any person's purpose in relation to it, it is because of its nature sexual'. This is a jury question, but s.78(a) makes clear that the jury need only consider the 'nature' of the act (e.g. the penetration of the rectum to cause an ejaculation), not its circumstances or purpose. It is therefore tentatively submitted by this writer that performing an electro-ejaculation on an incapacitous man could be viewed by a jury as an act that is 'sexual in nature' because it simulates natural sexual intercourse. In addition, if performed on a person with capacity without their consent, it would almost certainly be a criminal offence. In support of this novel argument, s.27(1)(b) of the Mental Capacity Act 2005 prohibits the application of the best interests test to 'sexual activity', of which an electro-ejaculation may be considered. This may prohibit the Court of Protection from authorising an electro-ejaculation upon a patient who lacks capacity solely for the benefit of another in future.[61]

(f) A fruitless retrieval if statutory consent to 'storage' and 'use' is absent.

The storage and use of gametes is governed by Schedule 3 of the Human Fertilisation and Embryology Act 1990 (as amended in 2008), and this requires the informed, written consent of the gamete provider:

> **Schedule 3: Consents to use or storage of gametes, embryos or human admixed embryos.**
>
> 1. Consent
>
>> (1) A consent under this Schedule must be in writing and, subject to sub-paragraph (2), must be signed by the person giving it.

No alternative method of consent was put forward by Parliament (such as presumed consent or a best interests test), or the application of a best interests test in respect of a person lacking capacity, and there is a raft of common law supporting the strict consent regime of the 1990

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[61] This writer has recently argued that performing electro-ejaculation upon a corpse for procreative purposes is a criminal offence under section 70 of the Sexual Offences Act 2003. See: L. Cherkassky, 'Is Interference with a Corpse for Procreative Purposes a Criminal Offence?' (2022) 85(3) *Modern Law Review* 577-597.

Act (detailed further above). Knowles J In *Y v A Healthcare NHS Trust* was aware that the consent provisions in the 1990 Act were ‘imperative’ and ‘carefully drawn for sound public policy reasons’ but were not satisfied in Y’s case.[62] She then turned to the Mental Capacity Act 2005 as an alternative route to consent. However, the Mental Capacity Act 2005 excludes itself from fertility treatment decisions under section 27:

> **Mental Capacity Act 2005**
>
> Section 27: Family relationships etc.
>
> > (1) Nothing in this Act permits a decision on any of the following matters to be made on behalf of a person:
> >
> > > (h) giving a consent under the Human Fertilisation and Embryology Act 1990/2008.

Since a patient who lacks capacity cannot issue their informed consent to the storage and use of their gametes under Schedule 3 of the 1990 Act, and since the court cannot issue an order appointing a deputy to consent to it on their behalf under s.27 of the 2005 Act, the storage and use of gametes is simply unavailable to incapacitous patients. Given that storage and use in this context is not a legal possibility, this renders the retrieval fruitless. Knowles J seemingly overlooked this provision in *Y v A Healthcare NHS Trust* because she authorised the retrieval, storage and use of Z’s sperm in accordance with his best interests.[63] In addition, Knowles J also concluded (mistakenly) that: ‘a relative would have to execute the consents *in Z’s presence* before he died, in the presence of a witness, in order to comply with the strict requirements of Schedule 3 of the 1990 Act’.[64] This minor misinterpretation of Schedule 3 of the 1990 Act (whereby the need for Z *himself* to direct a proxy to sign on his behalf was overlooked by Knowles J) not only removed the need for informed consent from the gamete provider under Schedule 3, but it ‘reframed’ the whole of the 1990 Act to cover incapacitous patients. This error of law subsequently manifested in *Re X (Catastrophic Injury: Collection and Storage of Sperm),* whereby Poole J stated that ‘the Court of Protection does have the power to declare the retrieval of gametes from an incapacitous person, and their storage, to be

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[62] *Y v A Healthcare NHS Trust* [2018] EWCOP 18, [16], [20].

[63] Ibid, [24]. Poole J in *Re X (Catastrophic Injury: Collection and Storage of Sperm)* made the same legal error.

[64] [2018] EWCOP 18, [19], [26]. Emphasis added.

lawful notwithstanding the absence of written consent', and he referred to *Y v A Healthcare NHS Trust* in support of this.[65]

(g) A troubling precedent.

The decision in *Y v A Healthcare NHS Trust* causes concern because of the way it circumvents the current statute law. Knowles J's judicial interpretation has meant that the Mental Capacity Act 2005 has seemingly 'crossed over' into the 1990 Act by inserting a best interests test into its rigorous consent scheme under Schedule 3. The consequences are that Z endured a highly invasive procedure upon his person without gleaning any benefit from it, and he may now father another child without ever knowing about it or consenting to it. Y and Z already had a son; how would the second posthumously conceived child react on learning about the circumstances of their conception? And that they will never meet their father as their older sibling did? It was not clear if Z would have consented to this arrangement, or whether he would have been happy to undergo an electro-ejaculation before his death. In addition, in what state does this leave the rigorous consent regime under Schedule 3, dubbed by the appeal courts as the 'backbone' of the 1990 Act? Has the door opened to procreating with patients who lack capacity in certain circumstances? Knowles J removed the decision to have (or not to have) a child from the self-governing individual and handed it to the party who will directly benefit from the outcome of the court order/best interests test (in this case, the spouse). The concern is that *Y v A Healthcare NHS Trust* has carved out a common law exception to informed consent under the 1990 Act owing to its desperate circumstances, an exception that can easily be applied to future cases, such as *Re X (Catastrophic Injury: Collection and Storage of Sperm)*. This is not a unique idea: a common law exception usurping a statutory provision was seen in the case of *R v Bourne*,[66] which constructed the necessity ('mental and physical wreck') defence to abortion in contravention of section 58 of the Offences Against the Person Act 1861 before the Abortion Act 1967 enshrined exceptions to the criminal offence into law. The case of *Bourne* suggests, despite its different context, that a judicial precedent can modify an established statutory benchmark in a controversial area of law where strict boundaries provide certainty. We now turn to this possibility for

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[65] [2022] EWCOP 48, [29].

[66] *R v Bourne* [1939] 1 KB 687.

assisted reproductive technology following the decision in *Y v A Healthcare NHS Trust*, and explore the ethical consequences of authorising fertility treatment upon incapacitous patients.

5. THE ETHICAL COMPLEXITIES OF USING INCAPACITOUS PATIENTS FOR PROCREATIVE PURPOSES

(a) Can presumed consent take the place of informed consent?

The question as to whether fertility treatment should be offered with an alternative form of consent, such as presumed consent, has been lightly canvassed by writers. This would modify the 1990 Act to require only one party (e.g. the competent partner) to consent to fertility treatment and for the Court of Protection to *presume* the consent of the other party (e.g. her incapacitous partner). Knowles J may have presumed the consent of Z with the words ‘it seems to me that Z *would have chosen to allow* clinicians to retrieve his sperm so that it might be used after his death’.[67] It has been suggested by Tremellen and Savulescu that presumed consent is acceptable for fertility treatment in tragic circumstances because of the benefit to the remaining spouse:

> A child may help give a widow new meaning to life, while being a source of companionship and support in later life. The positives of becoming a mother through posthumous conception are far more likely to outweigh the negatives … By not allowing [his wife] access to his sperm after [his] death, a husband may be harming his wife and even negatively infringing on [his] wife’s reproductive rights which can be construed as morally unjust … unless stated otherwise, a man is agreeing to help his wife have children in the future by entering willingly into marriage.[68]

This argument could be applied to patients who lack capacity, as their remaining partners can create a family and ‘live their lives’ in the mean time, but it is not overly convincing. The

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[67] *Y v A Healthcare NHS Trust* [2018] EWCOP 18, [24]. Emphasis added. This is remarkably similar to the recent decision in the posthumous case of *Jennings*, where Theis J stated: ‘the court can infer from all the available evidence that Ms Choya would have consented to Mr Jennings being able to use their partner-created embryo in the event of her death’ (n 36), [92].

[68] K Tremellen and J Savulescu, ‘A Discussion Supporting Presumed Consent for Posthumous Sperm Procurement and Conception’ (2015) 30 Reprod Bio Online 6-13, 9. See also: F Kroon, ‘Presuming Consent In The Ethics of Posthumous Sperm Procurement and Conception’ (2016) 1 Reprod Bio & Soc Online 123-130.

suggestion by Tremellen and Savulescu that there should be a balancing act between a competent woman and her deceased husband (or hypothetically, her incapacitous husband), and that she could be 'harmed' by not having access to his sperm, is both illogical and insulting. It is illogical because the deceased do not have 'needs' to be balanced against the living, and it is insulting to suggest that a woman would be 'harmed' without a man's sperm. It is also unreasonable to suggest, following *R v R*,[69] that marriage provides life-long consent to procreation. Marriage and procreation are two completely separate life events, they just happen to overlap. We do indeed use a presumed consent model for organ donation in England under the Human Tissue Act 2004 as a result of the Organ Donation (Deemed Consent) Act 2019, whereby the newly deceased is presumed to have consented to organ donation unless they registered their refusal during their lifetime on the NHSBT Blood and Transplant website (or in writing elsewhere), or unless they were incapacitated for a 'significant period' before their death under section 3(9)(b) of the 2004 Act, and it has been suggested that we should do the same for sperm (i.e., take it when we need it).[70] Therefore, is it fair to ask, 'if we can plunder dead bodies for their organs based on presumed consent, can we plunder patients who lack capacity for their gametes based on presumed consent too?' A sensible answer may be to distinguish the materials from one another. Sperm is not altruistically donated to sustain life in an emergency but rather, it is requested for selfish reasons, per Orr and Siegler:

> Requesting sperm retrieval without the consent of the dead man is not the same [as organ donation]; in fact it is not giving at all - it is instead taking, because its aim is to benefit the person making the request ... thus, proxy consent in this situation is not consent at all.[71]

There are no other instances in which we may use a presumed consent to lawfully plunder the bodies of the dead or the incapacitous for our own gains (confirmed in the context of the dead by the case of *CM v The Executor of the Estate of EJ*),[72] probably because it would be viewed

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[69] *R v R* [1991] 3 WLR 767.
[70] This is a very unique argument: N Hodson and J Parker, 'The Ethical Case for Non-Directed Post Mortem Sperm Donation' (2020) 1 JME 1-4.
[71] RD Orr and M Siegler, 'Is Posthumous Semen Retrieval Ethically Permissible?' (2002) 28 JME 299-303, 301. It should also be noted that the Human Tissue Act 2004 specifically excludes gametes from its ambit at section 53(1), because of their special nature.
[72] *CM v The Executor of the Estate of EJ* [2013] EWHC 1680.

by society as disrespectful.[73] Even in an autopsy under the Coroners and Justice Act 2009, the pathologist replaces the organs back into the body before burial (in addition to having a lawful purpose for their investigation: to reveal the cause of death). It is accepted that a patient who lacks capacity cannot be physically 'harmed' by the passing around of his gametes, but to treat such unique resources with such inconsequentiality (the body and the gamete) would reduce the value of both.[74] It would also undermine the importance of informed consent in general, since it would no longer act as a gatekeeper to the creation of life under the 1990 Act. Where could presumed consent lead in this context? Reversing the roles of Y and Z, could a husband be allowed to have intercourse with his comatose wife on the premise that they were lined up for fertility treatment and therefore she 'would have consented' to it? There would no doubt be moral outcry, but is rectal penetration with a probe any different to penile penetration by a spouse in this procreational context under sections 1, 2, 3, 4 and 30 of the Sexual Offences Act? Would it be appropriate for consent to be presumed for the former (rectal penetration with a probe), but not the latter (vaginal penetration with a penis), despite the objective being the same?[75]

(b) The unique nature of gametes.

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[73] There is possibly one instance - blood or bone marrow donation from a saviour sibling child. This writer has already suggested in several publications that this is not in the best interests of the saviour child and is exploitative, and that the emotional benefit is purely speculative: L. Cherkassky, 'Human Tissue Authority New Draft Code: Supporting Child Donors or Supporting Parents?' (2017) 5(2) *Legal Issues Journal* 1-21; 'The Interfamilial Principle and the Harvest Festival' (2016) 23 *European Journal of Health Law* 30-48; 'The Human Tissue Authority and Saviour Siblings' (2015) 3 *Journal of Bone Marrow Research* 158-167; 'Children and the Doctrine of Substituted Judgment' (2015) 1 *Medical Law International* 1-23, and 'The Wrong Harvest: The Law on Saviour Siblings' (2015) 1 *The International Journal of Law, Policy and Family* 1-20.

[74] Feinberg has famously argued that the dead can be harmed: J. Feinberg, 'Harm and Self-Interest' in *Law, Morality and Society: Essays in Honor of HLA Hart*, ed P.M.S. Hacker and J. Raz (Oxford: Clarendon Press, Oxford University Press, 1977), 284-308. Also see: G. Pitcher, 'The Misfortunes of the Dead' (1984) 21 Am Phil Quart 183-88; P. Griseri, 'Can a Dead Man be Harmed?' (1987) 10 Phil Invest 317-29; J. Fischer, 'Harming and Benefitting the Dead' (2001) 25(7) Death Stud 557; K.R. Smolensky, 'Rights of the Dead' (2009) 37 Hofstra L Rev 763; F. Tomasini, 'Is Post-Mortem Harm Possible? Understanding Death, Harm and Grief' (2009) 23(8) Bioethics 441; C. Moon, 'Human Rights, Human Remains: Forensic Humanitarianism and the Human Rights of the Dead' (2014) 65 Inter Soc Sci J 49-63, and M. Nair-Collins, 'Can the Brain-Dead be Harmed or Wronged? On the Moral Status of Brain Death and its Implications for Organ Transplantation' (2017) 27(4) Kenn Inst Eth J 525-559.

[75] Egg retrieval is not possible without weeks of drug injections first, although this may be a hypothetical option if time allowed. Incapacitous intercourse is not as shocking as it sounds: in *Tower Hamlets LBC v NB* [2019] EWCOP 27, a judge held that a man could have sexual relations with his wife who had a 'global learning difficulty' and 'limited senses' because her capacity had not been 'rebutted' under the 2005 Act. This is not a fertility case, but it is authority to support the theory that the best interests test can be used to measure whether a person with learning difficulties can consent to sexual intercourse with their spouse or not. This is despite sexual activity being expressly excluded from the 2005 Act under s.27(1)(b).

A significant consideration in favour of informed consent for fertility treatment is the unique nature of gametes. They carry genetic information that generates new life with a raft of emotional and financial responsibilities. In return, the borne child requires active and harmonious relations with both biological parents to understand their heritage and their 'selves'. The welfare of a whole human being emanates from the use (or misuse) of gametes, and the identity problems experienced by many adopted, fostered, orphaned and donor-conceived children have been canvassed for many years in the field of psychology.[76]

It seems fair to say that gametes come with significant emotional, social and psychological 'extras' that other biological material (such as an organ) does not.[77] A basic level of knowledge about the destiny of our own gametes, as Jansen bluntly puts it, would suffice to ensure that we maintain control over our reproductive choices:

> Each ejaculate or each ovulation hardly constitutes a major drain on an individual's resources. One simply does not care if ejaculates or ova are lost - provided that they are actually lost and that their information content, their genetic potential, is not going to be realised in a way one's not happy with.[78]

The Court of Appeal in *Evans* also agreed that it was a matter of public policy that the originator of the material should have complete control over it:

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[76] The welfare of *posthumously* conceived children will be canvassed at another time, but for now, see: K Ludlow, 'What About Me - How Far Do We Go in the Best Interests of the Child in Assisted Reproductive Technology' (2006) 6 Queens Uni Tech L & Just J 214. For the psychological perspective on the impact on a child of a deceased father, see: TL Trunnell, 'The Absent Fathers' Children's Emotional Disturbances' (1968) 19 Arch of General Psych 180-188; MO Huttunen & P Niskanen, 'Prenatal Loss of Father and Psychiatric Disorders' (1978) 35 Arch of General Psych 429-431; M Shinn, 'Father Absence and Children's Cognitive Development' (1978) 85(2) Psych Bulletin 295-324; R Levy-Shiff, 'The Effects of Father Absence on Young Children in Mother-Headed Families' (1982) 53(5) Child Dev 1400-1405; DW Krueger, 'Childhood Parent Loss: Developmental Impact and Adult Psychopathology' (1983) 37 Amer J Psycho 582-592; M Burgner, 'The Oedipal Experience: Effects on Development of an Absent Father' (1985) 66 Intern J Psycho 311-320; J Trowell & A Etchegoyen (eds.), *The Importance of Fathers: A Psychoanalytic Re-Evaluation* (London, England: Brunner/Routledge 2002); JA Cohen, *Treating Trauma and Traumatic Grief in Children and Adolescents* (The Guilford Press, New York, 2006); KA Jones, 'Assessing the Impact of Father-Absence from a Psychoanalytic Perspective' (2007) 14:1 Psycho Soc Work 43-58; D Atle, *Grief in Children* (2nd edn, London, Jessica Kingsley 2008), and PA Boelen, 'Prolonged Grief and Post-Traumatic Stress in Bereaved Children' (2017) 258 Psych Res 518-524.

[77] For an agonising testimony of a donor-conceived woman on the psychological distress she carried into adulthood of not knowing who her donor father was, see *R (on the application of Rose) v Secretary of State for Health* [2002] EWHC 1593, which resulted in the HFE Authority (Disclosure of Donor Information) Regulations 2004.

[78] R Jansen, 'Sperm and Ova as Property' (1985) 11 JME 123, 125. For the 'unique' nature of gametes, see: B Bennett, 'Posthumous Reproduction and the Meanings of Autonomy' (1999) 23 Melb Uni LR 286.

> The right of withdrawal [from fertility treatment] is granted in recognition of the dignity to which each individual is entitled. Such must include an individual's right to control the use of their own genetic material. In my judgement, it would be contrary to public policy for courts to enforce agreements to allow use of genetic material.[79]

The potential 'passing around' of genetic material without the consent of the originator therefore presents one of the biggest ethical difficulties in using patients who lack capacity for their gametes. The idea that these individuals should be used as a reproductive resource turns a blind eye to the special nature of genetic material, which we vehemently protect now more than ever before due to the importance of confidentiality, self-determination, modern technology, personal data, and human rights. It seems very unlikely, as a result of the complex and personal nature of gametes, that anything short of informed consent to their use would suffice.

(c) Relational autonomy.

An alternative form of consent could be based on the concept of relational autonomy, namely, that consent is 'entwined' between parties because of the social and emotional bonds that we form (particularly in the context of fertility treatment).[80] In practice, it means that the consent of one party, if a decision to procreate is made jointly, is a consent representing *both* parties and therefore presumed consent is not required. Parker applies this theory to the context of posthumous conception:

> Any 'we-desire' would survive the death of one partner, in the mind of the other, and the collective desire of the decedent is thereby carried into the future, since it is the

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[79] *Evans v Amicus Healthcare Ltd and Others* [2005] Fam 1, [120] (Arden LJ).

[80] There is no room to canvas the theory of relational autonomy in any detail on this occasion, but for the leading definitions of relational autonomy, see: J Nedelsky, *Law's Relations: A Relational Theory of the Self, Autonomy and Law* (Oxford, Oxford University Press, 2011); S Sherwin 'A Relational Approach to Autonomy in Health Care' in S Sherwin (ed.), *The Politics of Women's Health: Exploring Agency and Autonomy* (Temple University Press, Philadelphia, 1998), 19-47; A Donchin, 'Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethical Principles' (2001) 26 J of Med & Phil 367; C Ells, 'Lessons About Autonomy from the Experience of Disability' (2001) 27(4) Soc Theory & Practice 599-615; C Mackenzie and N Stoljar (eds.), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press, Oxford, 2002), and C Ells, MR Hunt and J Chambers-Evans, 'Relational Autonomy as an Essential Component of Patient-Centred Care' (2011) 4(2) Int J of Fem Approaches to Bioethics 79-101.

> same desire as that of the survivor. Collective intentionality supports posthumous conception, since as well as supporting the decedent's interest in parenthood expressed when he was alive, it shows that there remains a live desire which can be satisfied even though he is now dead.[81]

Relational autonomy is thought (by this writer) to be the underpinning rationale for Knowles J's decision in *Y v A Healthcare NHS Trust*. Knowles J was driven by understandable sympathy for Z's wife (Y), evidenced by the following quote:

> It was extremely important to [Y] that Z's death would not have been in vain and she was extremely worried that any flaw in the paperwork they had completed for their fertility treatment might mean that she was unable to conceive a further child with her husband's sperm. She told me in her statement that this would leave an irreplaceable hole in her life, the life of her son and the lives of their family.[82]

The phrases 'extremely important', 'extremely worried' and 'leave an irreplaceable hole in her life' appear to be highly emotive, phrased in this way (possibly) to serve as justification for making a decision in contravention of Schedule 3 of the 1990 Act. It is possible that, rather than presume Z's consent, Knowles J simply decided that since Y and Z were already married with a son and had discussed fertility treatment, that Y's consent was good enough for them both. Smajdor warns that the desire for offspring is 'so extraordinarily powerful' that such desires could 'make us bend the law to accommodate them in circumstances where an incapacitated person's body becomes the means by which another individual can achieve their desire'.[83] The problem with relational autonomy, therefore, is that it does not provide *actual* consent as much as it is the *imposition* of one person's agenda over another who cannot, for whatever reason, confirm or deny their own view. This may have happened in *Y v A Healthcare NHS Trust*. Informed consent from *both* gamete providers is preferred to authorise the use of assisted reproductive technology. This is not just for legal reasons (i.e., compliance and consistency), but, it is submitted, for ethical reasons too.

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[81] M Parker, 'Response to Orr and Siegler - Collective Intentionality and Procreative Desires: The Permissible View on Consent to Posthumous Conception' (2004) 30 JME 389-392, 391.

[82] *Y v A Healthcare NHS Trust* [2018] EWCOP 18, [10].

[83] A Smajdor, 'Perimortem Gamete Retrieval: Should We Worry About Consent?' (2015) 41 JME 437-442, 440. See also: AR Schiff, 'Posthumous Conception and The Need for Consent' (1999) 170 Med J of Aust 53-4, and S Simana, 'Creating Life After Death: Should Posthumous Reproduction Be Legally Permissible Without the Deceased's Prior Consent?' (2018) J of L & Bio 329-354.

(d) Respect for persons.

A popular ethical argument against using deceased patients for their organs (also applicable to incapacitous patients and their gametes) is to not treat them as a means to an end (a concern hinted at above in relational autonomy). Strong explains the connection between consent to procreation and respect for persons:

> Decisions about procreation have a bearing on concerns that are deep, personal, private, and that go to the core of self-identity. Because of this, respect for persons requires that we allow individuals to make their own procreative decisions. To make these decisions for others without their consent, whether explicit or reasonably inferred, is to treat them as mere means and not as ends in themselves … [this] is based on the deontological concern to treat others with respect and dignity.[84]

This is not a legal conundrum as much as it is an ethical one, and some may say that therefore, it does not provide a strong enough legal argument against the retrieval of gametes from incapacitated patients if their remaining partners wish to use assisted reproductive technology to expand their family. However, to give weight to this ethical concern would prevent one individual from exploiting another individual in an intimate and invasive way for their own ends. It would instead support a shared public ideal to treat every patient who lacks capacity with respect and dignity, and not to trespass upon that patient unless there was a medical need to do so.

In sum total, it appears that from an ethical standpoint, it would be very difficult to support the use of patients who lack capacity in assisted reproductive technology if they did not consent to it in advance for reasons of dignity, confidentiality, genetic destiny, public policy, and the individual’s right to choose parenthood.

6. CONCLUSION

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[84] C Strong, ‘Ethical and Legal Aspects of Sperm Retrieval After Death or Persistent Vegetative State’ (1999) 27 J of L, Med & Ethics 347-58, 353. See also: S Hostiuc and CG Curca, ‘Informed Consent in Posthumous Sperm Procurement’ (2010) 282 Arch of Gyn & Obst 433-438.

The provisions of the Human Fertilisation and Embryology Act 1990 (as amended in 2008) are underpinned by public policy (confirmed by *Blood*, *L*, *U* and *Hammersmith*). Parliament clearly favoured a high level of objectivity when opting for a written, informed consent regime as it gives each party the power to veto. It also provides a reliable licencing system for clinics, and the 'bright line' of consent has been found to be a proportionate interference with human rights by the ECtHR to allow for the self-governance of the individual. The Court of Appeal in *Evans*[85] stipulated that a judge 'should be extremely slow to recognise or to create a principle of waiver that would conflict with the [detailed and comprehensive] Parliamentary scheme'.[86] It can be fairly concluded, therefore, that the 1990 Act does not support the idea of an alternative form of consent, or carve out an exception to informed consent, and it was never intended to do so. It can also be concluded that the decision in *Y v A Healthcare NHS Trust* is not supported by the 1990 Act; the best interests test under the Mental Capacity Act 2005 should not have been used to authorise the storage and use of gametes under Schedule 3 of the 1990 Act, nor should it have been used to authorise the invasive common law retrieval of gametes from an incapacitous patient without any proven interest to him. This could involve a criminal offence (explored above) instigated by a highly subjective witness to use the incapacitous patient as a means to an end. The decision in *Y v A Healthcare NHS Trust* has therefore left the strict consent regime of the 1990 Act in a delicate position: should another 'extremely worried' woman come forward in the future and ask to retrieve, store and use the sperm of her incapacitous boyfriend, fiancé or husband, what might the judicial response be? Which statute would be applied, and whose interests would be met? Can doctors now perform an electro-ejaculation upon a man who lacks capacity, a highly invasive and (some would say) sexual procedure, on the request of a third party to satisfy her own procreative desires?[87] A couple may be bound together today, but they may not be bound together tomorrow. A competent adult has a private and independent mind that they do not have to share. It is not for our families or the judiciary to *presume* that we would procreate with our partners in *every* circumstance. What if, on the assumption that the doctrine from *Y v A Healthcare NHS Trust* is subsequently applied in the near future, a man one day wakes up

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[85] *Evans v Amicus Healthcare Ltd and Others* [2005] Fam 1.

[86] Ibid, [37] and [91] (Thorpe and Sedley LJJ).

[87] In a gender role reversal, if a woman who lacks capacity was harvested for her eggs so that her boyfriend, fiancé or husband could conceive her child, there would probably be significant criticism from a feminist, social, ethical and legal standpoint. There is the example of a pregnant woman being maintained on a life support machine until she gave birth, which was widely criticised: JE Frader, 'Have We Lost our Senses? Problems With Maintaining Brain-Dead Bodies Carrying Fetuses' (1993) 4 J of Clin Ethics 347-8. See also: DM Greer, AK Styer, TL Toth, et al., 'Case 21-2010: A Request for Retrieval of Oocytes From A 36-Year-Old Woman With Anoxic Brain Injury' (2010) 363(3) New Eng J of Med 276-83.

from his comatose state to find that he has several children with a partner whom he was planning to leave? Or no longer loved? What if an unscrupulous girlfriend wanted a share of her newly incapacitated wealthy boyfriend's inheritance and sought permission to conceive his child using old love letters as evidence of consent?[88] It is not outside the realms of possibility that some people may try to take advantage of the decision in *Y v A Healthcare NHS Trust* to conceive their 'perfect family' without the knowledge of the incapacitated partner.[89] The 1990 Act (and most other fertility laws around the world) require written consent from *both* gamete providers to guard against this very threat: it is proof of choice. It is proof of a lifelong goal, a vision and a nurtured plan, to become a genetic parent *with a particular person*. The question remaining is, what happens now?

The chances of a similar case coming before the Court of Protection in the near future are high. We await the decision for Louise Anderson, a grieving mother wishing to create her first grandchild using her trans-daughter's sperm.[90] We have just received the decision for Ted Jennings, who has won the right to use his deceased's wife's frozen embryo on the basis of an 'inferred' consent (the first case of its kind).[91] This has been followed by the decision in *Re X (Catastrophic Injury: Collection and Storage of Sperm),* in which a request for sperm retrieval and storage was refused by Poole J simply because the patient who lacked capacity had not discussed posthumous conception with his girlfriend before he had a stroke (suggesting that should those conversations have taken place, his consent to parenthood could be presumed).[92] These cases ask for, or implicitly suggest, the same usurping of Schedule 3 of the 1990 Act as seen in *Y v A Healthcare NHS Trust*, namely, for the court to authorise the use of gametes without the consent of the originator under Schedule 3, leading to a potential posthumous pregnancy and birth. The next 'incapacitous retrieval' case will be just around the corner. The more the technology is able to offer, the more unique court orders are going to arise. In the hope that the decision in *Y v A Healthcare Trust* has not led to a total

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[88] In *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48, a man suspected to be brain stem dead nearly had his testicle removed for his sperm, had his girlfriend testified that he discussed posthumous conception during his lifetime (he did not).

[89] This happened in the Australian case of *Re Cresswell* [2018] QSC 142 (see above, n 10-11). Note the following alarming headline from recent times: 'My Wife Wanted Another IVF Baby, So She Faked My Consent' *The Times,* 11th May 2022.

[90] David McCann, 'Transgender Girl's Sperm to be Stored Pending Case' *The Times*, 11th September 2020.

[91] Hannah Devlin, 'UK Man Brings High Court Case to Have Dead Wife's baby with Surrogate' *The Guardian*, Thursday 5th May 2022.

[92] Catherine Baksi, 'Dying Son's Sperm Cannot Be Frozen to Create Grandchild, Judge Rules' *The Times,* Monday 21st November 2022.

disarticulation of the 1990 Act, the next case is greatly anticipated and it is hoped that the decision will adhere to the clear rule of law on informed consent to the storage and use of gametes to prevent any further legal and ethical uncertainty.