Guest editorial

Hard cases make bad law?

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Not all that long ago, the law played only a minor role in the dramas enacted when medicine and morals collided. Today all is changed; law takes a starring role. Judges find themselves "on call", required, like doctors, to make decisions on birth and death, sometimes at unsocial hours. The disputes which reach the courts tend of necessity to be of the most heartrending kind. Less difficult dilemmas will have been settled by reaching some sort of consensus between the various other actors. The judiciary only gets "hard" cases. Just as judges find themselves thrust into the centre of debate on medical ethics so too do legislators. Parliaments increasingly regulate medical progress and whenever the public is dismayed by some tale of personal tragedy amidst ethical controversy, there are calls to change the law. In no field of medicine perhaps is the oft-stated desire for more law, for better law, more prominent than in the field of human reproduction.

Enthusiasts for more law must, however, take heed of the cautionary tales emerging from issues of reproductive choice. To legislate in haste is to repent at leisure and hard cases can indeed make bad law. Three such cautionary tales are recounted here: the fight by Diane Blood to have her dead husband's child; the series of attempts to use the courts to require women to submit to obstetric interventions to preserve their own and their child's welfare, and, the extraordinary story of a surrogate who changed her mind. Each of these diverse and tragic tales illustrates the dangers of allowing emotionally charged and complex individual cases to drive the formulation of legal principle and govern the pattern of legal regulation.

Let's help Diane?

Diane Blood's tale is truly tragic. She was a happily married woman planning to start a family when her husband was struck down by meningitis. As he lay dying, doctors agreed to Mrs Blood's request to take two sperm samples from him which were then stored at the Infertility Research Trust. Mr Blood died and his widow later sought to be artificially inseminated with his sperm. She, supported by both her own and her husband's family, maintained that the couple had discussed what to do if, before they had

children, he should be struck down by illness. They had agreed that his sperm should be collected if possible so that Diane could have their child even after its father's premature death. But when Diane sought to implement that marital agreement she fell foul of the apparently harsh provisions of the British Human Fertilisation and Embryology Act. There was no written consent from Mr Blood authorising storage or use of his sperm. Without such formal consent, the Human Fertilisation and Embryology Authority initially ruled that (a) it was illegal to store the sperm; (b) it would be unlawful for Diane Blood to be treated with that sperm in any licensed infertility clinic in the United Kingdom; and (c) Mrs Blood would not be permitted to export her husband's sperm to a country where she could lawfully be treated without proof of written consent from the sperm donor, her dead husband.

Mrs Blood went to court to challenge the authority. The trial judge ruled against her. Written consent, Sir Stephen Brown determined, was an absolute pre-condition for the storage and use of gametes in the United Kingdom, and, preventing the export of the sperm was a proper exercise of the authority's powers because the law should not be evaded by allowing those able to, to shop abroad for a more favourable system of legal regulation. Mrs Blood appealed and won her case.

The Court of Appeal¹ agreed that taking and storing Mr Blood's sperm without his written consent was unlawful. They confirmed that treating Mrs Blood would be unlawful in Britain. None the less, the judges invoked European Union law to allow Mrs Blood to take her husband's sperm to another EU country where doctors could lawfully treat her. She had, their lordships said, a right to receive medical services in any other EU state. United Kingdom law could only interfere with that right if (*inter alia*) some imperative requirement of public interest could be established to justify such interference. Given that the appeal court had ruled that taking sperm from an unconscious man without prior written consent was unlawful, the circumstances of the Blood case would not arise again. No precedent would be set, encouraging couples or doctors to flout British law. Mrs Blood's case was

tragically unique. The Human Fertilisation and Embryology Authority had failed to give proper weight to Mrs Blood's rights in European law and must reconsider her claim to take her husband's sperm abroad. Only if fresh and compelling reasons to deny her permission to do so were advanced could the authority sustain its bar on the export of Stephen Blood's sperm. The authority duly succumbed and ruled that Mrs Blood could have access to, and remove, the sperm abroad.

The appeal court judges' sympathy for Diane Blood was patent. The presiding judge, Lord Woolf, opined that there was compelling evidence Stephen Blood would have given the requisite written consent were he able to do so. He questioned the need for such consent in cases such as this suggesting that the "... need for formal requirements is not obvious in this situation".¹ Their lordships clearly thought that they had managed to do justice in a hard case. Lord Woolf's doubts about the stringencies of the law on consent were echoed by the distinguished fertility specialist, Lord Winston, who plans to seek to amend the Human Fertilisation and Embryology Act to allow, in special cases, for dispensation from the rule demanding written consent. Lord Winston would amend the law by inserting the word "normally" so that generally written consent is required for use of gametes, but, in cases where other evidence establishes consent the harsh letter of the law need not be enforced.

Lord Woolf sought to do justice to Diane Blood. Lord Winston wants to ensure that other deserving cases can be treated similarly. Both sets of "solutions" do damage to the operation of a just law for all. Massive inequity already prevails in relation to access to infertility treatment. In many parts of Britain only those with sufficient money to pay privately for treatment can obtain such treatment. Now we have three potential categories of patients, those who must rely on the slim chance of National Health Service (NHS) treatment, those who can pay for such private treatment as British law allows, and those who can pay enough to shop abroad for a Euro-state which allows them access to kinds of treatment British law prohibits. Perhaps this particular prohibition should never have been imposed? Consider, however, the practical impact of amending the law as Lord Winston proposes. Each case is decided on its merits, looking for substantive evidence of consent rather than formal rules. Imagine the next grieving woman seeking to use her dead partner's sperm. Perhaps in this case the couple are not married. His mother denies that he ever wanted a child at all. Her former partner decries her mothering skills. Will a less "virtuous" future Mrs Blood get such a good deal and who will decide her fate? Only one answer seems possible, the doctors. Doctors will sift out the deserving mother and look back into the mind of the dead father. Presumably too if the law becomes that only normally must there

be a written consent for use of sperm, that applies equally to all gametes. Will the grieving widower too, by special permission, be able to take eggs from his dying wife to create their child to grow in a suitable surrogate? His claim to our compassion seems no weaker than Diane Blood's. I doubt his case would generate the same sympathy.

Incompetent mothers?

In 1992 the President of the Family Division ruled in *Re S (Adult: Medical Treatment)*² that a woman's refusal to consent to caesarean section could be overridden if the life of the fetus was at risk. A storm of protest followed and the Royal College of Obstetricians and Gynaecologists issued guidelines declaring it to be unhelpful and inappropriate to seek judicial authority to overrule a woman's competent and informed refusal of caesarean surgery or other intervention in childbirth. For four years, it seemed the law withdrew from the labour ward. Then in 1996-97 a series of cases came before the courts once again asking judges to rule that women in, or about to be in labour, could be treated against their will. Several orders were granted authorising non-consensual treatment. At least two women were compulsorily detained and treated under the Mental Health Act. Judges called on to intervene in such cases studiously avoided pronouncing on the respective rights of the women and the fetus. They focused rather on the woman's capacity to consent to treatment. Ultimately the Court of Appeal³ did address the status of the fetus and concluded that English courts had no jurisdiction to intervene to protect a fetus at any point up to birth against the wishes of a competent mother. Only if she lacked capacity to determine whether or not to agree to what her doctors advised could the courts intervene. Confusion, shock, fatigue, pain, medication, panic induced by fear or phobia might all be factors inducing temporary incapacity in otherwise competent women. In the actual case before the appeal court the judges ruled that the patient's needle phobia was such that panic caused her to refuse the anaesthetic and the necessary caesarean section to deliver the fetus safely. That panic destroyed her capacity to decide whether or not to go ahead with the recommended surgery.

The essence of the principle adopted by the court is hard to fault. If a woman is truly incapable of making a decision on obstetric treatment then, just as with any other kind of treatment, that decision must be made for her. A woman brought unconscious into the labour ward after a road accident should clearly be delivered by surgery if that is what is required to preserve her welfare and that of her child. A woman whose mental disorder causes her to deny her pregnancy altogether is incompetent to make any judgment in relation to that pregnancy. No doubt there are other instances

of genuine incapacity. But consider the factors which the Court of Appeal suggested might induce incapacity in the pregnant woman, confusion, shock, fatigue, pain. All are in so many cases an inevitable part of childbirth. The court also stated that in judging capacity in labouring women the gravity of the decision in question must be taken into account. The graver the consequence of the decision, the commensurately greater must be the level of competence to take that decision. The way is left open to establish in a great many cases where women and doctors disagree about childbirth that the woman was incompetent so that what others consider her interests and her child's interests require can lawfully be done.

There are perfectly respectable, if highly controversial, arguments that the viable fetus does have interests which the law should protect even against its mother's wishes. Understandably the judges preferred to sidestep such controversy. Maternal rights rule, the law declares, except where mothers are incompetent. Incompetence is so defined that few women in labour could hand on heart declare themselves competent. "Hard" cases can be dealt with at doctors' and judges' discretion, ultimately undermining women's autonomy perhaps more significantly than if formal recognition had been afforded to fetal status.

Controlling surrogacy

A final cautionary tale emerged in May. A British woman agreed to carry a child for a Dutch couple. They had been put in touch with each other by the voluntary organisation COTS (Childlessness Overcome Through Surrogacy). She was to be paid, it was reported, £12,000 in general expenses and a further £1,000 for travel and other costs. Such payments to the surrogate are banned in the Netherlands. In the United Kingdom, commercial surrogacy in the sense of paying the surrogate for handing over the child is similarly prohibited. Surrogates in Britain may, however, be paid "reasonable expenses" and around £10,000 seems to be accepted as the norm. The surrogate was inseminated with the Dutch husband's sperm, the couple carrying out the process without medical intervention. She became pregnant but nine weeks later she first announced that she had terminated the pregnancy, then that she was still pregnant but intended to keep the child. She had become dubious of the commissioning couple's commitment to the child and concerned about their ability to meet her expenses. Public outcry ensued. Calls were made to ban surrogacy or if that was not possible to enforce strict guidelines limiting payments, enforcing counselling and bringing the whole process within a medical framework. COTS announced that they would no longer act for foreign couples. £13,000 was said to be near the point of being more than expenses.

The message again was that something must be done to alleviate the plight of the unfortunate couple let down by lax laws. Their grief is inescapable. Other issues are less clear. What could be done? Defining and limiting expenses is a tricky business. Why should £10,000 be acceptable yet £13,000 too much? Truly calculating expenses would require a variable sum. The more the surrogate's earning capacity foregone for part of pregnancy, the more expensive her tastes, the more she would have to be paid. Incentives would be offered to engage only the poorest of women to act as surrogates, often those least able to protect themselves from exploitation. Ban payments altogether? Is that really feasible? Must the surrogate pay all her own travel and medical costs? Should she get no compensation if she suffers loss of earnings? Ban surrogacy? Will the police search and seize any equipment which might be used for D-I-Y insemination? None of the above is likely to happen. Measures to control and monitor surrogacy may. Some have proposed that a "medical" framework be established to allow doctors to choose "good" surrogates for "good" couples. The law would deal with hard cases by handing them over to medical control.

Leave it to the doctors?

Whenever an attempt is made to establish general legal principles to govern human affairs as emotive as infertility treatment or regulating birth itself, those principles will yield some harsh individual results. The common good may not always be the individual's good. Changing the law in haste, stretching the law to accommodate the hard case is not the answer. It is particularly not the answer when, as each of the above tales illustrates, the form of that answer is to place individuals' rights at the mercy of medical discretion, however beneficent. The pattern of regulation of human reproduction is already to grant ever more regulatory powers to control human behaviour and to entrust the bulk of those powers to doctors. Are we convinced that this is right in principle or does it simply allow society to cope with hard cases and evade hard questions? Responding, as the British government has done to both the Diane Blood case and the furore over surrogacy, by setting up comprehensive reviews of the relevant laws at least avoids legislating in haste and regretting at leisure.

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References

- 1 *R v Human Fertilisation and Embryology Authority ex p DB* [1997] 2 All ER 687
- 2 [1992] 4 All ER 671.
- 3 *In re MB (caesarean section)*. (1997) 147 NLJ 600.