THE LEGAL CONSEQUENCES OF ARTIFICIAL INSEMINATION AND EMBRYO TRANSPLANTATION IN HUMANS

by

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Submitted in Partial Fulfilment of the Requirements of the Degree Doctor of Philosophy in the School of Law, University of Natal, Pietermaritzburg.

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FORMAL DECLARATION

I hereby declare that this thesis, submitted for the degree of Doctor of Philosophy in the School of Law, University of Natal Pietermaritzburg, is my own unaided work and that all my sources of information have been acknowledged.

To my knowledge neither the substance of this thesis nor any part thereof is being submitted for a degree in any University.

Dated at PIETERMARITZBURG this 21st day of November 1982.

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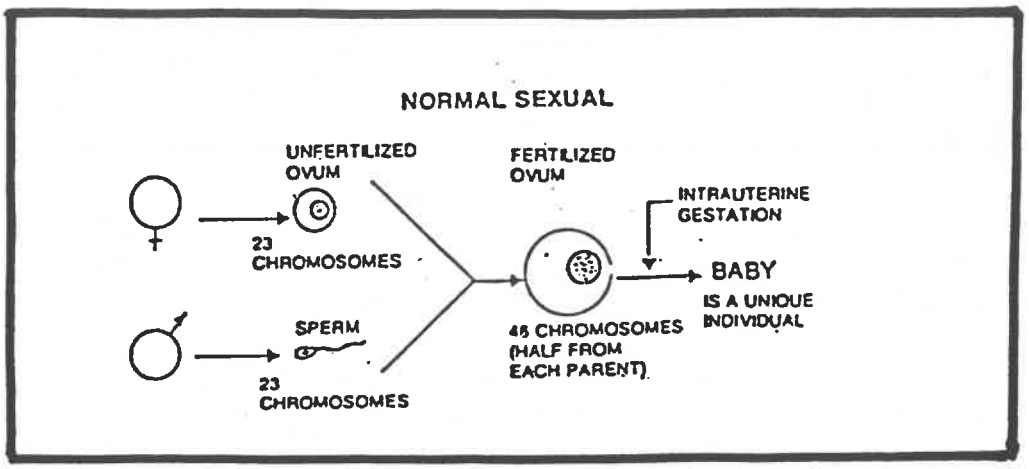
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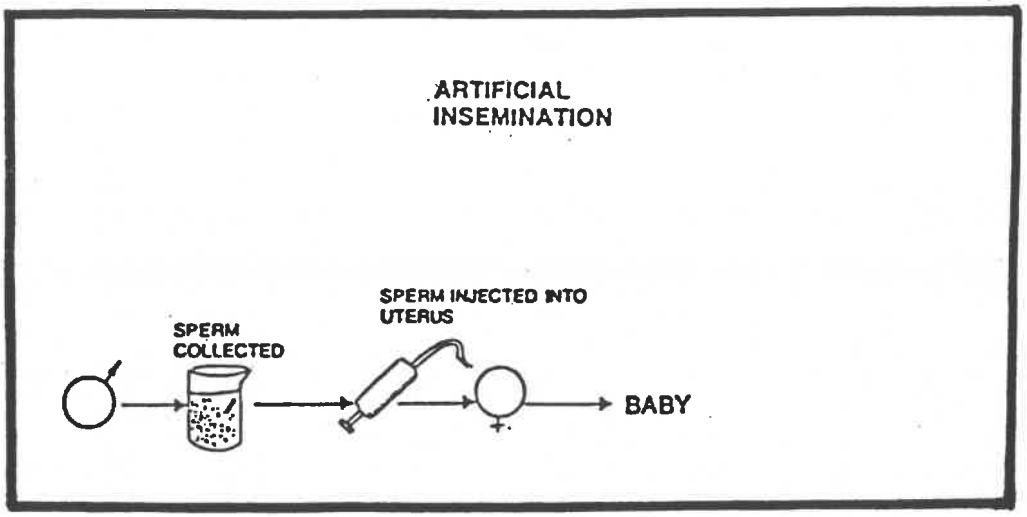
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Multa diversaque mulieribus contingunt, propter quae non pariunt (Hippocrates)

'Many and various are the ills that befall barren women'

Reproductive Techniques





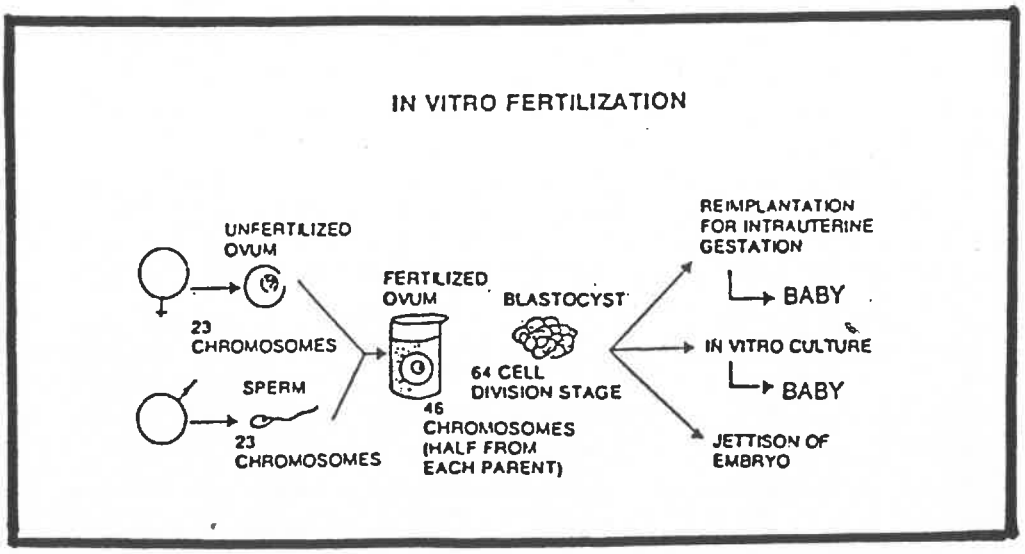


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GLOSSARY OF SELECTED TERMS

1. *Blastocyst* : A mammalian embryo. A modified blastula at the stage resulting from cleavage of the zygote at the time of implantation in the uterine wall.

2. *Embryo* : A Newly formed organism in its first stages of growth. In mammals these stages include the multiplication and differentiation of the fertilized egg-cell after it is implanted, until blood circulation is established between the new organism (by now a few million cells) and the maternal body.

3. *Fallopian Tubes* : The tubes connecting the ovaries to the uterus. Eggs are produced in the ovaries, move into the fallopian tubes where they may be fertilized, and then after fertilization, go to the uterus, where they develop into an embryo.

4. *Foetus* : The embryo after it has grown for two months in the uterus. At this time the blood circulation between mother and foetus is established and the general design (anatomy) of the future baby is formed.

5. *Gametes* : Haploid cells which fuse to form a zygote in sexual reproduction. In many organisms the male gamete is called spermatozoon and the female gamete is called ovum.

6. *Implantation* : The attachment of the fertilized egg-cell to the inner wall of the mother's uterus. This is the beginning of pregnancy.

7. *In Vitro* : Something happening outside the body, in a lab (such as an experiment in which cells from an animal are grown in a test tube). The word means literally "in glass". If cells are studied right in the organism, they are studied *"in vivo"*, or "in life".

8. *Oocyte* : An egg before formation of the first polar body.

9. *Ovaries* : The female reproductive organ, where eggs are produced.

10. *Ovulation* : The movement of the mature egg-cell in the female from the ovary to the uterus. During this period the egg-cell can be fertilized by sperm and then become implanted.

11. *Placenta* : The organ, similar to plant roots, by which the foetus is attached to the uterus and draws blood with oxygen and nutrients from the maternal body.

12. *Uterus* : The organ in women in which the fertilized egg grows into an embryo and then a foetus.

13. *Zygote* : A cell formed by the union of two gametes or reproductive cells

ABBREVIATIONS

AID : Artificial Insemination with the semen of a donor

AIH : Artificial Insemination with the husband's semen.

ET : Embryo transplantation

IVF : *In vitro* fertilisation

PREFACE

Through various so-called Revolutions man has dramatically changed his physical environment and raised his standard of living, comfort and education to levels undreamed of two centuries ago. This has been achieved by 'revolutions' in transport, agriculture, medicine, information, atomic energy and electronics. Having achieved all this man appears to have altered his gaze from the horizon and is looking at himself. In doing so he has realized that it is within his grasp to improve his own creation in the same way as he has controlled and improved his way of life.

Until the latter half of the 20th Century man has been able to alter his environment without disturbing the balance of nature, of organic and inorganic matter, of human and non-human life beyond the point of no return.

Within our generation, however, the greatest expansion of man's power to alter his environment and most specifically his disturbance of the age old balance of human life and death, has reached dimensions that put the continuation of all forms of life including human life, into question. In the words of Wolfgang Friedman:

> 'It is therefore becoming a matter of overwhelming importance for the future of humanity to determine the borderlines between the acceptance of life as part of nature in its totality, and the control of life, as part of man's unique capacity to order and alter the nature around him as well as the conditions of his own life, including notably the conditions of reproduction.'(1)

The biological revolution or the 'New Biology' has started man down the road to eventual control of his own reproduction. Of the three major categories of interference with the age old process of life and death; man is already heavily involved, in two of them. First, in quantitative control ie limitation of births by contraception, abortion and sterilization and the induction of life by

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(1) W Friedman 'Interference With Human Life : Some Jurisprudential Reflections' (1970) 70 Columbia Law Review 1058 at 1059.

AID and IVF and ET, and secondly interference with the duration of life by eg euthanasia and organ transplantation. The third area, and one in which sporadic unco-ordinated attempts have been made,[2] is in qualitative control of life through the use of preselected genes for the fertilization of selected ova.[3]

This thesis will concentrate on certain aspects of the first point viz the legal consequences of AID and IVF and ET.

The nucleus of organised human society is the family and it is within the family unit that man has reproduced himself. The entire Judeo-Christian culture and law has been built on the foundation of the monogamous family system in which legal ties are based on genetic links between parents and children who were conceived as a result of intercourse between their parents.

Not every family is fertile and the curse of barrenness has always posed a severe medical and social problem to which, until recently, the only solution has been acceptance or adoption. Medical technology has now developed a solution to both male and female sterility in the form of AID or ET. In doing so medical science has solved the problem of barrennes but created a host of legal problems becasue the SA law, in particular, has not yet adjusted to the consequences of the 'New Biology'.

The 'New Biology' has made it possible to create children who have genetic links to only one spouse, or to neither of them, and because this is a radical departure from the normal basis for a family and thus for the many facets of the law which regulate the relationships of a family with society and with the other members of a family, this thesis will attempt to highlight these problems

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(2) 'The Repository for Germinal Choice' (10 March 1980) Time; cf Nazi's attempts at breeding a super race.

(3) Friedman ibid.

in relation to the existing law and also submit possible developments which should take place in the law in order to deal with situations for which current law offers no adequate solution. It will also examine a possible new legal basis for the sort of families which are being created in increasing numbers by the 'New Biology'.

Because the breadth and scope of the legal consequences of the 'New Biology' covers a vast range of the law, it has not been possible to deal with every aspect in exhaustive detail. Many of the legal problems which are raised by the 'New Biology' do not have solutions which can be readily fashioned by adaptation of existing principles and I have thus 'stuck my neck out' and submitted solutions which may seem radical or are not easy to relate to current law.

In exploring and attempting to forge a pathway through the dense legal frontier posed by the 'New Biology' which will inevitably lead us to a brave new world, I have relied heavily on the twin compasses of common sense and moral decency.

CHAPTER 1

THE HISTORY OF ARTIFICIAL INSEMINATION AND EMBRYO TRANSPLANTATION

1. Introduction

The medical history of artificial insemination in humans, as opposed to animals, is of fairly recent vintage and has not been particularly well documented.(1) The concept of artificial insemination, however, is much older and dates back to Biblical times(2) where reference is made to it in the Talmud(3) and the Midrash.(4) Further historical evidence of the fact that the ancients were aware of the possibility that conception could take place sine concubito is contained in the advise of Rabbi Peretz ben Elijah of Corbeil who cautioned women to avoid lying on linen on which a man other than her husband had lain lest they become pregnant.(5)

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(1) A M C M Schellen Artificial Insemination in the Human (1957) 8; H Rohleder Test Tube Babies : A History of Artificial Impregnation of Human Beings (1934) 5.

(2) P Z Rabinowitz 'Conception Without Cohabitation' (1960) I Harope' Haivri 209.

(3) Ibid. The incident referred to occurred early in the second century when students debating with the famous scholar Ben Zoma at a Rabbinical Academy in ancient Palestine posed the question whether the High Priest, whom according to the law must marry a virgin, may marry a maiden who was pregnant but categorically denied having had sexual intercourse. His reply recorded in the Talmud was that 'We have to consider (the possibility) that she may have conceived in a bath in which a male had discharged semen'.

(4) Schellen op cit 8. The Midrash records the fact that a certain Ben Sirah was conceived in this way (see supra). His father was alleged to have been the prophet Jeremiah while his mother was said to have been Jeremiah's daughter. Contra the opinion of Chief Rabbi David Gans published in his Zemach David in which he denied that Ben Sirah had been conceived sine concubito.

(5) Schellen op cit 9.

2. Artificial Insemination of Animals

While the early history of artificial insemination in humans is one of theory rather than fact, there is well documented evidence to prove the successful practise of AI in animals. In 1322 one Arab tribe inseminated the mares of an enemy tribe with the semen of inferior stallions(6) to weaken their strains. In 1742 Ludwig Jacobi succeeded in fertilizing fish artificially.(7) In 1777 Lazaro Spallanzani a priest of Modena and professor at the University of Pavia embarked on a series of experiments on reptiles and succeeded in fertilizing a frog a toad and a reptile.(8) The success of these experiments encouraged him to attempt a more complicated experiment viz the internal fertilization of a female. In 1780 he attempted and succeeded in artificially inseminating a spaniel bitch which 62 days later whelped three living pups.(9) Other similar and successful experiments followed, yet surprisingly no one perceived the practical significance of this discovery.(10) It is submitted that these successful experiments were not taken to their logical conclusion and attempted on homo sapiens because of the Churches' objection and because society of the day was not yet mature and liberal enough to accept such a fundamental departure from nature.

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(6) A F Guttmacher 'The Rôle of Artificial Insemination in the Treatment of Sterility' (1960) 15 Obstetrical and Gynaecological Survey 767.

(7) R S Jacobs 'Social and Legal Aspects of Human Artificial Insemination' (1965) Wisconsin Law Review 860. The Dutch Scientists Swammerdam and Toesel had unsuccessfully attempted to fertilize fish spawn in 1670.

(8) B S Verkauf 'Artificial Insemination : Progress, Polemics, and Confusion' (1966) 3 Houston Law Review 279.

(9) Jacobs op cit 860; The great French biologist, Charles Bonnet commented as follows in a letter to Spallanzani, 'I am not so sure but that what you have discovered may not have consequences for mankind of no mean significance', see Schellen op cit 12.

(10) Jacobs op cit 860. Rossi, Bianchi, Albrecht, Millais, Von Plonis, Hoffman, Chelchowski and Lund, performed similar experiments, but it was only in 1907 that the Russian physiologist Iwanoff in a paper published in 12 Arch. Sci. Biol. St. Petersburg at p 7 and entitled De la fecondation artificielle chez les mammiferes, provided the scientific basis for and stressed the advantages of the large scale use of artificial insemination in animal husbandry.

A discovery of fundamental importance to the diagnosis and treatment of infertility and hence to the practice of AI was made in 1677 when Louis van Hammen, a student at Leyden, discovered spermatozoa.(11) The discovery caused such a sensation that even King Charles II expressed a desire to examine these spermatozoa through Van Hammen's microscope.

3. Artificial Insemination in Humans

3.1. A.I.H.

If one discounts the unsubstantiated reports that Bartholomeus Eustachius was the first man to practise AI on humans in 1550,(12) then it is generally accepted that the honour befalls that eminent English physician and surgeon John Hunter.(13) He was consulted in 1799 by a linen merchant who was unable to father a child due to hypospadias (a deformity of the penis in which the urethra opens on its under surface). This condition could not be cured by surgical intervention, so Hunter advised the merchant to draw up some semen from his wife's genital tract immediately after emission with a syringe and then inject it into the vagina. The procedure was followed and resulted in the first successful artificial impregnation of a human.(14) However the report of Hunter's successful experiment aroused little enthusiasm from the medical and scientific community and his epoch making discovery slipped into obscurity for

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(11) Schellen op cit 13.

(12) Schellen ibid. Eustachius is reputed to have advised the wife of a physician who had consulted him on her infertility to persuade her husband, after coitus, to insert his finger into her vagina and push the semen upwards towards the mouth of the uterus. This method allegedly operated successfully.

(13) Feversham Report 'A report of the Departmental Committee on Human Artificial Insemination', (1960) London, Her Majesty's Stationery Office Cmnd 110

(14) Sir E Home 'An account of the Dissection of an Hermaphrodite Dog' (1799) 1 Philos. Trans. Roy. Soc. 158. See also E J Klayman 'Therapeutic Impregnation : Prognosis of a lawyer - diagnosis of a legislature' (1970) 39 University of Cincinnati Law Review 293.

the next sixty years,[15] until it emerged from the shadows when a Frenchman, Dehaut, published a short pamphlet dealing with 'la fecondation artificielle'.[16] He preached the merits of AI without ever putting it into practice.

The practical renascence of the technique of AI took place in the United States where Dr J Marion Sims reported in 1866 that he had performed fifty-five inseminations on six women and had obtained one pregnancy.[17] The initial reaction of the American public was one of such indignation that Sims discontinued his experimentation.[18] Apart from Sims' pioneering efforts in America the practice and progress in the field of AI in the next 40 years occurred mainly in France.

Girault, in particular, adopted a more professional and scientific approach to AI in humans. In 1868 he published the results of 10 cases in which he claimed to have been successful eight times.[19] In 1867 Gigon, a surgeon of Angoulême, reported that as far back as 1846 he had successfully inseminated one of his patients.[20] De Lajatre reported in 1876 that he had treated 567

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(15) J L Spiegel 'Seed of Doubt' (1956) University of Pittsburg Law Review 659.

(16) F Déhaut De la Fécondation artificielle dans l'espéce humaine comme moyen de remédie de certaines causes de stérilité chez l'homme et chez la femme 1865.

(17) J M Sims Clinical Notes on Uterine Surgery 1866. See also C E Rice 'AID An heir of Controversy' (1959) 34 Notre Dame Lawyer 511; T Glover Artificial Insemination Among Human Beings (1948) 4-5.

(18) J M Sims Uterine Surgery (1876) 365: 'I have given up the practice altogether, and do not expect to return to it again ....'; A A Levisohn 'Dilemma in Parenthood - Socio-Legal Aspects of Artificial Insemination' (1959) 4 Journal For. Med. 147.

(19) Schellen op cit 14, Girault first undertook a proper medical examination of his patient, co-ordinated her menstrual cycle to ensure that he chose the most fertile period for the insemination. He then gathered the semen from the husband, placed it in a probe which was introduced into the cervix and then deposited in the uterus.

(20) P F Gigon 'Essay sur la Fécondation artificielle á la femme' (1871) 37 Thesis. He performed his AI by gathering sperm from the husband in a glass syringe, introducing a rubber tube into the cervical canal and then permitting the husband to inject the semen.

women recording only 63 failures. He does not indicate what method he used. In all probability he is the same De Lajatre who was condemned by the Tribunal de Bordeaux in 1883 for his doubtful practices.(21) Thomas, Salmon, Gaillard and Nicolas de Nancy were also, according to Koerner, actively engaged in the practise of AI between 1845 and 1885.(22)

A number of publications on AI also appeared during this period viz theses by Pierre Fabien Gigon(23) and Gerard,(24) a chapter by Courty in 1870,(25) and works by Paolo Mantegazza(26) in 1887 and Sociac(27) in 1897. Mersinga(28) reported a successful instance of AI in 1892 after which twenty years elapsed before the next report. This can be ascribed to the very low success rate at this time and also to the general atmosphere of secrecy(29) pervading the practise of AI which naturally leads to the deliberate falsification of records.(30) This of course further hampers the compilation of accurate statistics on the subject.

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(21) O de Lajatre Des grands obstacles á la fécondation : suppression rapide de la stérilité 1888.

(22) A Koerner 'Medico-legal considerations in artificial insemination' (1948) 8 Louisiana Law Review 484.

(23) P F Gigon 'Essay sur law fécondation artificielle a la femme' (1871) Thesis Paris.

(24) J Gerard Contribution á C'histoire de la fécondation artificielle A. Parent (1885) Paris.

(25) A Courty Traité pratique des maladies de l'utérus, des ovaires et des trompes 2nd ed 1872 P Assalin Paris 1152. In his work he distinguished a new method of coitus condomatosus.

(26) P Mantegazza Nota sulla fecondazione artificial nella donna Gazz. degli ospedali (1887) 81.

(27) L Sociac La stérilitá 1897 Milano 73.

(28) S A Mensinga 'Fakultative Sterilität' 7 Aufl 2 Bände, Leipzig (1900-1906).

(29) Schellen op cit 18.

(30) Rice (1959) 34 Notre Dame Lawyer 511.

3.2. A.I.D.

The first instance of donor insemination is reported to have taken place at the Jefferson Medical College in Philadelphia in 1884,(31) and was performed by Dr William Pancoast. He was consulted by a couple regarding their infertility. The husband was forty-one years of age and his wife was thirty-one, both were in good health. Pancoast's examination of the wife established that there was no indication that she was infertile, her husband's semen however proved to be bereft of spermatozoa which therapeutic treatment failed to remedy. Pancoast thus concluded that the husband's seminal ducts were blocked, a condition that had been caused by a mild form of gonorrhoea.(32) It was decided to overcome the husband's sterility by resorting to AID which proved to be successful, the wife subsequently giving birth to a son.(33) The publication of these events by Hard in Medical World evoked a storm of indignation from its readers. Egbert condemned Pancoast's action as dishonourable and immoral.(34) This form of protest is hardly likely to occur today as moral opinions are far more enlightened and responsive to this and other forms of therapy for infertility.

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(31) A D Hard 'Artificial Impregnation' (1909) 27 Medical World 163. This constituted the first publication on AID; see also A F Guttmacher 'Artificial Insemination' (1969) 18 De Paul Law Review 566 at 567.

(32) Guttmacher op cit 657.

(33) ibid; see also B Gregoire & G Mayer 'The Impregnators' (1965) 16 Fertility and Sterility 130. According to the latter reference, in the course of a discussion with six medical students about a case, one of them jokingly suggested to Pancoast that the solution to the problem was to call in the 'hired man'. It is likely that this flippant remark in fact led to the implementation of the following plan. The woman was anaesthetised with chloroform, semen was collected from the handsomest student and then injected into her uterus. Neither the husband nor wife were told what had been done. When Pancoast later confided in the husband he was delighted. A fortuitous fraud, but one that could have resulted in disastrous consequences for the doctor as his actions were hardly in keeping with medical ethics.

(34) C L Egbert 'Artificial Impregnation' (1909) 27 Med World 163. He submits that it would have been better for Pancoast to have seduced the merchant's wife and proceeded to attack AID by invoking Divine Law to support his protest.

AID was probably not practised again until the final years of the nineteenth century when two American gynaecologists, Cary and Dickinson independently began to perform the procedure and publish their results.(35) In 1908 Schwalbe published an article in which he stated that he had performed a 'Künstliche Befruchtung' with the semen of a donor after receiving the consent of both husband and wife. The impregnation, however, was unsuccessful.(36) In 1912 Leo published the fact that a successful AID had been performed by a certain Professor Winternitz in Vienna.(37)

The practice of AIH and AID continued to make steady progress and in Germany publications appeared from H Rohleder (1912), L Fraenkel (1914), Fürbringer (1916), Foerster (1917), Ludwig (1922) and Mettenleiner (1925). In France Vignes (1929), Duvergey (1933), Chalier (1936) and R and E Palmer (1944) published works. In Russia the woman doctor Schorohowa deserves special mention. In the United States Dickinson (1920), Cary (1920), Meaker (1924) and Kelly (1929) worked successfully in this field. Because of the innate conservatism of the medical profession in England they tended to adopt a wait and see approach to AI and it is n o t until 1943 that the publications of Mary Barton and her co-workers began to appear.(38)

The really rapid development of AI was initiated in 1936 in America by the husband and wife team of Seymour and Koerner whose well-known publication, The Present Status of Artificial Insemination in the United States as Shown by a Recent Survey,(39) aroused a lively reaction from the public and from medical

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(35) W Cary 'Results of Artificial Insemination with an Extra-marital Specimen' (1948) 56 Amer. J of Obstet & Gyn 727; Klayman op cit 293.

(36) J Schwalbe 'Die künstliche Befruchtung' (1908) Deut. med. Woch. Schr 515.

(37) F Leo 'Schwangerschaft nach künstlicher Befruchtung' (1912) 43 Verhandl. Berlin med. Ges. 225.

(38) M Barton 'Artificial Insemination' (1943) 2 British Medical Journal 312.

(39) F I Seymour and A Koerner (1941) 116 JAMA 2747.

quarters eg Folsome and Guttmacher who were great propagandists of AI.[40]

Some of the most recent exponents of, and authors on, the technique of AI are Guerrero,[41] Mintz,[42] Ennis,[43] James,[44] Hargrove,[45] Kelly,[46] Doülle,[47] Muller,[48] Behrman[49] and Coleman.[50]

3.3. Embryo Transplantation

The first recorded successful egg transfer experiment was conducted by Walter Heape of the University of Cambridge on the 27 April 1890 when he transplanted the fertilised ova of an Angora rabbit into a Belgian hare.[51]

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(40) Schellen op cit 22; see also A F Guttmacher 'The Rôle of Artificial Insemination in the Treatment of Sterility' (1942) 120 JAMA 442.

(41) R Guerrero 'Sex ratio : a statistical association with the type and time of insemination in the menstrual cycle' (1970) 15 Int Journal of Fertility 221-225.

(42) B Mintz Pre-implantation Stages of Pregnancy Ciba Foundation Symposium, Churchill, London 1965.

(43) J Ennis 'AID the gift of life' (1972) Nova 20-22.

(44) W H James 'Cycle day of Insemination, Coital rate and sex ratio', (1972) 1 Lancet 112-114.

(45) B Hargrove 'Artificial Insemination by Donor' (1958) 25 Solicitor 165.

(46) G Kelly 'Artificial Insemination : A Symposium' (1956) 24 University of Detroit Law Journal 135.

(47) H Doülle Vol II Familienrecht (1965) 46.

(48) H J Muller 'Genetical progress by Voluntarily Conducted Germinal Choice Man and His Future - Ciba Foundation Symposium G Wolstenholme editor (1963).

(49) S J Behrman 'Techniques of Artificial Insemination' Progress in Infertility edited by S J Behrman & R W Kistner (1968).

(50) A H Coleman 'Artificial Insemination, heterologous and the Illegitimate Child' (1965) Journal of the National Medical Association 331-332.

(51) W Heape 'Preliminary note on the transplantation and growth of mammalian ova within a uterine foster mother' 48 Proceedings of the Royal Society of London (Biological Sciences) 457-458. See also A McLaren and M G Kerr 'Egg Transplantation' (June 1970) Science Journal 51-56: '... two ova were obtained from an Angora doe rabbit which had been fertilised by an Angora buck 32 hours previously .... These ova were immediately transferred into the upper end of the Fallopian tube of a Belgian hare doe rabbit which had been fertilised three hours before by a buck of the same breed as herself .... In due course this Belgian hare doe gave birth to six young - four of these resembled herself and her mate, while two of them were undoubted Angoras.'

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The first successful fertilization of a human egg in vitro was achieved by the eminent Boston gynaecologist Dr John Rock at Harvard in 1944,[52] however none of Dr Rock's test-tube embryos grew beyond the three-cell stage.[53] Other pioneers of fertilization in vitro were Dr Landrum B Shettles of Columbia University who succeeded in maintaining embryos for six days to the blastocyst stage of development (34 cells and up)[54] and in 1961 by Dr Daniele Petrucci of the University of Bologna who succeeded in nurturing from fertilization a human embryo for 29 days, after which he detected abnormalities in the embryo and terminated his experiment.[55] In 1963 Hayashi reported that a few ova had cleaved following the insemination of oocytes and spermatozoa.[56]

The breakthrough in providing the basic technology to fertilize eggs in vitro on a regular basis was achieved by the research of M C Chang[57] of the Worcester Foundation for Experimental Biology in Shrewsbury Mass., and C R Austin[58] of Cambridge University. They solved the problem of in vitro capacitation of

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(51) (continued from previous page)
The fact that this type of experiment is fraught with problems is borne out by the fact that a further seven years elapsed before Heape was able to repeat his successful experiment.

(52) J Rock and M F Menkin 'In vitro fertilization and cleavage of human ovarian eggs' (1948) 55 American Journal of Obstet & Gynaec 440. See also G P Smith 'Through a Test Tube Darkly ; Artificial Insemination and the Law' (1968) 67 Michigan Law Review 127.

(53) R Rorvik 'Test Tube Baby is Coming' (18 May 1971) Look 83.

(54) L B Shettles 'A morula stage of human ova developed in vitro' (1955) 6 Fertility and Sterility 287.

(55) K Abel 'The Legal Implications of Ectogenetic Research' (1974) 10 Tulsa Law Journal 243. See also 'Man into Superman' (19 April 1971) 38 Time 51; 'Baby in a Bottle' 28 Jan 1961 America at 560. The results of Petrucci's experiments created a public furore in Italy and after being condemned by the Vatican he abandoned his work on ectogenesis.

(56) M Hayashi 'Fertilization in vitro using human ova' In: Proceedings VII Conference of the International Planned Parenthood Federation (1963) Singapore at 505-510, Editors G W Cadbury et al, Excerpta Medica, Amsterdam.

(57) M C Chang 'Fertilizing capacity of spermatozoa deposited in the fallopian tubes' (1951) 168 Nature 697.

(58) C R Austin 'Observations on the penetration of the sperm into the mammalian egg' 4 Austr. J Sci Res Sci B 581.

rabbit sperm, a process that enabled sperm to penetrate the egg in the laboratory. For a long time it was accepted that only uterine spermatozoa could successfully achieve fertilization in virto but subsequent research by Chang proved that epididymal spermatozoa could be used for the fertilization of hamster eggs in vitro.(59)

The foundations laid by the research of the above scientists was taken to its logical conclusion in 1969 when Steptoe and Edwards announced that they had fertilized human eggs in the laboratory.(60) The next stage of development involved the transplantation of an in vitro fertilized egg, a feat first performed by Dr Landrum Shettles. He fertilized the egg of one woman with the sperm of her husband and then implanted it in the uterus of a second woman. Two days later the recipient of the transplanted egg underwent a previously arranged hysterectomy. The excised uterus was examined and the embryo was discovered embedded in it.(61) In 1974 Dr Douglas Bevis of Leeds University made a sensational announcement at the annual meeting of the British Medical Association. He claimed that three women had, during the previous 18 months given birth to children as a result of ova which had been fertilized in a laboratory dish and reimplanted into their wombs. This claim was however never substantiated.(62)

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(59) R Yanagimachi and M C Chang 'In vitro fertilization of hamster ova' (1964) Journal Exp Zool 156 at 361.

(60) R G Edwards, B D Bavister and P C Steptoe 'Early stages of fertilization in vitro of human oocytes matured in vitro' (1969) 221 Nature 632. In reply to the furore that greeted their announcement Steptoe allayed fears that they were attempting to create babies outside the womb, by stating that their true goal was purely humanitarian, 'All that I am interested in is how to help women who are denied a baby because their tubes are incapable of doing their small part' (see Time 31 July 1978 at 45).

(61) Rorvick (18 May 1973) Look 83 86 and Abel (1974) 10 Tulsa LJ 247.

(62) Newsweek 'Test Tube Babies' 29 July 1974 70. When pressed for details Bevis was either unwilling or unable to document his claims, and as a result was so soundly denounced that he vowed to give up his research. However to this day no one really knows whether Bevis was making false claims or was a victim of the furious scientific competition between rival fertility researchers.

The public outcry following Bevis's announcement had a profound effect upon fertility researchers. They became wary of taking the public into their confidence and Steptoe and Edwards made very few reports on the development of their research. The effect in the United States was that almost all research with human eggs came to an abrupt halt. In terms of a Federal Order issued in 1975 the Department of Health, Education and Welfare was barred from funding any in vitro fertilization experiments unless they were first approved by a national ethics advisory board, which was convened for the first time in January 1978.(63)

The honour of producing the world's first test-tube baby went to the British pair Edwards and Steptoe whose years of consistent research were finally crowned with success, when Lesley Brown, 30, gave birth by natural means to a daughter on 3 October 1978 in the Oldham and District General Hospital.(64) Close on the heels of this came the announcement by Dr Sarof Bhatacharya of the world's second test-tube baby, a 3,35 Kg girl born to an orthodox Hindu housewife in Calcutta.(65)

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(63) Time 'The First Test Tube Baby' 31July 1978 at 45. One of this board's first tasks was to consider the long standing application of a fertility researcher from Vanderbilt University, Dr Pierre Soupart. His experiments which were suspended in 1975 were designed to establish whether there was any increased risk of chromosomal abnormalities when human eggs were fertilized in vitro rather than in the body. U.C.L.A. obstetrician Jaroslav Marik commented bitterly that the unofficial federal moratorium had robbed American researchers from being the first to deliver a test-tube baby.

(64) Daily Mail (London) 12 July 1978 page 1; Evening Standard (London) 11 July 1978 page 1.

(65) Natal Witness 7 October 1978 page 7.

CHAPTER 2

THE PROBLEM OF STERILITY

1. Background

I considered it advisable, in order to provide a balanced background to the subsequent legal problems which arise from the techniques of AID and IVF and ET, to discuss them at a layman's level. This chapter does not attempt to provide an in-depth discussion on a scientific-medical basis of these techniques.

One of man's strongest and most basic urges is to propogate his species and when this is denied a married couple because of sterility it causes great unhappiness.(1) From time immemorial man's power of reproduction has been, of necessity, a vital and central part of his temporal and spiritual life, and when fertility failed it was ascribed to the will of the Gods.(2) Many ancient cultures devised elaborate fertility rites(3) to appease the gods and ensure the blessing of fertility, and if this failed they ensured the continuation of their family by

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(1) G Langer, E Lemberg and M Sharf 'Artificial Insemination' (1969) 14 Int. Journal of Fertility 232. M Heiman and S Kleegman 'Insemination : A psychoanalytic and infertility study' (1966) 17 Fertility and Sterility 117.

(2) The Bible, 'Genesis' 30 1,2. Infertility was interpreted as being a Divine punishment, "And when Rachael saw that she bare Jacob no children, Rachael envied her sister; and said unto Jacob, give me children, or else I die. And Jacob's anger was kindled against Rachael: and he said, am I in God's stead, who has withheld from thee the fruit of the womb?"

(3) An African marriage is not considered complete until the wife has borne her husband at least one child. Before the drastic steps of divorce or the calling in of a seed-raiser are resorted to the woman and her family will attempt everything in their power to promote conception. Among the Zulus it was believed that the ancestors were responsible for reproduction. The woman concerned would consult a witchdoctor to diagnose and cure her malady. He might diagnose that the ancestors required a sacrifice, or that the woman's sexual organs needed 'doctoring' (misela). He would also prescribe that the wife drinks a potion drawn from the orange lily (gloriosa virescens), which bore roots in the shape of both the male and female sexual

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alternative arrangements in keeping with the custom and law of their tribes.(4)

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(3) (continued from the previous page)
organs cf E J Krige The Social System of the Zulu (1950) at 61, 62. Special dolls to promote fertility are used among Nguni and South Sotho cf M de Lange 'Dolls for the promotion of fertility as used by some of the Nguni tribes of the Basotdo' (1961) 1 Annals Cape Prov Mus 86-101. W D Hammond-Tooke (editor) The Bantu-Speaking Peoples of Southern Africa (1974) at 213.

(4) The obligation resting upon an African man to pay an agreed number of cattle to his prospective wife's kraal-head as lobola or bogadi is vital to the solemnization of a customary union (see S M Seymour Seymour's Customary Law in Southern Africe 4th (1981) ed at 149; N J J Olivier Die Privaatreg van die Suid-Afrikaanse Bantoe (1969) at 59). One of the primary consequences of this contract is that the woman's reproductive capacity is transferred from her kraalhead to the husband and his family, see Seymour ibid. However where the woman thus lobola'd is barren and fails to fulfil her essential function of bearing children African law and custom provide for this exigency:

(a) Sororate The barren woman is not usually sent home, especially if the dowry has been paid. (see M Gluckman 'Kinship and marriage among the Lozi of Northern Rhodesia and the Zulu of Natal' African Systems of Kinship and Marriage (1950) at 166-206). A duty then rests upon her family to provide an acceptable substitute for her, usually one of her sisters. The substitute is then placed in the barren wife's House to bear children on her behalf (see G M B Whitfield South African Native Law 2nd ed (1948) at 251).

(b) Divorce. Alternatively if the husband was not prepared to accept a sororate arrangement he could divorce his barren wife on the ground of her infertility and reclaim his dowry from her kraalhead (see Seymour op cit at 193; Colonel C B A Maclean Compendium of Kaffir Laws and Customs Reprint NO 30 1968 119; A Phillips and H F Morris Marriage Laws in Africa (1971) at 131).

(c) Husband Sterile or Impotent. Where the husband is the sterile partner in the marriage the cardinal factor of the dowry contract viz that he and his family are purchasing the wife's reproductive capacity, and therefore have a right to exploit it, in conjunction with the custom of ukungena will ensure that children are born to that House and that its line will survive (see Seymour op cit 281-290; Olivier op cit 108 109).

1.1. Sterility and Fertility Contrasted

Before attempting to define sterility it would be advisable to detail non-sterility or normality. In order to do this it is necessary to distinguish between:

1.1.1. Fecundity

This is a condition which implies the innate, potential creative capacity of an individual to generate and secrete mature and physiologically active germ-cells. Factors which influence fecundity are aspermia and ovarial disturbances. Fecundity is thus the capacity to produce children.(5)

1.1.2. Fertility

This term implies the total creative capacity present in a man and a woman which when united, would result in them producing a child. Fertility is affected or frustrated by contraception and marriage late in life.(6)

1.2. Definition of Sterility

In the light of the above distinctions we can thus define sterility as follows:

> '... the sterility of a man or woman(7) is the absence of the potential creative capacity to generate and secrete mature germ-cells',

while

> '... the sterility of a marriage(8) is the absence of the procreative capacity of a husband and wife.'

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(5) S J Kleegman 'Infertility in Woman' in Gynaecology, Diseases and Minor Surgery R J Lowrie ed, (1952) at 621; see also Schellen op cit 26.

(6) S Payne and R F Skeels 'Fertility as evaluated by artificial insemination' (1954) 5 Fertility and Sterility 32.

(7) M H Grody, D W Robinson and W Masters 'Managment and Treatment of Infertility' (1952) 49 J Missouri State Med. Assoc 327.

(8) C H Mazer & J Hoffman 'Female Sterility' (1929) 129 Medical J and Record 90. The American Society for the Study of Sterility defined a barren marriage as being one in which pregnancy failed to occur after a year of normal sexual intercourse.

1.2.1. Classification of sterility

1.2.1.1. Clinical

(i) Absolute sterility exists when fecundation is impossible.(9)

(ii) Relative sterility exists when only one of the partners in a marriage is incapable of reproduction.(10)

1.2.1.2. Primary sterility(11) occurs where a couple remains childless after two or three years of normal sexual intercourse, despite attempts to cure this deficiency by therapeutic methods.

1.2.1.3. Secondary sterility(12) This classification can be applied where a woman has given birth to one or more children after which conception has ceased despite therapeutic attempts to overcome this sterility.

1.3. Statistics concerning Sterility

The most accurate statistical assessment of the universal prevalence of involuntary sterility amongst married couples sets the figure at ten to twelve percent.(13) If this percentage is applied to the eight million married couples in the United kingdom then we arrive at a total of ± 800 000 couples whose desire for a family is frustrated because of infertility. Of the latter total approximately 30% can be ascribed to male infertility ie ± 250 000 couples.(14)

It would appear that the above figure of 10% sterility is also accurate for marriages in the United States, Brazil, Japan, Netherlands and the Scandinavian

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(9) P C Kok 'Diagnostiek en therapie van het steriele huwelijk' (1952) Thesis Leiden at 17.

(10) Ibid.

(11) J O Polak 'Studies in sterility in woman' (1927) 44 J Surg Gyn Obst 520.

(12) Op cit 521.

(13) Editorial 'Artificial Insemination' (4 Oct 1975) British Medical Journal 7.

(14) (4 Oct 1975) British Med J 7.

countries.[15] Despite the vital necessity for secrecy regarding AI it is clear that the number of children born as a result of AI is increasing rapidly especially as this method of reproduction is becoming more publicised and consequently more morally acceptable in contemporary society. In 1941 it was estimated that 10 000 births in the United States had resulted from AI.[16] By 1955 the estimate had risen to 30 000, while in 1960 Guttmacher[17] postulated that between 5 000 to 7 000 births per annum were then a result of AI. Figures released in Japan reveal that in one Tokyo clinic alone, several hundred inseminations were performed annually.[18] Behrman and Kistner[19] claim that in the United States 15% of married couples are unable to conceive (not necessarily because of sterility), which results in 30 million involuntarily childless couples. According to their research the major causes of infertility are: cervical factor 20%; tubal factor 30-35%; hormonal factor 15%.

1.4. Alternatives Available to a Childless Couple

There are numerous obstacles within a marriage which may frustrate a couple's natural parental desire to bear children eg impotence, physiological (genital) impediments, transferable genetic defects and improperly matched Rh blood factors.[20] The following alternatives are available to a couple who fall into one of these categories:

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(15) R L Slagle 'Artificial Insemination' (1969) 23 Arkansas Law Review 83; W L van Luyn 'Over het steriele huwelijk' (1951) Thesis Utrecht; M S Nakamura Artificial Insemination - Its acceptance in Brazil (1971) 7th Congress of Fertility & Sterility, Tokyo 511.

(16) Verkauf (1966) Houston LR 279.

(17) Guttmacher (1960) 15 Obs. Gyn. Surv. at 769. See also Behrman Progress in Infertility at 717 - who quotes a figure of between 5 and 10 thousand AID births for 1966 in the U.S.A.

(18) R Iisuka, Y Sawada, N Nishina and M Ohi 'The physical and mental development of children born following artificial insemination' (1968) 13 Int. J of Fertility 24-32.

(19) Behrman and Kistner Progress in Infertility 730.

(20) A McLaren 'Biological Aspects of AID' in Law and Ethics of AID and Embryo Transfer (1973) 17 Ciba Foundation Symposium 4.

1.4.1. Acquiescence

A couple may decide to accept their fate and resign themselves to a barren love. However, forced acceptance of a childless union may adversely affect the marriage itself.(21)

1.4.2. Extra-marital conception

This is obviously not a satisfactory solution because it violates the current fundamental moral values in society,(22) as well as the principle of consortium omnis vitae(23) which forms the basis of any sound marriage. This alternative does not really bear serious consideration as there are other, more socially acceptable remedies available.

1.4.3. Adoption

This is a socially acceptable and morally sound alternative by which a couple may resolve the problem of a barren marriage. It does however have one insoluble disadvantage, viz that the wife's biological desire to give birth to a child remains unfulfilled by this method. This lack of fulfilment can in turn have repercussions of a detrimental nature to both the harmonious mother-child relationship and the marital union as such.(24)

1.4.4. Artificial Insemination and Embryo Transplantation

On the one hand these therapy's satisfy the woman's biological desire to bear children,(25) but on the other hand it raises a number of vexing problems of a legal, social, cultural, religious, emotional and psychological nature. The most important of these at the moment is the legal uncertainty surrounding the

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(21) G P Smith 'Through a Test Tube Darkly : Artificial Insemination and the Law' (1968) 67 Michigan Law Review 130.

(22) ibid.

(23) H R Hahlo The South African Law of Husband and Wife 4 ed (1975) at 108; "Marriage ... creates a physical, moral and spiritual community of life - a consortium omnis vitae."

(24) Smith (1968) Michigan LR 130.

(25) "It is every woman's heritage to bear children" per Dr Frances Seymour 'Artificial insemination, present status in the U.S.A.' (1941) 116 JAMA 2747.

use of AID because there is no biological relationship between husband and child.(26) Moreover, although under normal circumstances the birth of a child may serve as a binding force in a marriage, an AID child may precipitate discord within the union where a woman seeks the image of her husband in the child and is unable to identify it.(27)

The present state of embryo transfer viz where the wife's egg is removed by laparoscopy, fertilised in vitro with her husband's sperm and the resulting blastocyst replaced in the uterus, does not present any legal or emotional problems.(28) If either the egg or the sperm comes from a donor then of course one is faced with the same legal and emotional problems referred to above.

1.5. AIH

1.5.1. Introduction

Medical science resorts to this form of therapy where it has been diagnosed that the husband is fertile but impotent or where the wife is physiologically or psychologically unable to indulge in normal intercourse, but is capable of normal conception and birth.(29) A child born as a result of AIH is the biological product of the husband and wife because the procedure is basically an auxiliary or alternative to coitus.(30) Clinically AIH merely involves the

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(26) Smith (1968) Michigan LR 131.

(27) Smith ibid. It would not be accurate to say that it is the child itself which precipitates the discord, but it is a well known fact that the average spouse reacting to the daily strains of a marriage tends to exaggerate the failings of the other. It is at moments like this that the wife may succumb to the idea that her husband's failure to procreate can be ascribed to a personal failing. Daily contact with the child will naturally tend to confirm this feeling. The husband's ego will naturally be devastated if this emotion is communicated to him.

(28) R G Edwards, P C Steptoe 'Biological Aspects of Embryo Transfer' (1973) 17 Ciba Foundation Symposium Mouton 15-16.

(29) McLaren (1973) 17 Ciba Foundation Symposium 6.

(30) M P Warner 'Artificial Insemination : Review after thirty-two years experience' (1974) New York State Journal of Medicine Science 2359.

gathering and artificial transplanting of the husband's semen in his wife.[31] As a result it is not subject to the violent moral and religious castigation which has been heaped upon AID,[32] nor is it complicated by the interrelation of the natural and biological parents of the child and the concomitant involved legal problems which this gives rise to.[33]

1.5.2. Indications for AIH

1.5.2.1. Male indications

The following symptoms in a male will render coitus and/or fertilization of a female impossible:

(a) Penal defects

(i) Very small penis.[34]

(ii) Very large penis.[35]

(iii) Hypospadias,[36] uncorrectable by plastic repair.

(iv) Stricture of the urethra.[37]

(v) Curvature and torsion of the penis.[38]

(vi) Absence of penis.

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(31) J A Silvoso 'Artificial Insemination : the Legislative Remedy' (1975) 3 Western State University Law Review 68.

(32) M Ulstein 'Fertility of husbands at homologous insemination' (1973) 52 Acta Obstet Gynec Scand 5.

(33) Editorial 'Artificial Insemination - Its Socio-Legal Aspects' (1948/49) 33 Minnesota Law Review 147.

(34) A Koerner 'Fertility of the male as related to the artificial insemination' (1946) 56 J Urology 133.

(35) Ibid.

(36) Hypospadias is the condition in which the semen canal opens on the underside of the penis, see Dorland, Illustrated Medical Dictionary 24th ed (1975) hereinafter cited as Dorland. See also Verkauf (1966) Houston LR 280.

(37) G Swyer 'Artificial Insemination by Husband' (1960) 185 Practitioner 163.

(38) Schellen AI in the Human (1957) 41.

(b) Nervous and psychic impotence

AIH can be successfully employed where the husband is impotent, provided he is able to produce sufficient semen by masturbation. In fact most births due to AIH have been achieved in cases of impotence.(39)

(i) Inadequate erection.

(ii) Ejaculatio praecipitata.

(iii) Nervous aspermia.

(iv) Impotentia coeundi, incapacity to perform the sexual act, because of psychological reasons.(40)

(c) Abnormalities of ejaculation

(i) A complete absence of ejaculation may occur following dorsal sympathectomy(41) or denervation of the seminal vesticles in abdominal-perineal resection.(42) In instances of the latter abnormality it would be prudent to consider the husband's probable life expectancy before performing the insemination.(43)

(ii) Retrograde ejaculation into the bladder(44) may occur consequent upon inflammation, trauma or congenital malfunction of the posterior urethra,(45) or where there has been a trans-urethral resection of the prostate.(46)

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(39) Feversham Report 20.

(40) G Swyer 'Artificial Insemination by Husband' (1960) 185 Practitioner 163.

(41) An interruption of the sympathetic nervous pathway of the back cf Dorland.

(42) Removal of sections of the lower part of the abdominal area and/or genitals, Dorland.

(43) Verkauf (1966) Houston LR 281.

(44) A Walters and S A Kaufman 'Sterility due to Retrograde Ejaculation of Semen : Report of Pregnancy Achieved by Autoinsemination' (1959) 78 Am J of Obs & Gyn 274.

(45) Part of the canal that carries urine or sperm, Dorland

(46) Gland present in males and surrounds the neck of the bladder and the urethra, Dorland

(c) Seminal deficiency

A husband suffering from oligospermia[47] or asthenospermia[48] but whose sperm is possessed of normal motility[49] and morphology[50] is a prime candidate for AIH.

The low sperm density associated with oligospermia can be overcome by a concentration process known as the split specimen or fractional ejaculation technique.[51] The object is to separate the first portion of the ejaculate which usually has a higher semen count from the rest. This method is thus used where a husband produces a high volume of semen containing a low sperm count.[52] By combining a number of portions of the low sperm count a semen specimen of sufficiently high sperm concentration for successful insemination can be obtained.[53] Another method by which the sperm count can be concentrated or 'boosted' in instances of oligospermia is by centrifugation and decantation.[54]

The above techniques of concentrating semen combined with the now perfected method of freezing[55] and storing semen without significant loss of sperm motility[56] have significantly improved medical science's ability to overcome infertility in husbands arising from oligospermia.

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(47) Deficiency in the amount of semen secreted or in the number of sperm in the semen cf Dorland.

(48) Reduction of the vitality of the sperm cf Dorland.

(49) Ability to move spontaneously cf Dorland.

(50) The science of forms and structures of living organisms Dorland.

(51) R D Amelar and R S Hotchkiss 'Fractionation of ejaculate' (1965) 16 Fertility and Sterility 46.

(52) E J Farris and D P Murphy 'The characteristics of the two parts of the partitioned ejaculate and the advantages of its use for intra-uterine insemination. A study of 100 ejaculates' (1960) 11 Fertility & Sterility 465.

(53) Verkauf (1966) Houston LR 282; a sperm count of 60 million sperm per cc is desirable, but is often as low as 20 million in fertile men cf Behrman & Kistner Progress in Infertility (1968) 738.

(54) G Langer 'Artificial Insemination' (1969) 14 Int. J Fertil 232.

(55) S J Behrman and Y Sawada 'Heterologous and homologous inseminations with human semen frozen and stored in a liquid nitrogen freezer' (1966) 17 Fertility & Sterility 457.

(56) D R Ackerman, Y Sawada and S J Behrman 'Motility and respiration of human spermatozoa after cooling to various low temperatures' (1967) 18 Fertility & Sterility 775.

(e) Sexual aberrations and physical incompatibility

The following sexual aberrations could result in a husband being unable to participate in normal coitus:

(i) Homosexuality, pseudo-hermaphroditism, perversion, fetishism and sadism.(57) However where the husband's inability to inseminate his wife is due to one of the above reasons great care should be exercised in investigating the stability of the marriage and the security of a child born into such a union(58) before resorting to AIH impregnation. Final indications for AIH are if the husband is so obese that he cannot have normal intercourse with his wife(59) or if he suffers from an extensive inguinal hernia or tumours in the area of the pelvis or urethra, or partial or complete paraplegia.(60)

1.5.2.2. Female Indications for AIH and AID

(a) Nervous defects

The following factors impede normal intercourse:

(i) Erethism of the vagina.(61)

(ii) Dyspareunia.(62)

(iii) Vaginismus.(63)

(iv) Anaesthesia sexualis feminarum.(64)

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(57) Schellen AI in the Human (1957).

(58) Feversham Report 20.

(59) Schellen op cit 40.

(60) Ibid.

(61) Excessive sensitiveness. Dorland

(62) Dorland. Difficulty or pain in coitus.

(63) Extremely painful spasm of the muscles surrounding the vagina, resulting in aversion to intercourse Dorland. Gynaecologists usually hesitate to recommend AIH in these circumstances because vaginismus in a woman may produce the same sort of psychological difficulties as impotence in a man. The birth of a child is not however likely to put an end to the woman's aversion to intercourse. Feversham Report 20.

(64) Lack of sexual desire attributed to deficient excitability of the nervus pudendus communis which innervates the clitoris. Dorland. The basis for the underlying cause may be successfully treated in most instances; if it is functional however, pregnancy is not advisable while the psychological condition continues see S J Kleegman and S A Kaufman Infertility in Women (1966) at 37.

(b) Mechanico-anatomical causes

1. In the vagina.

(i) Short vagina.(65)

(ii) Hypertrophy of the vaginal wall.

(iii) Excessive shallowness of the fornix posterior, favouring immediate reflux of the semen after coitus.(66)

2. In the cervix

(i) Hypertrophy of the labia of the external ostium.(67)

(ii) Hypertrophy of the cervical mucous membrane.(68)

(iii) Stenosis of the cervix.(69)

(iv) Narrowing of the internal ostium.(70)

(v) Occlusion of the cervical canal by a thick and tenacious plug of mucus through which the spermatozoa cannot penetrate.(71)

(vi) Amputated cervix or pelvic tumour.(72)

3. In the uterus

(i) Retroflexed uterus(73) and anteflexed uterus.(74)

(ii) Cochleate uterus.(75)

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(65) Schellen AI in Humans (1957).

(66) Kleegman & Kaufman Infertitliy in Woman (1966) 43.

(67) Schellen op cit 40.

(68) Morbid enlargement or overgrowth due to an increase in size of its constituent cells. Dorland

(69) Narrowing of the opening of the cervix Dorland. Stenosis of the cervix and conical cervix usually respond to surgical treatment and AIH should thus only be resorted to as a final expedient see Schellen op cit 41.

(70) Kleegman and Kaufman op cit at 46.

(71) Schellen op cit 43.

(72) Verkauf (1966) Houston LR 281.

(73) Hollow muscular organ in females which is the place of nourishment of the embryo and foetus and which is bent backward, Dorland.

(74) Uterus which has been bent forward, Dorland.

(75) An under developed uterus showing acute anteflexion, Dorland.

4. Chemical impediments

(i) Inflammation of the cervical mucus, endocervicites.(76)

(ii) Changes in reaction and other chemical properties of the vaginal and cervical secretion due to inflammation of these areas. This in turn results in the inflammation having a toxic effect upon the spermatozoa.(77)

(iii) Hostile environment in the uterus and adnexa due to inflammation of these areas.(78)

In AIH the husband's sperm is used because it is normal. The factors obstructing conception being due to an external cause or because the sperm is subnormal ie deficient in the required concentration of spermatozoa. This deficiency can be overcome by 'boosting' the spermatozoa content to the required density.(79)

1.5.3. Indications for AID

Whereas in AIH the husband's sperm is normal, the primary indication for AID, and hence the necessity to use the semen of a third party donor, is because the seminal deficiency of the husband is so severe that it is highly improbable that conception could ever be effected by the use of his semen.(80)

1.5.3.1. Seminology

(a) Composition

Semen is composed of two elements viz the seeds or spermatozoa and the seminal fluid or plasma which is the liquid medium in which the spermatozoa are contained.(81)

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(76) Inflammation of the mucous membrane of the neck of the uterus, Dorland.
(77) Schellen AI in the Human (1957).
(78) ibid.
(79) Verkauf (1966) Houston LR 282.
(80) Verkauf op cit 282.
(81) Feversham Report 8.

(b) Volume

The seminal fluid is derived from the seminal vesicles and to a lesser extent from the prostate. The volume of an ejaculation can vary from ½ to 5 or 6 cc averaging about 3 cc.(82)

The volume is significant as it has been proved that where the volume of an ejaculation was less than 1 cc only 6% of couples were able to conceive a child within a period of one year.(83)

(b) Spermatozoal standards

Conflicting opinions exist as to the minimum spermatozoal standards required for normal fertility. When human semen is analysed a count is made of the number of spermatozoa per cubic centimetre of semen. In a normal man there may be 100 million or more.(84) Sixty million may be regarded as below normal and the minimum density required for fertility;(85) yet not low enough for AID to be considered. However MacLeod is of the opinion that the oft-quoted figure of 60 million is too high.(86) There is in fact always an outside chance, albeit very slim, that so long as the count is not nil one cannot totally discount the possibility of conception.(87) On the other hand Farris has stated that:

> '... it is an accepted fact that only one spermatozoon is required for fertilization ... yet we have learned empirically that unless about 80 million active spermatozoa are deposited in the female by coitus, conception is not likely to occur.'(88)

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(82) R O'Rahilly 'Artificial Insemination : Medical Aspects' (1957) 34 University of Detroit Law Journal at 389.

(83) Ibid.

(84) Feversham Report 8.

(85) Ibid.

(86) A MacLeod 'Human Semen' (1956) 7 Fertil & Steril 368.

(87) I Bender 'End-results in treatment of primary sterility' (1953) 4 Fertil & Steril 34. The number of sperm per cubic centimetre is by no means constant, they may rise from 3 million to 60 million in a year, and a significant change can occur from one week to another. For this reason it is advisable to examine a husband's semen on several occasions before a decision is taken on AID. This precaution would avoid the undesirable situation where a donor child is followed by a child or children fathered by the husband.

(88) E J Farris quoted by O'Rahilly (1957) Univ of Detroit LJ 390.

(d) Spermatozoal motility and morphology

Motility may be expressed as the percentage of active cells. However, the quality of the motility ie the speed of their forward progression, is of greater significance as conception is produced most rapidly when the percentage of active cells is above 60%. The quality of motility may be arbitrarily designated as 1, 2, 3 and 4 in accordance with their increasing rate of forward progression. A rate of below 3 is considered to be subnormal.(89)

The morphology of the spermatozoa, by which is meant the structural appearance of the spermatozoal heads, is only important because there is a close relationship between abnormal structure and poor motility.(90)

1.5.3.2. Seminal deficiency

(i) Oligospermia of such a severe nature that conception is impossible.(91)

(ii) Necrospermia.(92)

(iii) Aspermia.(93)

(iv) Aspermatogenesis.(94)

1.5.3.3. Rhesus antagonism

Occasionally the husband carries a genetic factor in his sperm plasm which is disasterous as far as the offspring of the marriage is concerned. The most common defect is a homozygous Rh positive condition in the husband of a highly sensitized Rh negative wife who has given birth to a succession of stillborn infants. Donor insemination from an Rh negative man would overcome this problem.(95)

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(89) O'Rahilly (1957) Univ of Detroit LJ 390.

(90) Ibid.

(91) Verkauf (1966) Houston LJ 282.

(92) Absence of living sperm in the ejaculate, Dorland.

(93) Inability to secrete or ejaculate seminal fluid, Dorland.

(94) Absence of sperm in the testis. Non-functioning of the process by which spermatozoa are produced. Dorland.

(95) Modern medical technology has made it possible to save all but the most severe cases by means of a total exchange blood transfusion see A F Guttmacher 'Artificial Insemination' (1969) 18 De Paul Law Review 566 at 570.

1.5.3.4. Hereditary diseases

AID could be profitably resorted to, to avoid the transmission of a hereditary disease from a husband to his offspring. The most common of these are Huntington's chorea, haemophilia, hereditary blindness, amaurotic idiocy (Tay-Sachs) and certain types of muscular dystrophy.(96)

1.5.3.5. Other reasons

(i) Absence of testes in a husband.(97)

(ii) A husband, who because of his advanced age is impotent and incapable of impregnating his young wife. The husband is desirous of an heir but their application for adoption is rejected.(98)

(iii) Husband suffering from drug and/or alchohol addiction or venereal disease.(99)

1.5.4. Indications for In vitro fertilization

1.5.4.1. The function of the human ovary and the Fertilization of the Egg

The ovary is a remarkable organ, no bigger than an almond, but which houses approximately half a million eggs, many more than the woman will ever need during her 30 or so child-bearing years. In fact only about five hundred eggs will be released during the fertile period of her life. Starting at puberty,

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(96) Verkauf (1966) Houston LJ 282; Guttmacher (1969) 18 De Paul LR 566 and Feversham Report 8.

(97) A man without testes can undoubtedly be pronounced sterile, however it is possible to transplant testes from one man to another. The result of such therapy would be that spermatozoa would be produced but only for a limited period. The spermatozoa which would be produced would be those of the donor of the testis. Were such a transplant to be effected the result would be that a husband would in the process of normal coitus in fact merely be acting as the vehicle for the injection of the seed of another man. It would in effect be an act of AID see Feversham Report 9.

(98) M P Warner 'Artificial Insemination' (1974) 74 (13) New York State J of Med 2360.

(99) Schellen AI in Humans (1957).

eggs are released, usually one at a time about midway in the menstrual cycle. This intricate and marvelous system is stimulated by hormones which are part of the body's chemical signalling system. Responding to this stimulation a ripe egg is expelled from its grapelike encasement, or follicle in the ovary. At the same time the ovary is producing germ cells, which are an essential component in the hormonal or endocrine system of the woman, linking, responding to, and triggering a variety of biochemical messages in the pituitary and adrenal glands, the uterus and breasts, which in turn influence the whole development of the body and its psyche.

Once activated by the two gonadotropic hormones, FSH (follicle stimulating hormone) and LH(luteinizing hormone), the ovary enters into a process centering on monthly cycles. The follicle-stimulating hormone FSH, triggers the development of one or more follicles in the ovary. The nurse cells of the follicles in turn produce an estrogenic hormone, estradiol, which brings about changes in the epithelial lining of the vagina. Under its influence cells in the mucosal lining of the womb also proliferate as the surface becomes 'spongy' in preparation for a possible pregnancy. When the egg breaks out of the mature follicle, another team of hormones goes into action. The luteinizing hormone, LH, from the anterior lobe of the pituitary (hypophysis) persuades the cells of the ruptured follicle to change their chemistry and become tiny factories for the hormones for maintaining pregnancy should this occur. As the egg is passing down the fallopian tube, the hormone progesterone from the ruptured follicle brings the spongy tissue development of the womb to a high point, ready for implantation if fertilization occurs. When implantation occurs, the mucosal lining of the womb and later the placenta send hormonal messengers back to the corpus luteum as the ruptured ovarian follicle is now known and to the pituitary gland just under the brain. The corpus luteum will suppress development of any new follicles if pregnancy has begun. If not, it degenerates and a new cycle brings the maturation of a new follicle. With pregnancy the pituitary gland releases into the bloodstream yet another secretion, the lactogenic hormone which prepares the

mammary glands for milk production and urges the corpus luteum in the ovary to increase and maintain its secretion of progesterone for the uterus.(100)

Either of the female's two ovaries may contribute an ovum in the course of a particular month, which then enters the nearby fallopian tube. If coitus has taken place, the egg will shortly run into a swarm of tailed sperm that have managed, like salmon battling upstream, to fight their way into this passageway. In a dramatic headlong plunge a single sperm will penetrate the waiting ovum's outer layer, its 23 chromosomes joining the egg's 23. That produces the full complement of 46 chromosomes which contain all the genetic instructions necessary to produce a complete human being.

The fertilized egg continues its journey, dividing as it moves through the tube. Finally, after several days, it will have become a blastocyst, a hollow, ball-shaped cluster of fewer than 100 cells. By now it will have reached the uterus. There the blastocyst embeds itself in the uterine wall, where it begins drawing nourishment from the mother and starts the miracle of differentiation ie the rapid transformation of cells into tissue that soon becomes recognisable as heart, brain, muscle, kidneys and all the other components of a living self-sufficient being.

However, an egg's journey is a precarious one. Unless the proper hormones are present in appropriate concentrations, setting the stage for ovulation and fertilization, this intricate chain of events will not be initiated. The egg will not burst from the ovary, the cervical mucus will be too sticky for entry of sufficient sperm into the uterus, and the lining of the uterus will not prepare to receive the fertilized egg. Indeed, hormonal disorders at any point in the sequence make it so fraught with peril for eggs and sperm that perhaps a third of all potential pregnancies end at the time of implantation.(100)

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(100) R G Edwards 'Aspects of human reproduction' The Social Impact of Modern Biology (1971) 108 et seq; R G Edwards & P C Steptoe 'Laparoscopic Recovery of Preovulatory Human Oocytes After Priming of Ovaries with Gonadotrophins' (4 April 1970) The Lancet at 683; G F B Schumacher et al 'In Vitro Fertilization of Human Ova and Blastocyst Transfer - An Invitational Symposium' (1973) 5 Journal of Reproductive Medicine 192.

1.5.4.2. Indications

(a) Blocked fallopian tubes

By far the most frequent infertility symptom in women necessitating recourse to embryo transplant stems from malfunctioning fallopian tubes due to peritubal lesions, absence of the tubes, tubal occlusion, unsuccessful tuboplastic surgery and functionally obstructive uterine tubes.(101)

(b) Hereditary defects

Disorders such as haemophilia or a certain form of muscular dystrophy occur almost exclusively in males. A couple could thus avoid passing on this defect by doctors ensuring that only daughters are born to them.(102) This is achieved by sexing in vitro fertilized blastocysts.(103) Mongolism arises through a chromosomal error during cell divisions which can be detected by examination of the cleaving embryo.(104)

(c) Genetic disorders

Experiments have been successfully conducted on animals and although similar experiments have not been conducted on humans yet, potentially it is possible. The experiment involves remedying the defects in a blastocyst by injecting one or more donor cells into it in order to modify the characteristics of the resulting offspring.(105) The donor cells are taken from other embryos and the characteristics of the other embryos are partially conferred on the host embryo as it grows.(106)

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(101) Edwards & Steptoe 4 April 1970 Lancet; Edwards & Steptoe (1973) 17 Ciba Foundation Symposium at 15.

(102) Edwards Social Impact of Modern Biology (1971) 109.

(103) Ibid.

(104) Ibid; Downs' syndrome or mongolism is the result of trisomy or the presence of one chromosome too many.

(105) Edwards Social Impact of Modern Biology (1971) 110.

(106) R L Gardner (1968) Nature 220, 596.

2. Clinical Procedure

2.1. Embryo Transfer (ET)

2.1.1. Ovarian function

The ovary normally produces one egg in each menstrual cycle, but can be stimulated to produce several eggs at a particular time by injecting the patient with the hormones known as gonadotrophins. These hormones also cause ovulation to occur ie the process whereby the eggs are shed from the ovary and enter the oviduct. Fertilization occurs in the oviduct, and the egg is now an embryo, after which cleavage into cells takes place.(107)

2.2. The donor

2.2.1. Wife's own egg (ETW)

There are very few cases in which a wife's ovaries are incapable of producing an egg suitable for fertilization. In most instances the problem arises from the fact that because of a blockage in the oviducts or fallopian tubes it is not possible for the wife's system to transport that egg into the uterus where it can come into contact with the husband's spermatozoa to be fertilized.(108) It is to circumvent this malfunction of the oviductal passage that medical science resorts to the remedy of embryo transfer, which in effect is nothing more than a 'detour' or a device to 'by-pass' a blockage along the main route of transportation.(109) This is in effect the major potential clinical application of in vitro fertilization,(110) which at a conservative estimate would bring new hope of conception to 20 000 married women in the U.K. who have tubal occlusion and perhaps 120-150 000 in the U.S.A.(111)

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(107) Edwards Social Impact of Modern Biology (1971) 108.

(108) Edwards Social Impact of Modern Biology (1971) 109; Edwards & Steptoe (1973) 17 Ciba Foundation 11.

(109) Schumacher et-al (1973) 5 J of Reproductive Medicine 193.

(110) Ibid.

(111) Edwards & Steptoe (1973) 17 Ciba Foundation 16.

2.2.2. Third party donors (ETD)

A situation can arise however, where a wife's ovaries have been surgically removed, and she wishes to carry a child. In this case if her craving for motherhood is to be fulfilled she would have to resort to the implantation of a donated egg which had been fertilized in vitro with her husband's sperm.(112)

Secondly, a wife who is prone to miscarriages or who is physically incapable of carrying a foetus to term even though she and her husband are fertile could resort to obtaining the services of a surrogate mother to bear the child for them.(113)

Thirdly, a busy career woman who does not wish to interrupt her career for the discomfort of carrying and delivering a child could also resort to the procedure of using a surrogate mother to carry a child which is biologically hers and her husband's.(114)

When scientists have perfected the technique of transplanting embryos from one uterus to another it will become possible to terminate a pregnancy without killing the embryo. Women who thus find themselves unwillingly pregnant will be able to give their embryos up for adoption instead of destroying them by present abortion methods.(115)

2.3. Clinical Techniques (ET)

Whereas AID makes virtually no demands on scientific know-how, in fact the same results could be achieved by adultery, embryo transfer depends upon

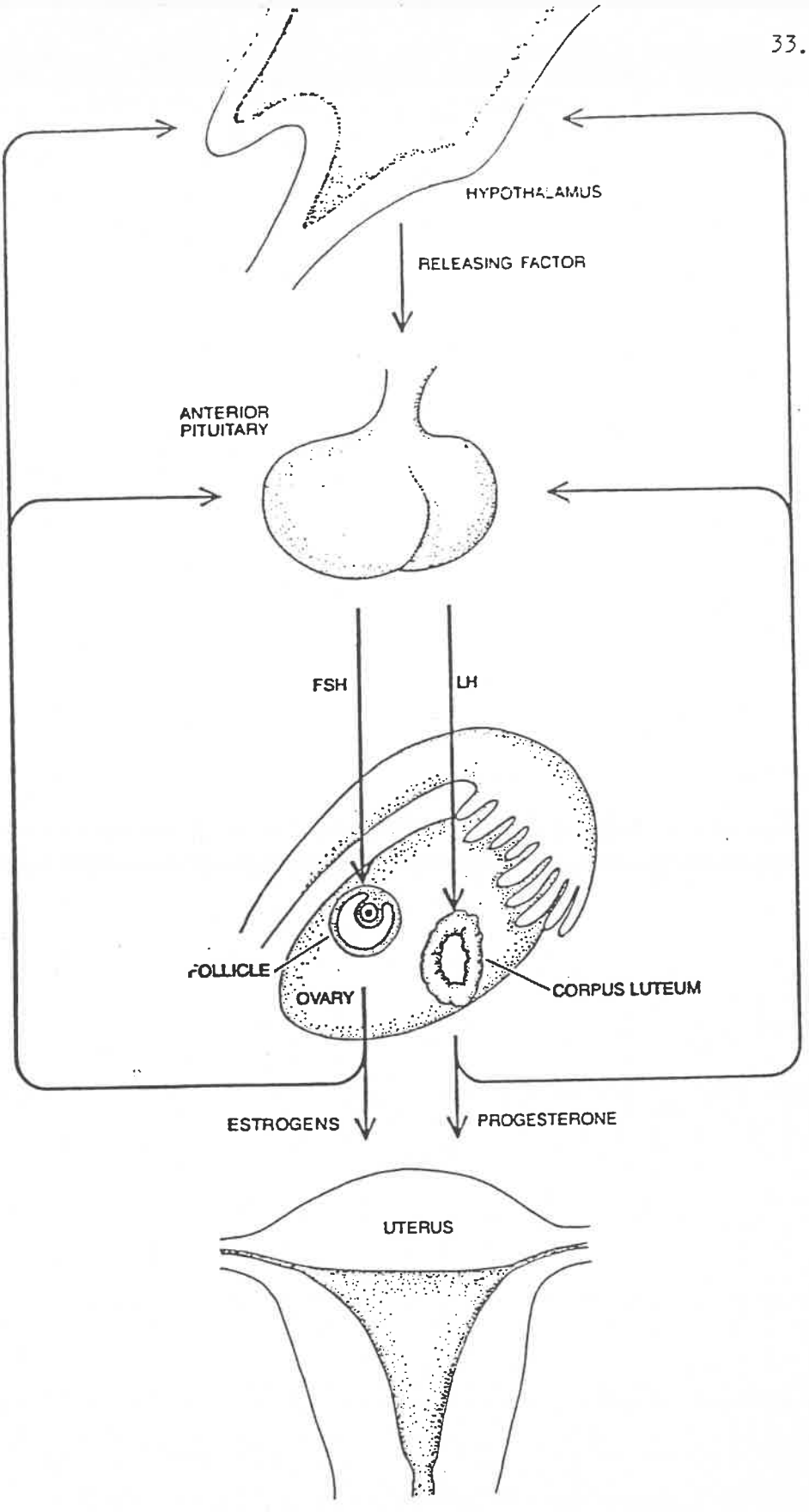
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(112) F lo Giatto 'Test Tube Babies' (1977) 42 U S Catholic 9.

(113) There are two possibilities; first, the wife's ovum could be fertilised with the husband's sperm in vitro and then implanted in the uterus of the surrogate mother. Second, the child could be conceived through normal intercourse and then transplanted into the womb of the hired woman. After the birth, the surrogate mother (who would remain anonymous) would return the child to the natural mother see Lo Giatto (1979) U S Catholic 9.

(114) L O Schroeder 'New Life : Person or Property?' (1974) 131 (5) Am Journal of Psychiatry 541; G Range 'Surrogate Mother Delivered; Legal Cautions Voiced' (1977) 12 (3) Ob Gyn News 14.

(115) Lo Giatto (1977) U S Catholic 9



INTERRELATED HORMONE ACTIVITY controls the female reproductive cycle. A releasing factor secreted by the hypothalamus at the base of the brain stimulates the adjacent anterior pituitary gland to secrete follicle-stimulating hormone (FSH) and luteinizing hormone (LH) into the circulation. The FSH causes one or more follicles in the ovary to grow and to produce estrogens, notably estradiol; the LH triggers ovulation and transformation of the follicle into a corpus luteum, which secretes progesterone. The estrogens and progesterone circulate to the uterus and prepare the uterine wall for the implantation of the egg; the ovarian hormones also feed back to inhibit or stimulate the secretions of the hypothalamus and the pituitary.

close collaboration between doctor and scientist as well as the development of suitable methods for obtaining, growing and transferring the embryo.(116)

2.3.1. Patient treated with fertility hormones

The doctor will normally ensure that his patient is menstruating regularly(117) before administering the fertility hormones (gonadotrophins). The object of this is that the gonadotrophins encourage the ripening of several eggs at the same time.(118)

2.3.2. Removal of the eggs by laparoscopy

While the woman is under anaesthesia an incision is made near the navel. Carbon dioxide is pumped into the abdominal cavity to expand it and separate the organs thus providing a clear space for the operator. A 135° laparoscope is then inserted into the abdominal cavity at the umbilicus and manouvered dexterously to seek out appropriate eggs which are then sucked into a small hollow needle. This aspiration needle fits neatly through a medium-bore needle which acts as a sleeve for repeated entry into and withdrawal from the abdominal cavity.(119)

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(116) Edwards & Steptoe (1973) 17 Ciba Symposium 11.

(117) O'Rahilly (1957) Univ of Detroit LJ 382.

(118) According to Edwards & Steptoe (4 April 1970) Lancet 683, their patients were given priming doses of H.M.G. ('Pergonal') containing approximately equal follicle-stimulating (F.S.H.) and luternising (L.H.) activity, followed by an ovulatory dose of H.C. 6 ('Pregnyl Organon). After between one and three injections of H.M.G. the patient was given one injection of H.C.G. between days 9 and 11 of her menstrual cycle to induce ovulation. The patient is brought into hospital on the day after the injection of H.C.G. for the aspiration of graofian follicles by laparoscopy.

(119) Edwards & Steptoe (4 April 1970) Lancet 684. The technique described supra does not make excessive demands on the patient, for hormone injections and laparoscopy, while not pleasurable experiences, are very mild forms of treatment and surgery. Laparoscopy is now a routine part of investigations into infertility and other illnesses, and the treatment does not damage tissues. Surgery takes less than 30 minutes and the patient only needs to stay in hospital for two or three nights at most. See also R G Edwards & Ruth Fowler 'Human Embryo in the Laboratory' (1970) 6 Scientific American 223

2.3.2.1. Technical problems

(a) Timing

Proper timing of the oocyte recovery is essential. The doctor must ensure that the ovum which he recovers is not 'over-ripe'; ova which are too old are fertilizable but often exhibit abnormal development after activation.(120) In order to achieve successful in vitro fertilization it is essential to work with a fresh ovum viz one which is not more than 12 hours old.(121)

(b) In vitro environment

The in vitro conditions must be created and carefully controlled so that the ovum development does not occur faster or slower than it would have if it had taken place in vivo, in fact, the conditions existing in the site of normal fertilization in vivo viz the distal third of the fallopian tube, must be duplicated.(122)

(c) Implantation

A discrepancy between the age of the egg and the level of development of the endometrium would result in a high rate of implantation failure. The timing of the transfer into the uterus would thus have to be carefully monitored to ensure successful implantation.(123) In fact practitioners of ET like Steptoe and Edwards have had a very low success rate to date.(124)

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(120) Schumacher et al (1973) 5 J of Reproductive Medicine 194. The presence of the first polar body is the sign that the egg is mature and ready for fertilization. See also G George 'Creating Life in the Lab' (1974) 75 Science Digest 28. The female germ cells are technically oocytes until after the second polar body has been given off. Since this event is unlikely to occur until after fertilization, there is probably, strictly speaking, no such thing as a human ovum, see O'Rahilly (1957) Univ of Detroit 391.

(121) O'Rahilly (1957) Univ of Detroit L J 391.

(122) ibid.

(123) Schumacher et al (1973) 5 J of Reproductive Medicine 194.

(124) Time 31 July 1978 47; A McLaren and M G Kerr 'Egg Transplantation' (1970) Science Journal 51 at 54. The problem Edwards & Steptoe have encountered involves hormonal balance: the mother's body chemistry changes during the course of the menstrual cycle and her pregnancy. Certain hormones must reach a certain proportional relation to each other at exactly the right time after the egg is returned to the body if the uterus is to accept, and the embryo to attain, attachment.

2.3.3. Culture of the egg in vitro

2.3.3.1. Correct type of oocyte

Experiments conducted on animals have established that embryos capable of correct cleavage and sustained foetal development to full term can only be achieved with oocytes recovered just prior to ovulation (preovulatory oocytes); they should be in metaphase of the first meiotic division and have completed their maturation in vitro before fertilization.(125)

According to Edwards preovulatory oocytes are easily identifiable. The oocytes which have been recovered by laparoscopy are collected in a small dish which can be placed under a binocular microscope for examination. The pre-ovulatory oocytes can be identified by the fact that they are surrounded by a large viscous matrix in which are embedded layers of diffuse cumulus cells. The oocyte and its adhering corona radiata can be clearly seen deep in the matrix. Once identified the preovulatory oocytes are collected and placed in a culture medium.(126)

2.3.3.2. Incubation & Fertilization

After incubation for 1-4 hours at 37°C under reduced oxygen tension and 5% carbon dioxide the preovulatory oocytes are then washed through two changes of Bavister's medium,(127) before being placed in the suspensions of spermatozoa; they would then be in metaphase of the second meiotic division and would be ready for fertilization.(128)

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(125) Schumacher et al (1973) J of Reproductive Medicine 195; C Grobstein (1979) 240 6 Scientific American 33 at 34-35.

(126) George (1974) 75 Science Digest 28-29.

(127) This medium consists of a tyrode solution of pH 7,5-7,6 containing pyruvate and bovine serum albumin see R G Edwards, P C Steptoe & J M Purdy 'Fertilization and Cleavage in vitro of Preovulator Human Oocytes' (1970) 227 Nature 1307 at 1308.

(128) Edwards, Steptoe & Purdy op cit 1307.

The next step is for the husband's ejaculated spermatozoa to be primed or capacitated.(129) In order to do this the chemical factors inhibiting or preventing the sperm from penetrating the egg must be removed from the surface of the sperm. Scientists are not yet certain how this is done in vivo but in the laboratory this is achieved by suspending the spermatozoa in Bavister's medium at a concentration of 10^6/ml.(130)

The oocytes are then added to the sperm suspension. Fertilization begins in a few hours, and pronuclei are discernable after 12 hours.(131)

2.3.3.3. Cleavage

Once fertilization has taken place the pronucleate ova are transferred into a dish containing a media suitable for sustaining cleavage of the embryo.(132) The most successful media to date is known as Ham's F10 which contains inter alia 25% human and 25% calf serum.(133) Once fertilization has taken place and cleavage has commenced experiments have shown that it takes between 123-147 hours for the blastocyst stage (100 or more cells) to be reached.(134) At this stage the embryo is ready for implantation.

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(129) Edwards, Steptoe & Purdy (1970) 227 Nature 1307.

(130) R G Edwards, P C Steptoe & J M Purdy 'Human Blastocysts grown in Culture' (1971) 229 Nature 132. The pH of the Ham's medium was standardised at 7,3, the osomotic pressure at 300 mos M/kg and the gas phase at 5% O_2, 5% CO_2 and 90% N_2.

(131) Edwards, Steptoe and Purdy (1970) 227 Nature 1307. Criteria which the above scientists have established for judging fertilization are: (i) the observation by phase - contrast microscopy of two pronuclei, two polar bodies and, if possible, a sperm tail in the cytoplasm of the oocyte; (ii) identification of pronuclei in the ova in culture, using a stereoscopic low-power microscope; (iii) cleavage of the egg, preferably after the identification of pronuclei.

(132) Edwards, Steptoe & Purdy (1971) 229 Nature 132.

(133) op cit 133.

(134) ibid.

2.3.3.4. Implantation

Before implanting the embryo it is essential for the doctor from both a medical and legal viewpoint(135) to conduct a careful chromosomal analysis by means of an amniocentesis test of the embryo in order to determine whether cleavage has been regular and that the embryo does not contain any anomalies.(136)

Should the analysis reveal that the embryo is normal it can then be implanted. This can be done by picking up the egg which is no bigger than a pin-head, with a narrow hollow tube or pipette and then inserting it through the cervix and into the uterus.(137) If all goes well it will implant itself in the uterine wall. Doctors will not be able to determine whether the patient is in fact pregnant for at least a week.(138)

2.3.3.5. Rejection of the blastocyst

Steptoe is on record as stating that of 60 implants he had attempted up to 1977 only three showed signs of normal development - one for 9 weeks, the others for two. Some of the possible explanations for this are: (i) difficulties

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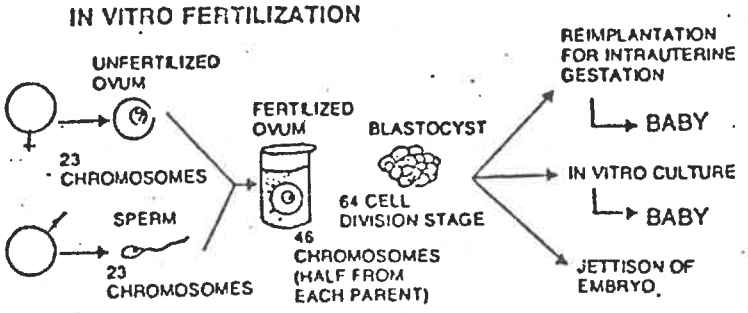
(135) If the doctor fails to do this and the child is born with abnormalities he can be held liable for his negligence. For a full discussion of the doctor's delictual liability see Chapter 4 infra.

(136) At fertilization each parent contributes 23 chromosome, therefore, a perfect embryo should contain 46 chromosomes. Dispermic fertilization, or the inclusion of the polar body chromosomes in the egg, can lead to triploidy, and errors in the movement of chromosomes on these spindles could lead to trisomy (the presence of one extra chromosome, as in Down's syndrome [mongolism]). Triploidy could arise through delayed fertilization but has not been detected in human embryos cleaving in vitro. See Steptoe & Edwards (1973) 17 Ciba Foundation at 15. For a full discussion on amniocentesis see page 137 infra.

(137) Edwards & Steptoe (1973) 17 Ciba Foundation at 15. Infections should be easily controlled and the fine catheters necessary to traverse the cervix and uterus should not cause any tissue damage.

(138) If the embryo does not attache itself to the uterus it simply passes out of her body while still in a microscopic stage. If it does attach it will continue to live and grow, soon becoming a recognizable foetus cf George (1974) 75 Science Digest 31.

in transferring the minute egg from the culture chamber into the uterus, (ii) undetected chromosomal abnormalities that doom the egg before it has a chance to implant itself, (iii) interference in the acceptance of the egg by the very hormones which were used to encourage ovulation.(139)



(140)

CONCEPTION IN A GLASS

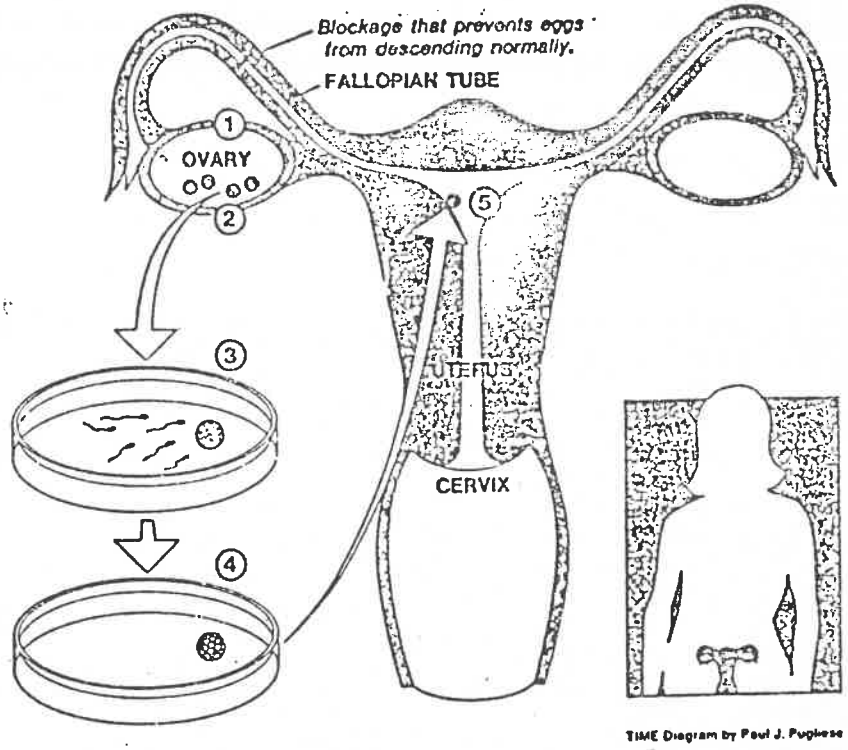
(1) The woman is treated with hormones to stimulate maturation of eggs in the ovary.

(2) To locate the ovary, an optical system, called a laparoscope, is inserted through an incision in the abdominal wall. Under direct vision, a needle is then inserted into the ovary to draw out the eggs.

(3) An egg is placed in a dish containing blood serum and nutrients, to which sperm is added for fertilization.

(4) Once an egg is fertilized by one of the many spermatozoa, it is then transferred to another dish of blood serum and sustaining nutrients. For the next three to six days, the fertilized egg divides, creating a cluster of cells called a blastocyst.

(5) After the woman receives further hormone treatment to prepare the uterine lining, the blastocyst is placed in the uterus, where it attaches to the wall and normal embryo development proceeds—as it would from a natural conception.



(141)

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(139) Time 31 July 1978.

(140) L Pakalnis & J Makaroto 'Reproduction and the Test Tube Baby' (Feb 1977) Canadian Nurse 27.

(141) F Golden 'The First Test Tube Baby' (31 July 1978) Time 43.

3. Clinical Procedure AID & AIH

3.1. Evaluation of Applicants

AI was a therapy rarely used by the medical profession until it started to receive widespread publicity thirty years ago.(142) The increased publicity immediately led to an increased demand from the public for this form of therapy to alleviate sterility. As a result patients began to be sent by general practitioners, gynaecologists and others to the few specialists known to be engaged in AID.(143) More recently with the perfection of the technique of in vitro fertilization and the establishment of the Bourn Hall & Monash Clinics there now exists an ever increasing demand for this form of therapy for infertility.

Before a practitioner initiates treatment for AID or ET he must ascertain whether the applicants are suitable or not. It is advisable for him to take the following steps:(144)

3.1.1. Obtain a written request and consent for the procedure signed by both the husband and wife and witnessed in the presence of the physician.

3.1.2. The physician should obtain a release from responsibility for any abnormal physical or mental condition of the offspring which is not due to his negligence.

3.1.3. No guarantee of success should be given.

3.1.4. The patient should be informed that no time limit for success can be predicted, nor can the number of inseminations which may be required for success be specified.

3.1.5. The legal implications and responsibilities of AID & ET should be clearly spelt out and understood by all parties concerned. The spouses should be

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(142) M Barton, K Walker & B P Wiesner 'Artificial Insemination' (13 Jan 1945) British Medical Journal 40.

(143) Feversham Report 13.

(144) B J Ficarra 'Artificial Insemination : A Medico-legal Concern' (1967) 4 Lex et Scientia 49; see also Feversham Report 13-15.

advised as to how the birth certificate is to be signed relative to paternity and the advisability of the husband to legally adopt the child thus securing its rights of succession to his estate in the case of AID.(145)

3.1.6. The physician should enquire in order to ascertain as accurately as possible that the applicant couple's marriage is a stable one and that they are emotionally well adjusted so as to be able to adjust to this form of parenthood.

3.1.7. It should be strongly recommended to the couple that they should not discuss the undertaking of AID or ET when the ovum is donated, with anyone other than their physician or religious consellor. This is particularly advisable for the protection of the child.(146)

3.1.8. If both the husband and wife are not enthusiastic about the procedure, the physician should not urge it but rather drop it completely.(147)

3.2. Medical Precautions

3.2.1. A reputable physician will not resort to AID or ET until he has by tests and examination assured himself that the wife is capable (at least organically) of conceiving and bearing a child.(148)

3.2.2. Before recommending the series of expensive tests to determine her fertility the physician will in an interview with the wife document her medical history and subject her to a physical examination to ascertain whether she ovulates habitually, has normal anatomic structures, possesses normal thyroid function, and has tubal potency.(149)

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(145) Guttmacher (1969) De Paul LR 571 submits that paternity should be accorded to the legal husband, not the donor, on both the hospital record and the birth certificate and that if this is not done the chief advantage of AID is abrogated. According to him only three people in the world viz the doctor, husband and patient should know that the child is not the child of the husband, otherwise AID has scant advantage over adoption.

(146) Behrman & Kistner Progress in Infertility 724.

(147) Guttmacher (1969) De Paul LR 571.

(148) Philip Reilly 'In Vitro Fertilization - A legal Perspective' in Genetics and the Law editors A Milunsky & G Annas (1975) 359 at 366.

(149) Aubrey Milunsky 'Prenatal Diagnosis' in Encyclopedia of Bioethics (1978) 1332.

3.2.3. The physician will then order a series of routine laboratory studies to rule out anaemia, foci of infection, diabetes, syphillis, hyperthyroidism and any other systemic diseases which might be present.(150)

3.2.4. The physician who inseminates the woman or performs the in vitro fertilization and reimplantation of the blastocyst should also deliver the child, as by this time there should be a bond of trust between the mother and the doctor.(151)

3.2.5. Professional charges for the procedure should be kept as low as possible.(152)

3.2.6. Once the physician is satisfied that the wife is capable of conceiving and bearing a child, he will test the fertility of the husband and if these tests reveal that the husband is incapable of fathering a child for one of the reasons supra 24-27; then AID is indicated. If ET is to be relied on, the physician must satisfy himself that the wife is capable of nourishing and carrying the re-implanted blastocyst to term.

3.3. Donors AID & ET

Considerably more care must be taken by the physician when he performs AID rather than AIH. The reason for this is that because in AID the semen of a third party donor is used, and this in turn causes the medical and legal (not to mention social, psychological and religious) implications to be significantly greater. It is thus necessary to take certain precautions, in addition to those mentioned above.(153)

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(150) Aubrey Milunsky 'Prenatal Diagnosis' in Encyclopedia of Bioethics (1978) 1332.

(151) R L Slagle 'Artificial Insemination' (1969) 23 Arkansas Law Review 83.

(152) Slagle (1969) 23 Arkansas LR 83. The physician should not attempt to profit from this form of therapy and thereby place it beyond the means of the average man. This could result in a doctor doing AID & ET in situations which do not merit it. This would in turn seriously affect the moral justification of this therapy. The doctor's chief reward should be the knowledge that he has assisted a worthy sterile couple to achieve a greatly desired and wanted baby, see Guttmacher (1969) De Paul LR 571.

(153) Verkauf (1966) Houston LR 282. As early as 1947 New York imposed specific regulations regarding donor insemination viz New York Sanitary

(continued on the next page)

3.3.1. Selection and Suitability of Donors

Most practitioners of AID testify to the fact that it is extremely difficult to find suitable donors.(154) Most doctors and lawyers are unanimous however about the fact that the donor should be anonymous to everyone except the doctor who performs the insemination.(155) Likewise the donor must not know the identity of the woman who is inseminated with his semen.(156)

A donor should furthermore measure up to the following characteristics:

3.3.1.1. He should not be a friend or relative of the spouses, nor should he use the husband of an infertile wife since this may enhance her sense of inadequacy.(157)

3.3.1.2. There is no general consensus on what physical and mental characteristics the donor should possess. Some practitioners prefer a donor who is older than thirty five,(158) married, and who has at least two healthy children, others however, prefer medical students as donors.(159)

3.3.1.3. It should be the object of AID to 'imitate nature' as far as possible. It would thus be advisable to attempt to match the donor and the husband both physically and mentally. . The doctor should ensure that the donor

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(153) (continued from previous page)
Codes para 112. The statute governs rules for ascertaining the health of the donor, his freedom from venereal disease and bacillus abortus, Bang infection, the necessity of Rh negative donors for negative recipients and the keeping of records of such inseminations for inspection by the health commissioner or his designate when requested.

(154) Feversham Report 10.

(155) L Hager 'Artificial Insemination : Some Practical Considerations for Effective Counselling' (1961) 39 North Carolina LR 217 at 223.

(156) Hager ibid.

(157) Verkauf (1966) Houston LR 284.

(158) O'Rahilly (1957) Univ of Detroit LJ 387, so that any latent hereditary conditions may be excluded.

(159) Verkauf (1966) Houston LR 284, because they have greater understanding of the use to which their semen is being put and a greater ability to evaluate objectively their own genetic background.

is of the same race, age and religion[160] as the husband. He should also attempt to match such features as colour of hair, skin, eyes and general build, or at least to ensure that the donor has no prominent physical characteristics which would result in the child looking markedly unlike his supposed father.[161]

3.3.1.4. If after one successful insemination a woman returns to the practitioner for a second AID child it would be advisable for him to use the same donor again.[162]

3.3.2. Medical and Clinical Precautions

Before collecting semen from a prospective donor a physician should ensure the following:

3.3.2.1. That the donor has a complete and thorough physical examination, with particular attention being paid to the genitalia.[163]

3.3.2.2. That the donor is free of venereal disease and Brucellosis.[164]

3.3.2.3. That as far as can be determined the donor has no inheritable defect.[165]

3.3.2.4. That there is no Rh and A.B.O. incompatibility between the donor and the recipient's blood groups.[166]

3.3.2.5. The physician should carefully evaluate the semen quality of the donor to ascertain whether it meets the minimum requirements.[167]

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(160) Feversham Report 11; Records kept by physicians reveal that they have provided Moslem couples with semen from a Moslem donor, and semen from a Jewish donor for a Jewish couple. Alternatively a doctor may be sued for damages for injuria and/or patrimonial damages if he intentionally or negligently inseminates a white woman with a black donor's sperm or vice versa. Cf D A Sergeant 'Legal Status of Artificial Insemination : A Need for Policy Formulation' (1970) 19 Drake Law Review 409 at 434.

(161) Feversham Report 11.

(162) Ibid.

(163) Verkauf (1966) Houston LR 284.

(164) A generalised infection, Undulant fever. Dorland.

(165) O'Rahilly (1957) Univ of Detroit LJ 387.

(166) Hager (1961) 39 North Carolina LR 223; Donors who may possibly create isoimmunization ie blood incompatibility between mother and infant should not be used. An Rh positive donor and a Group "O" recipient should not have an "A" or "B" donor when possible.

(167) Verkauf (1960) Houston LR 284;

(continued on the next page)

3.3.2.6. The physician doing the AID must keep confidential records of the donor's physical examination, the names and addresses of the donor and recipient and the date of the AID.(168)

3.3.3. Consent

It is essential for the physician to obtain the consent of the donor to use his semen, and to ensure that the husband and wife understand the implications of AI and that they give an informed consent to the use of the donor semen.(169) I will deal in greater detail with the implications of consent in Chapter 3.

4. Collection and Preservation of Semen AID & AIH

4.1. Collection

A potential semen donor should be instructed to observe the following precautions, viz to forego coitus for at least 24 hours prior to supplying a specimen for AI. If the specimen is to be collected by way of masturbation he should wash his hands and penis with soap and water, prior to securing the ejaculate in a clean, dry, widenecked bottle or jar which had been thoroughly sterilised before use. The receptacle should then be stoppered, kept at room temperature and delivered to the gynaecologist within an hour. He should perform the insemination shortly thereafter while the sperm are still viable and motile.(170)

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(167) (continued from previous page)
- (i) The sperm concentratoin should be greater than 100 million per cubic centimeter.
- (ii) There should be at least eighty percent motility.
- (iii) There should be fewer than twenty percent abnormal forms.
- (iv) The semen volume should be between 2,5 to 5,0 cubic centimeters.

(168) Verkauf (1966) Houston LR 284.

(169) E L Sagall 'Artificial Insemination' Medical Ethics & Liability (1976) at 265.

(170) Guttmacher (1969) De Paul LR; Sagall op cit 266; Langer et al (1969) 14 Int J of Fertility 233; Hager (1961) North Carolina LR 223.

Although masturbation is the most popular, practical and widely used method for collecting sperm, should it prove objectionable there are other methods such as puncturing a testicle and withdrawing the seminal fluid, massaging the prostate gland, coitus interruptus or coitus condomatus and extraction of semen from the vagina soon after intercourse.(171)

4.2. Motivations for storing semen

Although donor specimens presently constitute by far the greater number of stored semen specimens, it is becoming increasingly popular for a husband who is going to undergo a vasectomy to make a prevasectomy deposit with a semen bank as an insurance against unforeseen events eg to give the spouses the opportunity to replace a deceased child or to enable the man in the event of his divorcing his wife and remarrying to be able to father a child with his new wife.(172)

Living as we do under the cloud of an atomic holocaust it would be prudent for governments to arrange for the deposit of frozen semen, ova or zygotes (fertilised eggs)(173) in a place sheltered from harmful radiation so that the new generation to be born in the aftermath could be created without having been exposed to mutant producing radiation.(174)

Workers in factories, atomic energy plants and researchers who are constantly exposed to radiation which can result in sterility are increasingly making use of the facilities of semen banks to insure against such an eventuality.(175) Similar arrangements have been made to protect the issue of astronauts from

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(171) Langer et al (1969) 14 Int J of Fertility 233.

(172) Sagall, Medical Ethics & Liability (1976) 267. Current estimates are that from 600 000 to 1 million men per year undergo a vasectomy in the USA and this figure is rising.

(173) Mark S Frankel 'Sperm & Zygote Banking' Encyclopedia of Bioethics 1446.

(174) Guttmacher (1969) De Paul LR 572.

(175) W B Leach 'Perpetuities in the Atomic Age : The Sperm Bank and the Fertile Decedent' (1962) 48 ABAJ 942 943.

mutations resulting from ionizing radiation in space.(176) Certain chemical and radiation therapies prescribed to alleviate cancer would render the patient sterile. His only hope of fathering a child would be to make a pre-therapy sperm deposit with a semen bank. Even if the treatment killed the husband his wife could bear his child with his sperm. A similar deposit could be made by a man prior to having his prostate gland surgically removed.(177)

In addition the banks help men with low sperm counts (oligospermia) by freezing and storing several ejaculates. Later these can be combined and concentrated for insemination into his wife.(178)

4.3. Semen Banks

The technique of successfully freezing and storing human (and animal) semen in a bank so that it retains its fertilizing ability when thawed is firmly established in a number of countries today.(179) However, it was more than 100 years ago in 1866 that Montgessa's experiments revealed that human spermatozoa survived after exposure to a temperature of -15°C.(180)

The operation of semen banks is most highly developed in the USA, and although there is no official registry, there are 16 known banks. These include 8 operated by universities, five by fertility clinics, and three commercial banks. The university banks generally emphasise research, although they also undertake AI. They mostly use sperm donated by medical students. The fertility clinics are operated by gynaecologists or 'family planning' organizations. They try to help a couple overcome the problems preventing conception by such methods as consultations, hormonal treatment, as well as AI.(181)

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(176) Comment 'A Survey on Artificial Insemination' (1968) Notre Dame Lawyer 718.

(177) P Kouler 'Sperm Banks' (1976) 45 Harper's Weekly 3169.

(178) Ibid.

(179) R S Ledward et al, (1976) 83 12 British J of Obs & Gyn 917 918.

(180) Guttmacher (1969) De Paul LR 572.

(181) Mark S Frankel 'Sperm and Zygote Banking' Encyclopedia of Bioethics 1446; Shapiro & Spece Bioethics & Law (1981) 366.

The three commercial banks are the Genetics Laboratory in Minneapolis, the Xytex Corporation in Atlanta, and the Idant Corporation in New York. These banks buy semen, store it and then supply it to gynaecologists who need it for women whose husbands are infertile. They pay the donor about $ 35.(182)

4.3.1. Freezing of the semen

After collection the semen should be allowed to liquify at room temperature. Before freezing the volume, sperm count per ml, freedom from disease and motility of the ejaculate should be established to ensure its suitability for use in AI. Certain banks such as Xytex Corporation, the Tyler Clinic in Los Angeles and the University of Nebraska in Omaha, in addition, perform a chromosome check to ensure that there are the correct number of chromosomes and that they are normal.(183) The sperm should then be diluted with an equal proportion of K S protective medium prior to cooling.(184) This medium ensures a much higher survival rate for the spermatozoa. The mixture should be stored in 1,2cc glass ampules which are placed inside a silver cylinder the size of a cigar holder and then placed in vats which are cooled over 45 minutes to -196°C in liquid nitrogen.(185)

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(182) Mark S Frankel 'Sperm and Zygote Banking' Encyclopedia of Bioethics 1446.

(183) K G Bregulla 'Studies on the storage of human sperm by deep freezing' (1971) 7th Congress of Fertility and Sterility Tokyo at 374.

(184) The K S medium is constituted as follows (i) egg yolk, 20% by volume (ii) glycerol, 14% by volume (iii) a mixture of 5% glucose aqueous solution and 2,9% sodium citrate aqueous solution in proportion of 2 to 3 (66%). For each ml of the final mixture, 4 x 1mg erythromycin and 5 x 20mg of glycine were added. Cf R Iizuka 'Medical analyses of heterologous artificial inseminations with special reference to frozen storage of human spermatozoa' (1971) 7th Congress of Fertility and Sterility Tokyo at 360.

(185) Iizuka op cit 360.

4.3.2. Thawing the semen

Thawing is accomplished in 20 minutes by immersion of the ampule in water which is heated to a temperature of 37°C. Two of the 1,2cc ampules are generally used for a single insemination.(186)

5. Technique and Timing of Insemination

5.1. Routine examination

It is vital to thoroughly evaluate the fertility of a wife prior to the performance of an insemination so as to exclude any impediments to impregnation. It is thus recommended that the patient be subjected to the following routine examinations:

(a) Daily recording of the basal body temperature (BBT).

(b) A histological evaluation of the uterine endometrium.

(c) Culture of the menstrual flow for tuberculous bacilli.

(d) Potency test of the tubes by means of hysterosalpingography ie by an injection of radio-opaque material into the uterus and uterine tubes and subsequent X-ray examination of the organs.

(e) Cervical mucus test.

(f) Vaginal cytology.(187)

It takes 3 months to complete these tests and patients with satisfactory results are suitable candidates for AID.(188)

5.2. Timing

Ovulation(189) is a prerequisite for fertilization in the human.(190) Thus

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(186) Guttmacher (1969) De Paul LR 573.

(187) Iizuka (1971) 7th Congress of Fertility and Sterility 360.

(188) Ibid.

(189) Ovulation is that process whereby an oocyte is shed from an ovarian follicle. The female germ cells are technically oöcytes until after the second polar body has been shed. Since this event is unlikely to occur until after fertilization, there is probably, strictly speaking, no such thing as a human ovum. Cf O'Rahilly (1957) Univ of Detroit LJ 391.

(190) Ibid.

in order to achieve the greatest measure of success with AI it is important to time the insemination correctly, however there are as yet no standardised methods of predicting the precise time of ovulation. Ovulation usually occurs roughly 14 days before the next menses, but because the length of time during which the oocyte is capable of being fertilised and during which the spermatozoa in the female reproductive tract retain their fertilizing power varies between 12 hours to 48 hours at most, it is important to be able to predict the time of ovulation accurately.(191)

Certainty as regards ovulation can only be obtained by direct observation ie by laparoscopy or culdotomy, the recovery of an oocyte by washing out the uterine tubes, or the subsequent occurrence of pregnancy.(192) However in routine clinical work a doctor must rely on indirect evidence,(193) the usefulness of which, in order of decreasing value are: endometrial biopsy, basal temperature, pregnanediol assay, ovarian hyperaemia test,(194) study of cervical mucus, intermentrual spotting,(195) cytological examination of vaginal smears. No one method should be relied on.(196)

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(191) Ibid.

(192) J Jackson 'Clinical methods of determining ovulation' (1952) 169 Practitioner 151.

(193) Ibid.

(194) E J Farris Human Ovulation and Fertility (1956).

(195) N Bromberg and C Bercovici 'Occult intermenstrual bleeding about the time of ovulation' (1956) 7 Fertility & Sterility 71.

(196) H Brown 'The ovary' (1955) 6 Fertility & Sterility 475. Occult intermenstrual bleeding may be detected by a benzidine test for hemoglobin.

5.2.1. B.B.T.

Researchers have established that there is a link between the rise in the basal body temperature (BBT) and ovulation which can be used as a guide for timing AI. The rise in temperature is apparently caused by ovarian hormones in the circulation.(197) A close correlation has also been found between the rise in temperature and the time of ovulation as determined by endometrial biopsy.(198)

5.2.2. Vaginal Smears

Changes in the cellular appearance of smears taken from the vagina reflect the phases of the uterine cycle.(199) A close correlation has also been established between the vaginal smear and the BBT in that in many instances the 'ovulatory smear' was present on the day preceding the thermal shift to the low point of the curve, however in other cases this type of smear was identified on the first day of the thermal rise.(200)

The greatest drawback to the use of this method is that it requires a considerable degree of proficiency for correct interpretation of the slides.

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(197) The phases of the ovarian cycle are under the hormonal control of the pituitary gland. T Kalant et al, 'Timing of ovulation' (1956) Fertility and Sterility 57.

(198) In several hundred instances of AID all conception occurred from 2 days prior to 2 days after the low point preceding the sustained rise in BBT cf J Payne & A Skeels 'Fertility as evaluated by artificial insemination' (1954) 5 Fertility & Sterility 32.

(199) Microscope slides reveal that the more superficial cells of the vaginal epithelium cornify during the proliferative phase as a result of hormonal influence, and this is an indication of ovulation, cf Riley et al 'Use of serial vaginal smears in detecting the time of ovulation' (1955) 6 Fertility & Sterility 86.

(200) Ibid.

5.2.3. Cervical Mucus

Cyclic changes occur in the cervical secretion eg alterations in the viscosity of the cervical mucus occur during the uterine cycle and this is attributed to ovarian hormones.(201) Research has established that during the most fertile portion of the cycle the mucus is thin and profuse.(202) A test based on this fact has been devised for timing AI.(203)

It is also important to remember that semen and ovulation are not the only conditions necessary for conception, but that conditions in the cervix must also be favourable to migration of the sperm to the uterus. This in turn requires adequate estrogenic stimulation of the cervical secretion and the absence of a corpus estrogenic stimulation of the cervical secretion and the absence of a corpus luteum which inhibit this function.(204)

5.3. Techniques of Insemination

When the doctor has established the expected day of ovulation the patient should be notified to report to his office on the appointed day. The techniques are so simple that they are never done under anaesthesia and in fact the patient

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(201) M Roland 'A simple test for the determination of ovulation, estrogen activity and early pregnancy using the cervical mucus secretion' (1952) 63 Am J Obs Gynecol 81.

(202) M R Cohen, I F Stein & B M Kaye 'Optimal time for therapeutic insemination. Spinnbarkeit as the preferred criterion' (1955) 7 Fertility & Sterility 169.

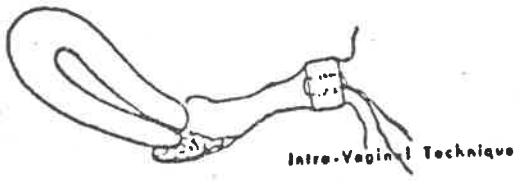
(203) The capacity of liquids to be drawn into threads (spinability) is generally called Spinnbarkeit. When the cervical mucus is profuse, thin and acellular and the Spinnbarkeit is 10 to 20cm it can be accurately predicted that ovulation will occur within the next 24 hours. Experiments have also revealed that Spinnbarkeit as a measure of ovulation timing coincides, with few exceptions, with the proper interpretation of BBT and the accurate reading of daily vaginal smears, cf E Steinberger 'Cervical aspects in sterility and infertility' (1955) 6 Fertility and Sterility 169.

(204) P Bergman 'Spermigration and cyclic changes in cervical mucus' (1953) 4 Fertility and Sterility 183.

or her husband could probably perform the insemination as successfully.(205) Most doctors perform one to four inseminations during the pre-determined ovulatory period. This increases the expense but shortens the number of months of exposure for success.(206)

The patient should be put into the lithotomy position with 15 degree Trendelenburg.(207) She is then ready for the insemination. All the instruments to be used should be ready and sterile.

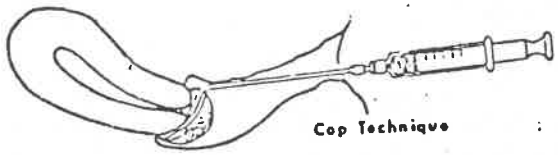
5.3.1. The intravaginal method



A cannula is inserted directly into the upper vagina without exposure of the cervix and the semen is injected into the vagina and vaginal vault.(208)

5.3.2. The paracervical method

The semen is placed in a sterile glass syringe to which a metal intravenous needle or cannula is attached. The cannula is placed loosely within the mouth of the cervix which is then sprayed with semen in spurts as would occur in normal ejaculation.(209) Alternatively the semen is placed in a small cap which is inserted into the vagina and fitted over the cervix.(210)



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(205) Self-insemination is useful in cases of defective coitus eg hypospadius, impotence or dyspareunia and is usually done by the intravaginal method cf Verkauf (1966) Houston LJ 286.

(206) Behrman & Kistner Progress in Infertility 725.

(207) Ibid.

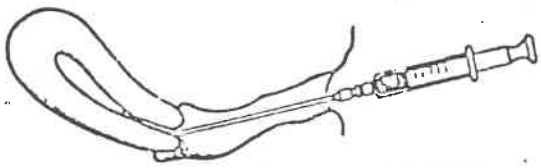
(208) G I M Swyer 'Artificial Insemination by Husband' (1960) 185 Practitioner 163.

(209) R H Boyd 'Indications for the Techniques of Artificial Insemination and Man' (1957) 50 Royal Society of Medicine Proceedings 685.

(210) Verkauf (1966) Houston LJ 286.

5.3.3. Intracervical method

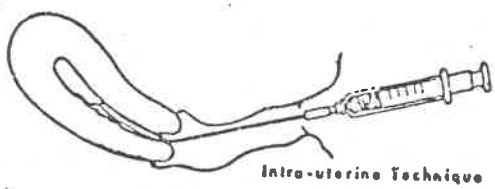
This method is sometimes used in cases of external cervical os stenosis. A cannula is inserted in the mid-portion of the cervical canal, and the semen is injected into the cervical canal below the internal os. Care should be taken to ensure that no semen enters the uterus.(211) Endometris(212) and pelvic inflammatory disease following the use of this method have been reported.(213)



Intra-cervical Technique

5.3.4. Intrauterine method

According to this method a small volume of semen is injected directly into the uterine cavity. However, this method is not often used as it is unphysiologic, since in normal coitus semen does not enter the uterine cavity, because ordinarily the sperm cells swim out of the seminal plasma into the cervical mucus. Experience of this method has shown that when the amount exceeds 0,1cc the patient develops violent uterine cramps as the uterus attempts to expel the irritating material.(214) Salpingitis(215) and uterine bleeding have also been reported following the use of this method.(216)



Intra-uterine Technique

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(211) Swyer (1960) 185 Practitioner 165.

(212) Inflammation of the mucous membrane that lines the cavity of the uterus cf Dorland.

(213) D A Goss 'Current Status of Artificial Insemination with Donor Semen' (1975) 122 American J of Obs & Gyn 246 at 248.

(214) This method should only be used when the endocervical mucus is impermeable to sperm cf S J Kleegman & S A Kaufman Infertility in Women at 62.

(215) Inflammation of the Fallopian tubes cf Dorland.

(216) Swyer (1960) 185 Practitioner 166.

In cases of AID certain authorities have suggested that the husband and wife should have intercourse subsequent to the insemination so as to give the husband a sense of participation. Alternatively a sample of his sperm should be mixed with that of the donor giving him an outside chance of fathering the child.(217)

6. Success Rate of AI

Research and clinical practise has established beyond doubt that AI is technically feasible and that it does not result in any serious complications for either the parents or the offspring, furthermore it has achieved wide acceptance amongst medical practitioners and communities throughout the world as a therapy for infertility.(218)

Having thus firmly entrenched itself it becomes important to evaluate the number of successful conceptions achieved by AI. It is generally accepted and understandable that greater success has been achieved in the use of AID than AIH because, the donor, chosen in accordance with the standards set out above, will invariably provide more effective semen.(219) When it is necessary to resort to AIH there is usually an existing barrier to conception such as the subnormal semen of the husband, however new techniques in sperm concentration and freezing which enables several ejaculates of the husband to be combined for a single insemination at a future date has raised the possibility of increased success-rates for AIH in the near future.(220)

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(217) Verkauf (1966) Houston LJ 286.

(218) Verkauf op cit 287; Guttmacher (1969) De Paul LR 575.

(219) Iizuka (1971) 7th Congress of Fertility & Sterility at 360.

(220) Verkauf (1966) Houston LJ 287.

6.1. AIH

Generally, the results reported in this category are poor.(221) If the true indications of impotence, hypospadias, cervical stenosis, or physical incompatibility are used, the results are reasonably good.(222) But where oligospermia is the indication they are invariably poor.(223) It appears that a low count is frequently accompanied by other physical and metabolic deficiencies of the sperm. In these instances the use of split ejaculate to obtain the most fertile sperm in the first portion of the ejaculate is recommended.(224)

6.1.2. Statistics(225)

Researcher	Deficiency	Results
Schultz	uterine hypoplasia	4 pregnancies out of 28 cases
Schultz	cervical lesions	3 out of 19
Payne & Skeels	Varied abnormalities	159 cases, 35% success
Whitelaw	Oligospermia	14 out of 32

6.2. AID

6.2.1. Fresh Semen

Universally good results have been obtained by a large number of practitioners most of whom achieved a success rate in excess of 60%.(226) Guttmacher

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(221) A T Gregoire & R C Mayer 'The impregnators' (1965) 16 Fertility & Sterility 130; M Pollok 'Sex and its problems. Artificial Insemination' (1967) 199 Practitioner 244. These researchers quote a success rate of about 20% with AIH but state that results are difficult to evaluate because they are in fact determined by the quality of the semen used.

(222) A success rate of up to 85% has been reported in a group with coital difficulties cf Pollok supra.

(223) Langer et al (1969) 14 Int J Fert 232 at 235.

(224) Behrman & Kistner Progress in Infertility 727, 728.

(225) As reported by A Guttmacher 'The rôle of Artificial Insemination in the Treatment of Sterility' (1960) 15 Obstetrical & Gyn Survey 767 note 55 at 779.

(226) Behrman & Kistner op cit 726 727. J O Haman 'Therapeutic donor insemination : a review of 440 cases' (1959) 90 California Med 130-3. In a series of 177 cases of AID reported a success-rate of 75,7%.

submits that 75% of women who become pregnant by AID do so within the first 6 months of treatment.(227) To illustrate this he constructed the following table(228) of the reported work of 4 investigators:

Success Rates

Researcher	Months of Treatment					
	1	2	3	4	5	6
Guttmacher		80%		90%		
Kleegman			78,2%			90,2%
Portnoy	31%	56%	71%			85%
Shields	38,5%	57,4%	74,4%	87,4%		
Langer et al(229)	19/156	45/156	54/156	19/156	4/156	8/156

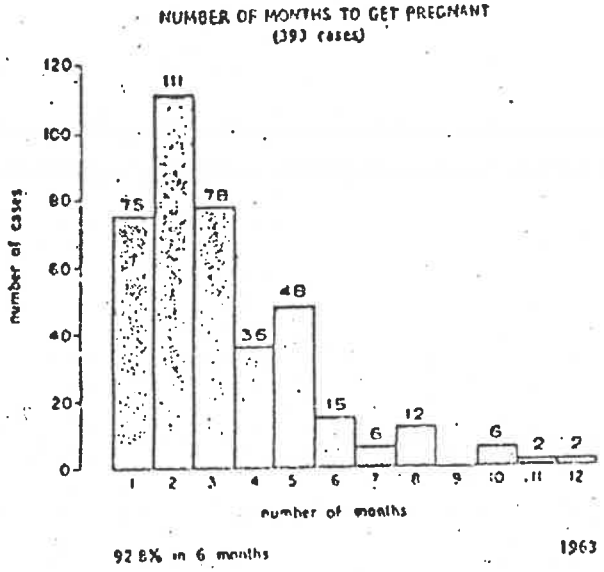


Fig 32-3. Occurrence of successful pregnancy following artificial donor insemination in 393 successful cases (From S J Behrman and J Gosling. Fundamentals of Gynecology 2d ed (1966).(230)

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(227) A F Guttmacher (1960) 15 Obst & Gyn Survey 767 note 55.

(228) Guttmacher (1960) 15 Obst & Gyn Survey 767 note 55.

(229) Langer (1969) 14 Int J Fert 235, the remainder of the 156 pregnancies occurred as follows: 5 in the eighth month, 1 in the ninth and 1 in the 10th month of AI. The average was 3,04 months trial per patient until pregnancy occurred.

(230) G Schaud 'Medical and psychological preliminaries for artificial insemination' (1971) 7th Congress Fertility & Sterility Tokyo 365 at 366, reports that he has inseminated 608 couples over a period of 5 years, producing 412 conceptions.

(Continued on the next page)

Comparative Data from 186 Artificial Insemination Pregnancies in Function of Age

Age Group	Pregnancies		Months Trial of AI		Children Living		Mean Duration of Pregnancy (Live Child)	Mean Weight of Children (Live Child)	Fertile Pregnancies			Infertile Pregnancies (Abortion, Missed Labor, etc.)
	No.	%	Primiparae	Multiparae	♂	♀			Normal Delivery	Cesarean Section	Forceps Vacuum Extraction	
							days	gm.				
20-25	28	18	2.5	2.3	12	12	269	3280	21	2	1	4
26-30	58	37	2.7	2.3	26	29	269	3210	47 1†	5 1‡	3	3
31-35	52	33	3.5	3.3	23	22	267	3370	39 2†	3	1	3
over 35	18	12	3.9	3.1	12	6	267	3150	14	4	0	0

* Pregnancy not delivered.
† Twins.
‡ Antinatal death (premature ruptured placenta).

(231)

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(230) (continued from previous page)

Total number of cases	608
Number of conceptions	412
Births (including 24 2nd births)	303
Pregnant at present	109

288 children were born after artificial insemination using fresh human spermatozoa. 15 births resulted after use of deep frozen sperm.

There was no significant change in the rate of complications during these pregnancies compared with other pregnancies (Table 2)

Table 2 Number of births after artificial insemination with fresh human spermatozoa or deep frozen sperm

Age	Births			
	Fresh human sperm		Deep frozen sperm	
	♂	♀	♂	♀
21-30	92	105	4	9
31-40	35	45	–	2
over 40	9	5	–	–
Total	288		15	

(231) Table 1 reveals the following. Eighteen per cent of the patients were 20 to 25 years old on conception, 37 per cent were 26 to 30 years old,

(continued on the next page)

For most healthy women an AI induced pregnancy passed uneventfully and the foetal results were no different from those in natural births.(232)

6.2.2. Frozen Semen

The average success rate to date using frozen semen is approximately 50% with the same number of months of exposure as for fresh semen.(233) This disadvantage is balanced by the fact that it is easier to arrange and carry out insemination with frozen semen.(234)

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(231) (continued from previous page)
33 per cent were 31 to 35 years old, and 12 per cent were in the 36 to 41 year group. As expected, fertility decreased with age: 2,5 months trial were necessary in the age group of 20 to 25; 2,7 months trial in the 26 to 30 year group; 3,5 months trial in the 31 to 35 year group, and 3,9 months trial in the 35 to 41 year group. This was only true for primipara, we found no such significant differences for the various age groups of multipara.

The number of artificial inseminations performed during the month in which pregnancy occurred varied: 32 women had only one AI, 51 women had 2 inseminations, 68 women had 3 inseminations, 4 women had 4 inseminations, and 1 woman (treated by Pergonal) experienced 3 AI, in the case by AIH. This gives an over-all average rate of 2,3 inseminations in the month in which conception took place.

(232) Haman (1959) 90 Calif Med at 130, reported a miscarriage rate of 17,9% which, according to him, is about the same as coitus induced pregnancies. Langer et al (1969) 14 Int J Fertility 236 reported that from 156 pregnancies, 142 live and healthy children were borne by 97 patients in 139 deliveries (3 being twins). Two threatened abortions went to term after treatment. Eight women suffered from slight toxemia and one from severe toxemia.

(233) H G Mutke 'Results in 41 pregnant women following heterologous insemination with semen preserved in nitrogen' (1971) 7th Congress Fertility & Sterility Tokyo 376.

(234) Behrman & Kistner Progress in Infertility 727.

The calculated life of frozen semen in the genital tract after thawing does not exceed 24 hours, consequently it is vital that the timing of ovulation should be very accurate otherwise results are likely to be very poor.(235) The preservation of semen in nitrogen also results in the selection of spermatozoa because only the best and strongest viz those required for fertilization, survive the preservation process. The inferior quality spermatozoa die or are damaged so they are unable to reach the ovum or are incapable of penetration and fertilization.(236)

The use of frozen semen is steadily increasing in line with the improving techniques of storage. Keio University School of Medicine in Tokyo reported 4 pregnancies following frozen AID in 1958, this number had grown to 103 in 1968.(237)

Breakdown of 347 patients inseminated out of 1 000 patients accepted by the Fertility Institute for at least 1 month's observation and treatment during a 5-year period (1966-1970)

AIH*	AID** alone or with AIH	Fresh semen		Frozen semen	
		AIH	AID	AIH	AID
231	116	254	77	2	65

* Husband insemination

** Donor insemination

7. Physical and Mental Development of AID Children

A study of fifty-four AID children undertaken by a team of physicians at Keio University in Tokyo revealed the following results concerning their mental and physical development:(238)

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(235) Behrman & Kistner Progress in Infertility 727.

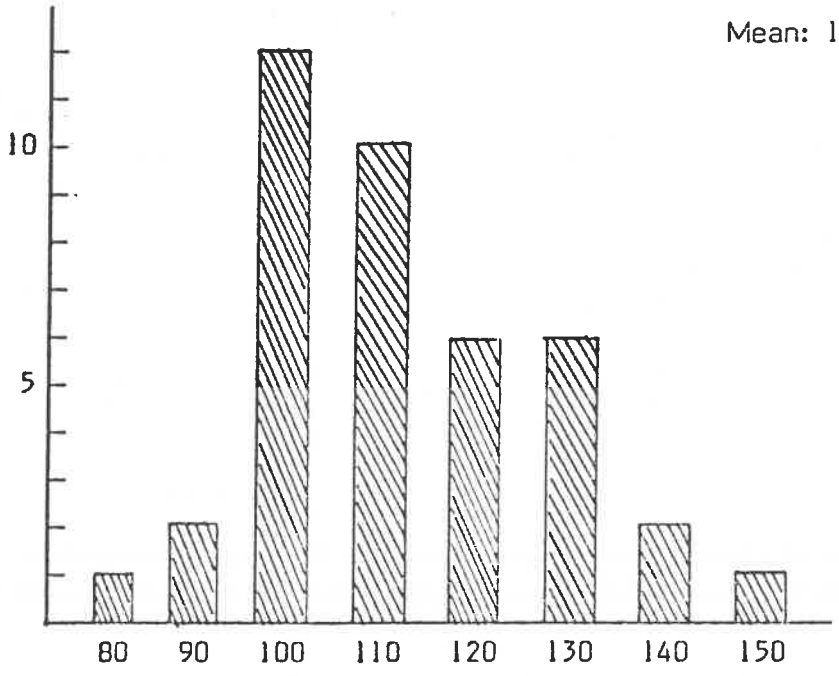
(236) Mutke (1971) 7th Congress Fertility & Sterility Tokyo 377.

(237) Iizuka (1971) 7th Congress Fertility & Sterility Tokyo 360. The semen used in 1958 had been stored for 2 to 20 days, while that in 1968 from 1 to 315 days.

(238) R Iizuka, Y Sawada, N Nishina and M Ohi 'The Physical and Mental Development of Children Born following Artificial Insemination' (1968) 13 Int J of Fertility 24.

7.1. I.Q's.

The distribution of I.Q's of the children who were 2½ years of age or older was found to be in a higher range than that of the controls, with the peak at 103 and the mean at 111,7 using Binet's method as modified by Tanaka.(239)



A Child from AID with frozen-stored Semen

Figure 1. Intelligence quotients of 40 AID children.

7.2. The physical and mental development of children born following AID was found to be in no way inferior to that of the control group resulting from natural impregnation. None of them were malformed or showed any physical retardation.(240)

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(239) R Iizuka, Y Sawada, N Nishina and M Ohi 'The Physical and Mental Development of Children Born following Artificial Insemination' (1968) 13 Int J of Fertility 27. Nine children in this series were conceived after insemination with donor semen which had been frozen to, stored at, and thawed from -79°C. All donors whose semen was used for AID at this clinic were young healthy students of the medical faculty.

(240) Iizuka et al (1968) 13 Int J of Fertility at 31. The physical development of the babies was evaluated on the basis of their body lengths, body weights, heart diseases, development of extremeties and postpartum diseases.

7.2.1. The intellectual development of children sired from frozen-stored semen was found to be in no way inferior to that of the controls.(241)

TABLE 1

Mental and Physical Development of AID Children from Frozen-Stored Semen

Name	Age	Sex	Storage-Duration	I.Q.	D.Q.	Body Weight	Body Length
			days			kg	cm
N.O.	2yr. 8 mo.	♂	4	103		12,5	89,0
A.S.	2yr. 8 mo.	♀	1	113		13,0	90,0
T.K.	4yr. 8 mo.	♀	53	116		13,1	112,3
Y.A.	1yr. 5 mo.	♀	33		108	10,5	78,0
M.S.	10 mo.	♂	11		100	8,6	71,0
S.I.	1yr. 11 mo.	♀	93		113	10,5	83,0
I.W.	1yr. 6 mo.	♀	43,6		153	9,1	76,0
N.I.	2yr. 1 mo.	♂	11,63		99	11,3	85,0
Y.M.	1yr. 6 mo.	♀	28		114	9,7	78,0

8. Critical Evaluation of AI and Semen Banks

In concluding this chapter let us make a sober and considered analysis of artificial insemination, particularly AID and its influence on human relations. The basic rationale for AI is the fact that most 'normal' married couples wish to have children and that having children usually stabilizes the marital life of spouses. There are however, many unforeseen pitfalls in establishing any new and unusual human relationship and it is advisable to view the problems of AI in their totality before we recognize its validity as a boon to mankind.

The social and legal problems arising from AID differ vastly from those involved in AIH, although the medical technique employed in both is identical.(242) However, religion and law, being conservative disciplines, were slow to view AID

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(241) Op cit 25.

(242) Behrman & Kistner Progress in Infertility 728.

in its proper perspective or to place their seal of approval on it.(243) The technique has, for example, made illicit relations to achieve a pregnancy in the marriage of a fertile wife to a sterile husband, unnecessary. The use of this therapy extends the satisfaction of raising their own children to a large number of infertile couples.

The success of this therapy viewed in its widest sense requires of the physician to select his applicants and the anonymous semen donor with the utmost care. AID is not a form of medical therapy which qualifies for assembly line medical treatment. Each case must be individualised, properly evaluated, and handled with understanding. It has been a long and tortuous journey from the legends and practices of 14th century Arabs to the laws and techniques of AID which evolved in the 20th century.(244) On the way one catches glimpses of the unfolding of man's mind and the emancipation of his spirit and now with the passage of statutes validating the practise of AI(245) and the favourable decisions of courts,(246) the law has begun to catch up with social and medical progress in this area.

8.1. Donor selection

The problem of donor selection is an important one which has given rise to some anxiety on biological grounds. Fears have been expressed that undesirable personaltiy traits or genetic defects may be passed on to a disproportionate number of progeny.(247)

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(243) Z S Bohn 'Artificial Insemination. Psychologic and Psychiatric Evaluation' (1957) 34 University of Detroit Law Journal 397 at 402.

(244) Guttmacher (1969) 18 De Paul LR 583.

(245) Georgia Code Ann. 74-101 (1964); Oklahoma Statute Ann. para 216 and Kansas 1970 Supp 23-128.

(246) People v Sorensen 437 P 2d 495, 66 Cal. Rptr 7 (1968). This decision represents the most enlightened approach to the problems posed by artificial insemination. The court relied heavily on the public policy favouring legitimacy to uphold the conviction of the husband for failure to support a child born to his wife as a result of artificial insemination.

(247) A McLaren 'Biological Aspects of AID' in (17) Ciba Foundation (1973) 3 at 6.

These fears have proved to be unfounded as reports have clearly indicated that medical practitioners using fresh semen have been most circumspect in their choice of a suitable donor,(248) while semen banks only accept deposits from men who are going to utilize this sperm to fertilize their present or future wives, or where they are going to sell sperm commercially they subject the donor and the sperm to stringent 'quality control' tests.(249)

8.2. Patient selection

A physician should exercise the greatest care and judgment before agreeing to subject an infertile couple to AI treatment, because of the potentially disasterous consequences for the child and the marriage. He should ensure that the couple's mental health and emotional status are beyond reproach, that they are mature, have a true love of children and that their marriage is stable.(250)

It is submitted that the following questions should at least be answered to the satisfaction of the physician intending to undertake the procedure:

(a) Has either party been married before?
(b) If so, why was the first marriage not a success?
(c) Why is this one different?
(d) Does the couple live harmoniously?
(e) Are both parties emotionally stable?
(f) Are the couple's finances sufficient to support the child?
(g) Is the future of the marriage based on having a child?
(h) What is the husband's attitude toward having an AID baby?
(i) What is the wife's attitude?
(j) Has the couple considered the possibility of a deformed child being born?
(k) Does the couple have a high degree of confidence in the doctor?(251)

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(248) A McLaren 'Biological Aspects of AID' in (17) Ciba Foundation (1973) 3 at 6.

(249) R Iizuka 'Frozen sperms for storage and AID' (1967) 5th World Congress of Gynaecology & Obstetrics 870.

(250) M P Warner 'Artificial Insemination' (1974) New York State Journal of Medicine 2358 at 2359.

(251) Verkauf (1966) Houston LR 283; Shapiro & Spece Bioethics & Law (1981) 492.

The physician should also by consultation and discussion with the couple ensure that they are entirely aware of the many consequences of this form of therapy. He should also refer them to an attorney for a briefing on the legal consequences of their act.(252)

8.3. Genetics and Eugenics

Criticism has been levelled at the fact that the doctor exercises a degree of positive eugenic selection, that he in fact 'plays at God', since he only uses donors who are physically and mentally sound, with a good medical record and semen of high quality.(253) He invariably introduces his own value judgments as to which personality types (for example) would make the best fathers.(254) There is however an obligation on the doctor to choose carefully, in fact, failure to do so would be regarded as negligence.(255)

However, the effect of this selection when viewed in regard to the entire population of a country would be trivial unless the numbers of AID progeny from an individual donor were to become very large.(256) Some doctors try to match the donor to the husband as closely as possible, others always inseminate with a mixture of semen from different donors, so that the actual father of any given baby is unknown.(257)

Concern has also been expressed on whether AID will ever be used in the interests of positive eugenics for the genetic improvement of mankind or to further some less reputable social or political aim.(258) It is difficult to predict the future but experts are of the opinion that such applications are unlikely to occur for the next generation or two. They argue that the principles of selective

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(252) Langer et al (1969) 14 Int J of Fert 239.
(253) McLaren (17) Ciba Foundation (1973) 3 at 7.
(254) Guttmacher (1960) 15 Obst & Gyn Survey 570 572.
(255) See chapter 4 infra.
(256) McLaren ibid.
(257) McLaren ibid.
(258) McLaren ibid.

breeding have been known for centuries, but no serious attempt has ever been made to apply them to our own species.(259)

8.4. Physical abnormalities

Fears that were raised in this regard have been allayed by statistics showing that the figures are in fact lower for AID children than for normal births.(260) This is to be expected however when one realizes that two significant factors in the etiology of abnormalities and abortions are being eradicated by this procedure viz the insemination is done with tested, highly fertile sperm as compared with the average sperm count, furthermore, it takes place at the optimum time before aging of the ovum becomes a factor.(261)

8.5. Incest(262)

Concern has been expressed as to the possibility that AID conceived children from the same donor, and who were therefore half-brothers and half-sisters, might unwittingly marry and have children.(263) The progeny of first-cousin marriages show a higher than normal mortality and malformation rate; half-brothers and half-sisters are more closely related genetically than are first cousins, so their children would be at a still greater disadvantage.(264) However, even in normal circumstances a certain number of half-sibling marriages must take place unwittingly as a result of extra-marital conceptions, and any increase

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(259) H J Muller 'Genetical Progress by voluntarily conducted germinal choice' in Man and his Future Ciba Foundation (1963) submits that a system of positive eugenics via AID should be embarked on in an effort to improve the quality of the human race. Conversely, however, P B Medawar 'The genetic improvement of man' (1969) 4 Austr Annals of Medicine 317-320, submits that '... the human genetic system does not lend itself to improvement by selective inbreeding ...'.

(260) Behrman & Kistner Progress in Infertility 728.

(261) Ibid.

(262) See also chapter 5 infra.

(263) McLaren (17) Ciba Foundation (1973) 3 at 7.

(264) Ibid ; see also Shapiro & Spece Bioethics & Law (1981) 459.

in their number due to AID could be expected to be very small provided that the number of babies fathered by a single donor remained small.(265) In this way the risks of incestuous marriage are minimised in addition to avoiding any demographically undesirable effects of donor selection.(266)

8.6. Future scope of AID

There is little doubt that the incidence of AID will continue to increase, the rate of increase will however, depend upon the following factors:(267)

(i) The number of suitable couples

(ii) The availability of suitable semen

(iii) The extent to which the practice is publicised and officially recognised.

8.6.1. The number of suitable couples

Since the primary reason for AID is that the husband is infertile, the number of cases where AID is undertaken depends to a certain extent on the number of marriages where the husband is infertile.(268)

In considering whether the actual number of cases of AID is likely to approach the estimated total number of possible cases it is necessary to bear the following factors in mind:(269)

(i) the number of people who are involuntarily infertile and do nothing about it;

(ii) the many who object on principle to AID; and

(iii) those who accept AID but do not know how to obtain it.

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(265) H J Muller 'Human Evolution by voluntary choice of germ plasma' (1961) 134 Science 643.

(266) Ibid.

(267) Feversham Report 17.

(268) See statistics supra at pages 15 & 16.

(269) Feversham Report 18. The attitude of the public to AID and infertility has undergone a radical change since the beginning of the century when it was tended to be regarded as a God-given affliction, a stigma or punishment. With a more enlightened attitude to AID now prevailing, more and more people are turning to medical science for treatment.

8.6.2. The availability of donated semen

The ease and frequency of AID is rapidly moving into a new era with the advent of technology providing for freezing and preserving semen. Conversely the availability of donors as well as the number of couples considered suitable for AID depends to a large extent on the standards adopted, which must of necessity be high.(270)

8.6.3. Publicity and Official Recognition

The more widely AID is publicised the more infertile couples approach practitioners to attempt to relieve their problem by means of this therapy.(271) There are however still large sections of the medical profession especially in the Catholic countries who disapprove of this therapy on religious and ethical convictions.(272)

Most governments and legislatures have adopted a wait and see attitude to AI, neither encouraging nor discouraging this phenomena.(273) I submit that AID and embryo transplantation have reached the stage where they have proved themselves as viable and acceptable therapies for infertility(274) and that the legislature should amend the law so as to regulate and place its seal of approval on these methods.(275) This would in turn encourage many of the doctors who are hesitant to embark on AID to pursue it as a treatment, and it would also encourage a greater number of suitable donors to offer their services.(276)

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(270) Feversham Report 18.

(271) op cit 19.

(272) Guttmacher (1969) 18 De Paul LR 578.

(273) H S Chandler 'A Legislative Approach to Artificial Insemination' (1968) 53 Cornell Law Review 497 at 509.

(274) Verkauf (1966) Houston LR 307.

(275) Draft Child Care Bill (28 October 1981) 7864 Government Gazette section 39 page 28.

(276) Verkauf (1966) Houston LR 307.

8.7. Future of AI

The present state of the law is such that there is a good deal of uncertainty regarding the legitimacy of an AID child.(277) There are however a number of simple ploys to avoid an antiquated law which is many years behind sociological and scientific progress.(278) A far more practical and honest solution to the problem is to be found in Weinberger's(279) words:

> 'The future of artificial insemination is in the hands of the state legislatures, who must take their cue from the will of the people. But with its facilities for finding and evaluating facts, the legislature today should be as much a molder of public opinion as it is a follower, especially in a field as new as this one. Intelligent legislative action is needed for the control and social adjustment of artificial insemination. The legal status of the child should be determined by legislation and the practice carefully controlled so that all children will be healthy, intelligent and born into a family ready and able to raise them to be happy, well adjusted, and socially responsible citizens.'

8.8. Semen Banks

Deep freezing of semen is a tried, tested and successful technique in the sphere of animal husbandry, where commercial interest in the animal breeding industry stimulated extensive research which led to scientists perfecting the frozen-storage of bull spermatozoa.(280)

The concept of semen-banks for preserving human semen has taken longer to become accepted by society and with the initial lack of commercial stimulation of research it also took longer to perfect the freezing and preservation techniques.(281)

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(277) R L Slagle 'Artificial Insemination' (1969) 23 Arkansas Law Review 81 at 89.

(278) E L Sagall 'Artificial Insemination : Legality Considerations' (1972) Medical Counterpoint 55.

(279) As quoted by Behrman & Kistner Progress in Infertility at 722.

(280) J K Sherman 'Improved Methods of preservation of human spermatazoa by freezing and freeze-drying' (1963) 14 Fert Steril 49 at 53. Over 6 million calves are produced in the U.S. each year through the use of frozen-stored semen. Some semen has produced calves after more than 19 years of frozen-storage.

(281) Mark S Frankel 'Role of Semen Cryobanking' (1974) 220 American Medical Association 619. It was not until 1949 that it was discovered that the use of a small amount of glycerol before freezing enhanced the survival rate of the spermatozoa. In 1953 Dr Jerome Sherman at the University of Arkansas, using dry ice as a freezing agent, reported the first human pregnancy with

(continued on the next page)

The improved preservation and freezing techniques led to increased fertility percentages and this factor combined with the rising popularity of vasectomy as a means of birth control encouraged the frozen storage of semen. Private physicians, fertility clinics and university hospitals began to store frozen semen for research as well as for use with wives of infertile husbands and they in turn started charging fees for performing artificial insemination with the frozen sperm.(282)

The introduction of a commercial element into artificial insemination led to the establishment of the first commercial semen banks in the late 60's and early 70's in the major metropolitan areas of the U.S.(283)

8.8.1. Potential Hazards

Fertility followed by the birth of normal progeny is the key to the success of human semen banking, it is in fact the essential ingredient for the future of this type of venture.(284)

There has however, been a certain degree of scepticism about whether frozen semen retains 100% fertility or whether it suffers cryoinjury and accelerated loss of function such as motility and metabolic activity, as compared with unfrozen cells.(285)

Sherman submits that the reduced per cent fertility may be minimised by more precise timing of insemination relative to ovulation and/or by modification of the insemination technique to compensate for latent cryoinjury and its deleterious consequences which are manifested with time after thawing.(286) Sherman

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(281) (continued from the previous page)
frozen sperm. In 1969 the preservation technique was greatly improved by the utilization of liquid nitrogen at -196,5°C as a means of freezing.

(282) L Carlborg 'Some Problems Involved in Freezing and Insemination with Human Sperm' Current Problems in Fertility (1971) at 23.

(283) Frankel op cit 619; Kouler (1976) 45 Harper's Weekly 3169.

(284) Sherman (1973) 24 Fert. Steril. 408.

(285) J K Sherman 'Freeze-thaw-induced latent injury in cryobiology' (1967) 3 Cryobiology 407.

(286) There is a reduction in survival (motility) of frozen-stored spermatozoa in the cervical mucus from 48 to 24 hours as compared to unfrozen controls,

(continued on the next page)

is also of the opinion that a reduced rate of fertility is not necessarily a bad thing as the weakest sperm cells are destroyed first and in fact the strongest cells survive.(287)

8.8.2. Precautions

A prospective depositor of frozen semen whose intention it is to obtain 'fatherhood insurance' after a vasectomy in this way, should be warned of the hazards by the semen bank. It would also be advisable for anyone undergoing a vasectomy solely because of the prospect of 'fatherhood insurance' via frozen semen to discuss all the ramifications of his action with his physician before taking this serious step, especially in view of the 'no guarantee' clause which all semen banks impose on their clients.(288)

The rapid growth of commercial semen banks in the U.S. has led to improved storage techniques and has provided the impetus and foundation for gathering the details necessary to formulate tabular predictions of percentage possibilities of fertility after certain storage intervals.(289)

In order to instil greater public confidence in human semen banking requests have been made to governmental health agencies to exercise a system of control by way of licensing, to ensure that semen banks maintain the strictest standards in relation to technical materials, methods and business practices.(290)

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(286) (continued from previous page)
cf L Carlborg 'Some Problems involved in freezing and insemination with human sperm' in Current Problems in Fertility edited by A Ingelman-Sundberg & A Lunell (1971) 23.

(287) J K Sherman 'Long-term cryopreservation of motility and fertility of human spermatozoa' (1972) Cryobiology 332.

(288) Sherman op cit 409.

(289) Sherman (1972) 9 Cryobiology 332.

(290) op cit 410.

8.8.3. Potential Benefits

The security of governmental control of human semen banking would allay the fears of those members of the public who are as yet still dubious about this practice. Public confidence is vital to the success of the commercial semen banks to whom large scale support is essential if they are to survive and conduct the research which is necessary to perfect this operation.(291)

It is submitted that human semen cryobanks are an important instrument in reducing the awesome consequences of overpopulation because males can confidently undergo vasectomy after having made a deposit in such a bank thereby ensuring their continued fertility. They can also contribute to raising the genetic and health standards of a community and a country, and assist in fostering research in allied areas of human reproduction.(293)

9. Conclusion

The number of pregnancies resulting from AID are increasing at an encouraging rate and even the lower success-rate in AIH justifies attempting the procedure. From a medical point of view one can thus assume that AI is in certain circumstances a useful therapeutic measure and in fact, it is only as such that AI is presently advocated by the vast majority of physicians. It is the belief of these physicians that couples who want to rear a child who is the biological child of at least the wife and who want to experience as husband and wife a period of pregnancy, should be given this opportunity. When employed in this way AI becomes a therapeutic means of circumventing what is either a diseased or abnormal physiological condition while simultaneously satisfying parental desires.(294)

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(291) Sherman (1972) 9 Cryobiology 332.

(292) G Wolstenholme Ed Man and His Future (1963) at 263 264.

(293) H J Muller 'Genetic Progress by Voluntarily Conducted Germinal Choice' in Man and His Future (1963) at 247.

(294) Verkauf (1966) Houston LR 289.

The progress of medical science, while it continually opens up new problems, can also contribute to solutions which accord with the dignity of man and which display absolute respect for the human personality.(295)

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(295) O'Rahilly (1957) 34 Univ of Detroit LJ 396.

CHAPTER 3

CONSENT

1. General requirements regarding consent to medical treatment

The legal relationship between a doctor and a patient is based on consent.(1) The necessity for a doctor to obtain a comprehensive, informed and a clear unequivocal consent before initiating treatment is nowhere more essential than before embarking upon fertility therapy by means of AID or ET.(2) Failure on the part of the doctor to obtain the necessary consent from all the parties involved exposes him to litigation at the instance of a party whose consent had not been timeously solicited, because his acts would then be unjustified.(3)

It is not sufficient for the doctor to merely obtain a consent from the spouses to AID or ET, their consent should have been obtained in the light of a knowledge and appreciation(4) of the risks involved eg that the AID or ET might fail to conceive a child, or that it might be necessary to abort the foetus because it is defective.(5) The spouses must furthermore have voluntarily consented to the risks implicit in the doctor's AID or ET treatment.(6)

In order to ensure that the consent given by the spouses to AID or ET therapy is an informed consent, it is submitted that the doctor concerned achieves this by a two step procedure viz:

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(1) S A Strauss Doctor, Patient and the Law (1980) 6.

(2) Jeffrey M Shaman 'Legal Aspects of Artificial Insemination' (1979/1980) 18 Journal of Family Law 331 at 348.

(3) S A Strauss & M J Strydom Die Suid-Afrikaanse Geneeskundige Reg (1967) 186; Strauss Doctor, Patient and the Law (1980) 148.

(4) Esterhuizen v Administrator, Transvaal 1957 (3) SA 710 (T); Dean I Scaletta, 'Informed Consent and Medical Malpractice : Where Do We Go From Here' (1980) 10 Manitoba Law Journal 289 at 293.

(5) Paula D Turner 'Love's Labor Lost : Legal and Ethical Implications in Artificial Human Procreation' (1981) 58 Journal of Urban Law 459 at 479.

(6) Waring & Gillow v Sherbourne 1904 TS 340 at 344.

The first part would constitute a written consent form which would contain the following information:

(i) a statement of purpose

(ii) procedures

(iii) risks involved

(iv) discomforts

(v) alternatives and rights.

The second part, it is submitted, should consist of a short list of questions based on the information contained in the first part with the objective of checking how well the prospective patient understood the information expressed there.(7)

2. Legislative Requirements in regard to Consent

The legal position regarding AID is still somewhat uncertain in South Africa particularly in regard to the precise requirements for consent. In order to obtain clarity on the issue we must refer to the Anatomical Donations and Post Mortem Examinations Act(8) which controls the transplantation of gonads.(9) Section 7(1) of the Act stipulates that the use of 'any gonad so removed' in the body of another person, other than a spouse, shall be unlawful where such use may result in procreation, unless the Minister of Health has consented thereto.

The question now arises as to whether these provisions have effectively prohibited AID and ET. It is submitted that as far as AID is concerned that the removal of semen from the body of the donor, is not performed by a medical practitioner as envisaged by section 7 of the Act.(10) The semen is normally obtained from the donor by masturbation and this it is submitted does not amount to 'removal' by a doctor as envisaged by section 7(1).(11)

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(7) David A Sergeant 'The Legal Status of Artificial Insemination : A Need for Policy Formulation' (1970) 19 Drake Law Review 409 at 434.

(8) Act No 24 of 1970.

(9) A gonad is defined as '... the human tissue or group of germinal cells essential for the reproduction of the species'.

(10) Strauss Doctor, Patient and the Law (1980) 147.

(11) Steyn J in V v R 1979 (3) SA 1006 (T) at 1009F held that s 7(1) was not applicable to AID, because the semen used for AID was not '... removed by a medical practitioner'. See also J D van der Vyver (1980) THRHR 89 at 91.

As far as in vitro fertilization and ET is concerned, it is submitted that as long as the embryo, which is removed from the wife and fertilised in vitro, is transplanted back into her own uterus, the provisions of section 7(1) & (2) are likewise not applicable. However, any situation in which the embryo is fertilised in vitro and implanted into a woman other than the owner thereof is prohibited by section 7(1) unless prior consent is obtained from the Minister of Health in writing.(12)

2.1. Comparative study of consent requirements in other legislations

2.1.1. The United States

Although the technique of AID has been practised in the U.S. for more than fifty years and has resulted in the birth of a significant number of children,(13) there has been a paucity of legislation on the legal issues involved. However a common proviso stipulated in all the statutes that have been passed is the requirement of written consent on the part of the husband and wife concerned.

Bills concerning AID had been introduced in seven states since 1945 but the first successful enactment only occurred in 1967 when the Oklahoma legislature(14) legalised the practice of AID, legitimated the children so conceived, and established minimum procedural controls over the practice of AID.

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(12) Strauss Doctor, Patient and the Law (1980) 147.

(13) It has been estimated that at least 250 000 children have been conceived this way at the rate of between 6 000 to 10 000 per annum cf Robert C Black 'Legal Problems of Surrogate Motherhood' (1981) 16 New England Law Review 373 at 375.

(14) Okla Stat Ann tit 10 paras 551-53 (Supp 1967)

'The Oklahoma statute provides:

s 551. Authorization

The technique of heterologous artificial insemination may be performed in this State by persons duly authorised to practice medicine at the request and with the consent in writing of the husband and wife desiring the utilization of such technique for the purpose of conceiving a child or children.

s 552 Status of child

Any child or children born as the result thereof shall be considered at law in all respects the same as a naturally conceived legitimate child of the husband and wife so requesting and consenting to the use of such technique.

(continued on the next page)

The legislation passed by the state of North Carolina[15] stipulated that any child born to a married woman as a result of donor insemination would be legitimate if both the husband and wife, in writing, request and consent to the use of such technique.

The Georgia statute[16] of 1973 stressed the legitimacy of AID children as well as the requisite of written consent by the husband and wife. The most

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(14) (continued from previous page)

s 553. Persons authorized - Consent

No person shall perform the technique of heterologous artificial insemination unless currently licensed to practice medicine in this State, and then only at the request and with the written consent of the husband and wife desiring the utilization of such technique. The said consent shall be executed and acknowledged by both the husband and wife and the person who is to perform the technique, and the judge having jurisdiction over adoption of children, and an original thereof shall be filed under the same rules as adoption papers. The written consent so filed shall not be open to the general public, and the information contained therein may be released only to the persons executing such consent, or to persons having a legitimate interest therein as evidenced by a specific court order.' (My underlining).

(15) North Carolina General Statutes, Section 49A-1 (1971)

'Any child or children born as the result of heterologous artificial insemination shall be considered at law in all respects the same as a naturally conceived legitimate child of the husband and wife requesting and consenting in writing to the use of such technique.' (My underlining)

(16) Georgia Code s 74-101.1 (1969)

'(a) All children born within wedlock, or within the usual period of gestation thereafter, who have been conceived by the means of artificial insemination, are irrebuttably presumed legitimate if both the husband and wife consent in writing to the use and administration of artificial insemination.

(b) Physicians and surgeons licensed to practice medicine in accordance with and under the provisions of Chapter 84-9 shall be the only persons authorised to administer or perform artificial insemination upon any female human being. Any other person or persons who shall attempt to administer or perform, or who shall actually administer or perform, artificial insemination upon any female human being shall be guilty of a felony, and on conviction therefor shall be punished by imprisonment in the penitentiary for not less than one year nor more than five years.

(c) Any physician or surgeon who shall obtain written authorization signed by both the husband and wife authorizing him to perform or administer artificial insemination shall be relieved of civil liability to the husband and wife or to any child conceived by artificial insemination for the result or results of said artificial insemination: Provided, however, the written authorization provided for herein shall not relieve any physician or surgeon from any civil liability arising from his or her own negligent administration or performance of artificial insemination. (My underlining)

significant contribution of the Kansas statute[17] is that it makes specific provision for the retroactive legitimacy of AID children.

2.1.2. The United Kingdom

There is no legislation in England which prohibits AID or which prescribes any formalities which must be adhered to. The whole question including the necessary consent must therefore be regulated by the principles of common law or by related statutes. AID would be deemed to be medical treatment and as such would require the consent of the recipient-patient. Since 1969 it would appear that any woman over the age of 16 can validly consent.[18] If a wife

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(17) Kansas Statutes s 23-128 (1969) -

'The technique of heterologous artificial insemination may be performed in this state at the request and with the consent in writing of the husband and wife desiring the utilization of such technique for the purpose of conceiving a child or children.'

Kansas Statutes s 23-129

'Any child or children heretofore or hereafter born as the result of heterologous artificial insemination shall be considered at law in all respects the same as a naturally conceived child of the husband and wife so requesting and consenting to the use of such technique.'

Kansas Statutes s 23-130

'After the effective date of this act the consent provided for in this act shall be executed and acknowledged by both the husband and wife and the person who is to perform the technique, and an original thereof may be filed under the same rules as adoption papers in the probate court of the county in which such husband and wife reside. The written consent so filed shall not be open to the general public, and the information contained therein may be released only to the persons executing such consent, or to persons having a legitimate interest therein as evidenced by a specific court order.' (My underlining)

(18) See s 8 Family Reform Act 1969:

'The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.'

underwent such treatment without her husband's consent and he objected, it is likely that a court would consider this to be an irretrievable breakdown of the marriage and grant him a divorce.(19)

2.1.3. France

There is at present no law which forbids artificial insemination or its practice in France, in fact the French Civil Code ignores artificial insemination.(20) Artificial insemination can, for legal purposes, be deemed to be a medical contract which has consequences for the parties concerned within the fields of criminal and civil law. However, because of the paucity of legislation and precedent, lawyers are forced to resort to legal principles to evaluate medical responsibility and the effects of AID on the law of affiliation.(21)

If AID is treated as a contract then according to the principles of contract the consent of the spouses is required,(22) and this in turn raises the problem of whether the parties concerned have the necessary legal capacity to enter into a contract.(23)

2.1.4. Germany

There is no legislation in Germany which forbids artificial insemination, however it is also an established fact that the law will not sanction an immoral act, thus where a conflict exists between justice and morality it will be resolved by referring to the existing standards of morality in the country.(24)

Art 1(1) of the Grundgesetz reads as follows:

'The dignity of man shall be inviolable. To respect and protect it shall be the duty of all state authority.'

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(19) O M Stone Ciba Foundation (1973) 69.

(20) M Revillard Ciba Foundation (1973) 80.

(21) Ibid.

(22) The consent of the wife in particular is essential to guard against an allegation of indecent behaviour with constraints or voluntary constraint with malice aforethought see M T Thelin 'Insémination artificielle' (1947) Annales de Médecine Légale 209-216.

(23) Schellen Artificial Insemination in the Human (1957) 327-28.

(24) Schellen Artificial Insemination in the Human (1957) 329.

Arguments have been advanced that artificial insemination is incompatible[25] with this legal injunction, but there is at present no firm ruling either way on the above submission.

Art 6(1) of the Grundgesetz states that:

'Marriage and family shall enjoy the special protection of the state.'

Again it has been submitted that this article can be interpreted so as to apply to AID[26] viz to the effect that AID constitutes an act which infringes the sanctity of a marriage and that no-one can perform an AID without the sanction of the State.

To sum up thus it is submitted that in the absence of any clear-cut legislation or judicial decisions on the above mentioned articles in the Grundgesetz that the parties involved in AID viz the spouses and the physician do not require the consent of the State before proceeding with the AID; however if AID is performed without the consent of both the husband and the wife it can give rise to a number of actions.

A physician who inseminates a wife without her husband's consent thereby infringes the family honour and pride, of which the husband as the protector, can bring an action for damages. He can also bring an action for divorce against his wife whose unilateral conduct constitutes a serious breach of matrimonial fidelity.[27]

2.1.5. Netherlands

The Dutch Code is not specific concerning the requirements or implications of AID except in regard to disputes concerning the legitimacy of the child.[28]

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(25) Schellen Artificial Insemination in the Human (1957) 329.

(26) Ibid.

(27) Diemer v Solomon 1982 (4) SA 13 (CPD) at 14.

(28) C Asser Personen - En Familierecht Deel 1 10th ed (1974) at 72-73; A G Chloros The Reform of Family Law in Europe (1978) 33.

However in terms of accepted legal principles the consent of both spouses is absolutely essential. Lack of consent can give rise to grounds for divorce.(29)

2.2. Consent of the Various Parties Concerned in the AID

2.2.1. Consent of the Wife and her Husband

In order to evaluate the acceptability of AID one must seek a guiding norm between the two extremes which it poses viz that on the one hand AID has been introduced as a solution(30) to the very real human problem of providing a child to a married couple where the husband is sterile,(31) while on the other hand this very solution creates the problem of the wife receiving the seed of a person other than her husband.(32)

It is thus clear that in the light of the latter submission, despite the fact that there are no specific legislative requirements in South African law which require the husband's consent,(33) it is essential to obtain both the husband and wife's consent, preferably in writing. Consent by a husband amounts to more than the mere approval of his wife being subjected to the AID procedure, it strongly implies a willingness on the part of the husband to accept the child as his own and to support and educate such child as though he were the true father. Failure to do so, it is submitted, would render the wife subject to an action for divorce on the ground that her unilateral act amounted to a gross

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(29) R Dierkens 'Artificiele Filiatie' (1979) Nederlandse Juristenblad 367 at 376-377.

(30) Until AID was introduced there was no means other than adultery, whereby the wife could bear her own child, with the result that the couple were doomed to live with their childlessness which often imposed a very great strain on the marriage. See also Feversham Report op. cit 38.

(31) Feversham Report 35.

(32) This to many people is precisely the decisive argument against AID viz that it goes against the essential nature of a marriage despite the fact that its effects are wholly good. Cf G P R Tallin 'Artificial Insemination' (1956) 34 Canadian Bar Review 166 at 178.

(33) Section 39(1) of the Draft Child Care Bill (28 October 1981) 7864 Government Gazette stipulates that an AID child will only be regarded as being legitimate if both the husband and wife consented to the insemination.

breach of the marriage contract, which is par excellance one of uberrimae fides, and that consequently there had been an irretrievable breakdown of the marriage.(34)

The written consent of the recipient wife and her husband are naturally essential and the following forms recommended by the Legal Division of the American Medical Association appear to cover all eventualities:

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(34) S 3 & 4. The Divorce Act No 70/1979 and H R Hahlo and J D Sinclair The Reform of the South African Law of Divorce (1980) at 22:

> 'In the result, irretrievable breakdown of the marriage may be proved in South Africa in one of two ways: by evidence of one of the factual situations set out in s 4(2) in the guidelines under (a), (b) or (c); or by evidence of any other facts or circumstances indicative of marriage breakdown'. (My underlining)

R Dierkens 'Artificiele Filiatie' (1979) Nederlandse Juristenblad 367 at 377; O M Stone 'English Law in relation to AID and embryo transfer' in (1973) 17 Ciba Foundation at 70.

'The undersigned _____ (hereinafter referred to as the husband), and _____ (hereinafter referred to as the wife), both being of legal age, represent that they were married on _____, 19__, at _____ and that they have continuously cohabited together as husband and wife since the aforementioned date. The undersigned authorize Dr _____ (hereinafter referred to as the physician), and such assistants as he may assign, to inseminate the wife artificially subject to the following conditions and agreements:

1. The insemination may be repeated at times recommended by the physician until the wife becomes pregnant.

2a. The physician shall use only semen collected from the husband.

2b. The physician shall use pooled semen from the husband and a donor or donors whose name or names shall not be required to be disclosed to the husband and the wife.

2c. The physician shall use semen of a donor or donors whose name or names shall not be required to be disclosed to the husband and the wife.

3. The husband and wife agree to co-operate fully with the physician in all phases of this procedure and never to seek to discover the identity of any unknown donor or donors.

4. The husband and wife have been fully informed by the physician of the hazards, risk, and possible consequences involved, and nevertheless, individually and jointly, agree to hold the physician and such assistants whose services he may utilize, the donor or donors, free and harmless of any injury or complications whatever which may result directly or indirectly from any treatment or artificial insemination performed pursuant to this agreement.(35)

Signed _____(husband)

Signed _____(wife)

Date _____

Witness _____

Accepted _____ M.D.

Use applicable paragraph under section 2. Paragraphs 3 & 4 would also be altered in cases where husband is the donor.

Should the wife however decide to take the chance and consent to an AID unilaterally without obtaining her husband's consent(36) then the validity of her

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(35) It is submitted that this exemption clause is unnecessarily wide because as it reads now it would exempt the physician for negligent application of AID. This is surely not the spouses' intention.

(36) It is submitted however that it would constitute a breach of medical ethics for a doctor to provide a married woman with his services for an AID without obtaining her husband's written consent cf Strauss Doctor, Patient and the Law (1980) 148.

consent would hinge purely on her legal capacity. The fact that she was married subject to her husband's marital power would not inhibit her capacity to consent to what amounts to a form of medical treatment.

> 'An operation on her requires her consent while her husband's consent is not essential'.(37)

Marriage confers the status and capacity of majority on a minor(38) so a 16 year old wife would have the required capacity to consent to an AID, and, although it is submitted that medical practitioners should not provide AID for single women, in terms of section 20(8A) of the Children's Act(39) an 18 year old girl would have the capacity to consent to such therapy.

> 'Notwithstanding any rule of law to the contrary, any person over the age of eighteen years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon, or any medical treatment of, himself.'(40)

2.2.2. Donor's and Donor's wife's consent

Because of the nature of collecting the semen for AID, viz the fact that the donor contributes the semen after masturbation, it is difficult to conceive that a donor will donate other than freely and with his consent, except where his semen has been obtained by fraudulent or deceitful means eg where an individual has made semen available to a doctor for medical tests and that doctor then uses it for AID.

Semen banks in countries like the United States facilitate the practice of AID because of the ready availability and access to semen. Where these facilities are not available the donor must be ready to produce semen by masturbation not more than three or four hours before the insemination is to be performed and to deliver it to the doctor's rooms.(41)

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(37) Hahlo The S A Law of Husband & Wife 4th ed (1975) 154 and Palmer v Palmer 1955 (3) SA 56 (O) at 59.

(38) Hahlo op cit 107.

(39) Act No 33 of 1960, this section was inserted by s 1(b) of Act No 43 of 1976.

(40) Section 20(8A) Act No 33 of 1960. (My emphasis).

(41) M Curie-Cohen, L Luttrell & S Shapiro 'Current Practice of Artificial Insemination by Donor in the United States' (1979) 300 New England J Medicine 585 at 586.

It would appear that the policy amongst doctors in South Africa is not to pay donors for their semen,(42) but merely to ensure by way of a small disbursement, that their expenses have been covered. The reason for this policy is to exclude undesirable persons who are only doing it for the money, and because it may amount to a criminal offence, unless the sperm bank is an 'authorised institution' in terms of the Anatomical Donations Act.(43)

2.2.2.1. Documentation of donor's consent

Despite the fact that it is virtually impossible for a person to donate his semen without consent, however see supra, it is advisable for the physician to acquire this consent in writing. The reason for this is that a donor could subsequently simulate ignorance as to the use of his semen and bring an action against the physician for using his semen for a purpose which he did not authorize.

It is therefore submitted that the semen donor should sign one of the following documents or a similar document, in order to absolve the physician and the recipient of his sperm of any form of liability:

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(42) See 'Suggested Code of Practice for Artificial Insemination by Donor' (8 November 1980) S A Medical Journal 781 at 782.

(43) Strauss Doctor, Patient and the Law (1980) 148.

Donor of Semen

'To Dr. : 1. I hereby offer my services as a donor of semen with the understanding that if I am accepted in this capacity you shall not reveal my identity to any recipient nor shall the identity of any recipient be disclosed to me, except as may be required by legal or judicial process.

2. I represent that to the best of my knowledge and belief I was born of exclusively _____ ancestry, that my religion is _____ and that the nationality of my ancestry is predominantly _____.

3. I represent that I am in good health, that I have no communicable disease, that I am not now nor have I ever suffered from any physical impairment or disability, whether inherited or as a result of any disease or ailment, except as follows: _____.

4. I represent that I am not now nor have I ever been afflicted with syphilis or any other venereal disease, nor any mental ailment or emotional disturbance, except as follows: _____.

5. I represent further that none of my grandparents, parents, brothers or sisters, if any, children, if any, nor their lineal descendants, have, to the best of my knowledge and belief, ever been afflicted with insanity or mental illness or any inherited physical disabilities or disease, except as follows: _____.

6. For the purposes of determining whether I am acceptable as a donor of semen, I hereby consent to a physical examination of myself by you or any other physician whom you may designate, and the taking of any blood or any other body fluid as may be required for laboratory examination.

I hereby swear that all of the representations made by me in the foregoing paragraphs are true and correct.(44)

Signed _____

Witness _____

Date _____

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(44) Neal Weinstock 'Artificial Insemination - The Problem and the Solution' (1971) 5 Family Law Quarterly 369 at 400-401.

AGREEMENT - SEMEN DONOR

WHEREAS:

I, _____, have been given the opportunity to donate my semen for the purpose of artificial insemination of a woman whose identity is unkown to me, and would wish to have protection of my interests and those of all concerned:

THEREFORE:

1. I acknowledge that I understand the purpose of such artificial insemination is to produce a child or children.

2. I acknowledge that I do not expect to have divulged to me the identity of the said woman, her husband, or of the child or children who may be produced as the result of such insemination, nor do I expect to learn whether such insemination(s) do indeed result in the birth of a child or children.

3. I agree not to seek out the identity of the said child or children, nor of either of the parents.

4. I understand that no consideration will be given to the religion of either the donor or the recipient.

5. I take full responsibility for any decision to inform any of my own relatives of this semen donation and its purpose, or to withold such information, and full responsibility for any actual or alleged effects that this donation may have on any of them, with the understanding that my identity will not be divulged to the woman or women inseminated by my semen, nor to her marital partner, nor to any child or children conceived by such insemination(s). In fact, I donate my semen with the agreement that the doctor who is responsible for this collection undertakes to keep my identity confidential and unknown to anyone except those directly involved in the collection.

6. I agree to submit to a standard physical examination and to any tests which are explained to me for the detection of any inheritable disease or other defect, and to supply true and full answers to the said doctor in connection with questions bearing upon heritable or communicable diseases in myself or relatives, or risk thereof. It is my understanding that such information will be treated in confidence, and not linked to my identity in any documents outside the confidential files of the doctor responsible for the semen collection.

7. It has been explained that any financial or other compensation I may receive will be restricted to considerations such as the expenditure of my time, loss or income or travel expense caused by my donation.(45)

WHEREFORE:

The donor and doctor have hereto set their hands and seals this _____day of _____19__.

Donor _____

Place _____ Doctor _____

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(45) P Creighton Artificial Insemination by Donor (1977) at 66.

2.2.2.2. Donor's wife's consent

'Marriage does not make husband and wife one in law ... but it creates a physical, moral and spiritual community of life, a consortium omnis vitae .... Flowing from the marital relationship are the duties of cohabitation, loyalty, fidelity, mutual assistance and support .... spouses are under a duty to be faithful to each other'.(46)

The conjugal fidelity referred to by Hahlo supra also includes the '... wettelick gebruick ban malkanders lichaem,'(47) and the object of this right is clearly a performance in the form of prescribed and circumscribed human conduct. It is submitted that an essential right created by a marriage and one which is reflected by the requirement of fidelity and the lawful use of one another's bodies is the mutual and exclusive exchange of procreative powers.(48) In other words, a husband may not give to a third party what he has exclusively contracted to give to his wife.

A right (in this case fidelity or the exclusive right to a spouse's procreative powers) involves a relationship between the holder of the right (eg the wife) and the object of the right (eg the exclusive use of the husband's semen) and between the holder of the right and other legal subjects. The powers which a spouse enjoys in this respect amount to nothing more than the powers of enjoyment that every right comprises. If the object of such a right is, as we have illustrated in our example, a performance, viz, the wife's exclusive use of her husband's body more specifically his sperm, then we can classify this right as a personal right.(49)

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(46) Hahlo S A Law of Husband and Wife 4th ed (1975) 109 110.

(47) De Groot Inleiding Tot De Hollandsche Rechts-Geleerdheid 1.5.1, by Dovring, Fischer, Meyers, Leiden (1965) at 16.

(48) 'Wettelick gebruick van malkanders lichaem' - this concept it is submitted, can be interpreted as meaning the exclusive exchange of procreative powers. See also G J Annas 'Fathers Anonymous : Beyond the Best Interests of the Sperm Donor' 1980 Family Law Quarterly 1 at 9.

(49) J Church 'Consortium Omnis Vitae' (1979) 42 THRHR 376 at 377-378; W A Joubert Grondslae van die Persoonlikheidsreg (1953) 131 at 132.

It is submitted however, that it is within the wife's power to waive her exclusive right by consenting to her husband donating his sperm. It is further submitted that the infringement of the wife's right to her husband's procreative ability takes place not because he has donated his semen, but because he has done so without his wife's consent.(50)

Marital rights and other personal rights, for example those arising ex contractu, belong to the same category in so far as they have performances as objects. However, the remedies for a breach of marital obligations differs from those available for a breach of contract.(51) Thus where the wife's right to conjugal fidelity (husband's procreative powers, lawful use of his body) has been infringed by his donating his semen without her consent she may not claim damages from her husband, but only from the third party involved viz the recipient wife whose husband is sterile, and this is impossible because the physician is bound by the medical code of ethics to protect the privacy of his patients(52) and because her husband has contracted not to be informed as to the identity of the recipient of his semen.

It is submitted however that the aggrieved wife may sue her husband for divorce on the basis that his donation of semen secretly or against her will has resulted in the irretrievable breakdown of the marriage.(53)

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(50) Lucinda Ann Smith 'Artificial Insemination : Disclosive Issues' (1980) 11 Columbia Human Rights Review 87 at 93.

(51) W A Joubert Grondslae van die Persoonlikheidsreg (1953) 131 at 132; J Church 'Consortium Omnis Vitae' (1979) 42 THRHR 376 at 377-378; N J van der Merwe Die Beskerming van Vorderingsregte uit Kontrak teen Aantasting Deur Derdes (1959).

(52) See also 'Suggested Code of Practice for Artificial Insemination by Donor' (8 November 1980) S A Medical Journal 781 at 782.

(53) See section 4(1) & (2) Act No 70/1979; 'Artificial Insemination : A Legislative Remedy' (1975) 3 Western State U L Rev 48 at 66; Feversham Report 35.

Consent Form signed by Wife of Donor

To Dr. _____ : 1. I have read the above application to serve as a donor of semen which my husband has executed and to the best of my knowledge and belief the representations therein contained are true and correct.

2. I understand that if my husband is accepted by you as a donor, it is your intention to use such semen for the purposes of artificial insemination, but not with respect to myself.

3. I understand further that artificial insemination is a medical procedure intended to cause pregnancy of a woman through the use of semen introduced by means other than sexual intercourse.

4. Knowing full well that in serving as a donor of semen, my husband may become the father of a child or children of which I am not the mother, I nevertheless consent to the performance of such services by him.

5. To induce you to accept my husband's services as a donor of semen, I agree that I shall neither directly nor indirectly attempt to discover the identity of any recipient, and I further agree not to bring any action in law or in equity, or otherwise, against you or my husband as a consequence of any services which my husband may render as a donor of semen. I thus consent and the Agreements therein contained are given freely and voluntarily.(54)

Signed _____

Witness _____

Date _____

2.3. Failure to obtain consent and the implications

Although it was submitted supra that it would be unethical for any medical practitioner to practice AID upon a wife without her husband's written consent, the technology involved in AID is so simple that the wife could easily perform the act herself.(55)

Before examining the implications of AID without the consent of one of the spouses, the question arises whether such an act is ever justifiable. Take the following situations as examples: in order to shield her husband from the knowledge that he is sterile the wife undergoes AID, or the husband, in order to prevent his wife from discovering that he is sterile, arranges for her to be

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(54) Weinstock (1971) 5 Family L.Q. 401.

(55) Guttmacher (1969) 18 De Paul LR 573; G P Smith 'A Close Encounter of the First Kind : Artificial Insemination and an Enlightened Judiciary' (1978/79) 17 J of Family Law 41 at 42.

inseminated with the semen of a donor during the course of a gynaecological examination.(56) The examples are far fetched but not beyond the realms of possibility.

It is however submitted that despite the fact that the knowledge that one of the spouses is sterile may have an unfortunate effect upon the marriage relationship, that this is the lesser of two evils and that AID without the consent of both spouses should never be permitted or sanctioned, because to introduce the seed of a third person into a marriage in this way is a fraud which might result in even more unfortunate effects not only on the relationship between the spouses, but also on any child which might be conceived in this way. This idea is strongly emphasised by Lord Wheatley in Maclennan v Maclennan:

> 'It is almost trite to say that a married woman who, without the consent of her husband, has the seed of a male donor injected into her person by mechanical means in order to procreate a child who would not be a child of the marriage has committed a grave and heinous breach of the contract of marriage.'(57)

A wife who employs AID without her husband's consent thus runs the risk of incurring her husband's anger and jealousy when he learns the truth of the child's conception as well as the possibility of a divorce action.(58) If performed with the husband's approval, however, AID involves none of these harms. The real harm of adulterating the husband's blood line is not the introduction of a strange child into the family, because legal adoption does just that, but it is the introduction of the child without the consent of the husband. The husband's consent thus destroys his basis for claiming irretrievable breakdown of the marriage as a result of AID since instead of injuring her husband his wife is in fact serving him by her act.(59)

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(56) Feversham Report 35.

(57) S.L.T [1958] 12 at 14.

(58) See section 4(2) of the Divorce Act 70 of 1979.

(59) Author anonymous (1952-53) Indiana Law Journal 620 at 626.

Where the wife does submit to AID without her husband's consent his duty of support (pater est quem nuptiae demonstrant) would depend on his subsequent actions. If he continues to support the child after discovering the true nature of its conception he might be estopped from denying further support, or, alternatively his actions may be of such a nature as to give rise to a presumption that he intends to stand in loco parentis to the child. However in view of the fact that it is policy to discourage AID without the husband's consent seeing that it is an infringement of the consortium omnis vitae, it is highly unlikely that any action to force the husband to support a child born in these circumstances will be upheld.(60)

It is submitted that premarital AID without her future husband's consent is analogous to stuprum(61) because although there is no act of intercourse the result is the same viz an attempt at fraudulently foisting another man's child onto an unsuspecting husband.(62) It is further submitted that in such a situation the husband's remedy should also be similar to that in the case of stuprum viz he should have the option of annulling the marriage.(63)

If a doctor performed AID without the husband's consent which it is difficult to perceive him doing other than intentionally, then his act constitutes a breach of the consortium omnis vitae which will result in the following consequences. First, the husband can sue his wife for divorce on the basis that her gross breach of faith has led to the irretrievable breakdown of the marriage.(64)

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(60) R S Jacobs and H P Luedtke 'Social and Legal Aspects of Human Artificial Insemination' (1965) Wisconsin Law Review 859 at 881.

(61) Stuprum means pollution by lust, defilement, debauchery.

(62) Stander v Stander 1929 AD 349 at 355; see also Venter v Venter 1949 (4) SA 123 (W) at 132 and Van Niekerk v Van Niekerk 1959 (4) SA 658 (GW) at 665.

(63) P M A Hunt (1962) 79 SALJ 429; (1963) 80 SALJ 329.

(64) See section 4(2) Act No 70 of 1979.

Second, the husband can claim damages from the doctor for infringement of the consortium,(65) and third, in terms of medical ethics the doctor's act is wrongful in not obtaining the husband's consent and it is probable that the Medical Council will take action against him.(66)

2.4. Revocation of Consent

The nature of the consent obtained by the physician from the recipient's husband is significant, because it is possible for him to retract his consent at any time prior to conception.(67) A prudent physician would thus ascertain whether the consent is of a blanket nature encompassing the entire course of treatment, ie until the recipient conceives or until doctor and patient mutually agree to cease the treatment, or, whether the consent is limited to a single course of treatment and a fresh consent is required for each additional series of inseminations.(68)

The consent obtained should also specify whether it covers insemination by a specific donor only or whether it extends to the semen of other donors as well.(69)

3. In Vitro Fertilization

At the present level of development of medical science the three controversial methods of altering the natural process of human conception(70) have an

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(65) Church (1979) 42 THRHR 384; Hahlo S A Law of Husband & Wife 4th ed (1975) 122, 384.

(66) Sergeant (1970) 19 Drake LR 434.

(67) B Hargrove 'Artificial Insemination by Donor' (1958) 25 The Solicitor 165 at 166.

(68) ibid.

(69) ibid.

(70) Artificial insemination, in vitro fertilization, embryo transplantation and cloning. Cloning is the process of obtaining multiple nuclei somatic (non-germ) cells and placing a single nucleus into an enucleated ovum. The zygote and subsequent being would have genetic characteristics identical to those of the donor of the somatic cells. Robert L Sinsheimer 'Asexual Human Reproduction' in (1978) Encyclopedia of Bioethics 1451-1453.

(Continued on the next page)

Orwellian connotation[71] which has at times prompted the call for at least a temporary ban of all such research,[72] and for legislation forbidding these methods.[73] Because the research will probably continue,[74] it seems logical to ensure that it is properly controlled and that the legal rights of all persons involved are carefully defined. What follows infra are certain submissions based on current law and legal principles which may serve as guidelines for defining the legal position in regard to the requisite consent of the husband, wife, donor(s) and physician involved in this procedure.

3.1. Potential Variations involving in vitro fertilization and embryo transfer

The legal implications of reimplanting a fertilised ovum into the woman who produced it are minimal in comparison with the issues raised by implanting the fertilised ovum into another woman viz 'embryo transfer' or 'embryo donation'. Notwithstanding the variety of ways in which the embryo may be created (see infra), the legal problem can be expressed fairly simply viz when it came to determining the child's mother would the law recognize the biological origin of the child or consider only the circumstances surrounding the child's

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(70) (continued from previous page)

Cloning thus bypasses the sexual processes which lead to a scrambling of the genetic material of both parents, with the result that the products of a clone (except for rare mutations) are genetically identical cells or individuals. Every time a plant is grown from a cutting the plant is, in effect, being cloned. However, the application of the idea of cloning to animals is much more difficult. Cf A Jones and W F Bodmer Our future inheritance, choice or chance? (1974) at 112.

(71) M A B Oakley 'Test Tube Babies : Proposals for Legal Regulation of New Methods of Human Conception and Prenatal Development' (1974) 7 Family Law Quarterly at 386.

(72) M Lappé 'Ethics of In-Vitro Fertilization : Risk-Taking for the Unborn' (Feb 1972) 2 The Hastings Centre Report 1; H R 7724, 93d Congress 2d Sess (1974) as amended by the Senate.

(73) A resolution introduced into the Ohio legislature in 1955 would have fined those involved in artificial insemination $ 500 and sentenced them to 5 years imprisonment cf Ohio S 93 (1955). The resolution was, however, not enacted.

(74) A McLaren 'Biological Aspects of AID' (1973) 17 Ciba Foundation 3 at 8.

birth? In other words, which of the two contestants, the biological mother or the hostess mother, should be recognised as being the child's legal mother?(75)

3.1. Wife's ovum, husband's sperm, wife carries the child

When the husband provides the sperm and the wife the oocyte which is fertilised in vitro and the cleaving blastocyst is then reimplanted into her uterus, the legal position is analogous to that of AIH. The child which is conceived and born as a result of this technology is the genetic and biological offspring of both the husband and the wife.(76)

The informed consent of both spouses, in writing, should be obtained for the laparoscopy as well as for the in vitro fertilization and reimplantation. It is submitted however that the provisions of section 7(1)(77) regarding Ministerial permission are not applicable in these circumstances in view of the fact that the fertilised oocyte is reimplanted into the spouse from whom it was removed.

To sum up, this process has been compared with the procedure for facilitating birth by Caesarian section, and was originally designed to make possible the birth of children to married couples where the wife suffers from a disability such as a tubal occlusion.(78) Successful in virto fertilization and reimplantation will result in the birth to the woman of a child of whom her husband is the biological father and consequently biological and legal relationship will coincide.(79)

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(75) D J Cusine 'Some Legal Implications of Embryo Transfer' (28 June 1979) New Law Journal at 627 628.

(76) Mary Ann Oakley 'Test Tube Babies : Proposals for Legal Regulation of New Methods of Human Conception and Prenatal Development' (1974) 8 Family Law Quarterly 385 at 391.

(77) Anatomical Donations and Post-Mortem Examinations Act 24 of 1970.

(78) Stone (1973) 17 Ciba Foundation Symposium 73.

(79) Oakley (1974) 8 Family L.Q. 391.

Consequently the child will be the legitimate child of the spouses concerned and may be registered as such in terms of the Births Marriages and Deaths Registration Act.(80)

3.2. Wife's ovum, donor's sperm, wife carries the child

The following set of medical circumstances would give rise to this situation, viz where the wife is suffering from blocked fallopian tubes and the husband's sperm is infertile as a result of aspermia.

The consent required by the physician to secure himself against any actions from the various parties, and to meet the requirements of the law, is as follows:

3.2.1. Provisions of the Anatomical Donations and Post-Mortem Examinations Act 24 of 1970

(a) Removal of the wife's embryo

Because the wife's embryo is reimplanted into her uterus after in vitro fertilization, Ministerial consent in terms of section 7(1) is not required.

(b) Donor's semen

It is submitted that the provisions of section 7(1) are likewise not applicable to donated semen.(81)

For purposes of the law it is thus sufficient if the doctor obtains the donor's consent to use his semen to fertilize the wife's ovum.

3.2.2. Removal of the Embryo

The wife's embryo is removed by way of a minor operation known as laparoscopy but because, as with all operations, there is a risk involved the

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(80) Act No 81 of 1963.

(81) Strauss Doctor, Patient and the Law (1980) 147.

physician should obtain the wife's written consent before operating.(82)

3.2.3. Husband's consent

The husband should clearly realise the implications of his wife being impregnated with the sperm of a donor viz that the child will be illegitimate unless it is formally adopted by the spouses.(83) The husband should thus give his informed consent to his wife's embryo being fertilised with the semen of a donor. The donor's identity should at no stage be revealed to the spouses(84) and the physician should match the donor as closely as possible to the husband in all respects.(85)

Without the consent of the husband the fertilization and reimplantation of the wife's egg will constitute a grave offence against the marriage and render the wife liable to divorce(86) and the physician liable to damages for injuria.(87)

3.3. Husband's sperm, ovum donated, wife carries the child

The consent required in this set of circumstances can be broadly divided into the informed consent which the physician should obtain in writing, from the spouses and the donor of the ovum and the consent required in terms of Act No 24 of 1970.

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(82) Strauss & Strydom Die Suid-Afrikaanse Geneeskundige Reg (1967) 209-214.

(83) V v R 1979 (3) SA 1006 (TPD) at 1016.

(84) See page 165-166 for full discussion.

(85) Feversham Report 11.

(86) See chapter 6 for full discussion of the issue.

(87) MacLennan v MacLennan 1958 SLT pp 7-8; Strauss & Strydom op cit 349; M de Villiers The Roman and Roman-Dutch Law of Injuries (1899) at 15; W A Joubert Grondslae van die Persoonlikheidsreg (1953) 83. See also page 146.

3.3.1. Spouses' Consent

The legal implications involved in this form of fertility therapy are extremely complicated and it is submitted that the physician involved should work closely with the spouses' attorney.(88) He should not take any steps to implement the therapy until the spouses have been properly informed as to all the legal implications by their attorney eg the fact that in terms of S A law, as it now stands, the child conceived and born by this method will be illegitimate.(89) The spouses can only give an informed, and thus a valid consent, if the legal implications have been explained to them.

The doctor, having satisfied himself that the couple are informed as to their legal position, must then obtain the spouses' consent in order to proceed with the medical aspects of the treatment viz the implantation of the fertilised ovum into the wife's uterus.(90)

3.3.2. Ovum donor's consent

The physician would have to obtain the ovum donor's consent to first undergo a laparoscopy to remove the ovum required for the in vitro fertilization, and secondly her informed consent to the fact that the ovum so removed is going to be fertilised and reimplanted into the uterus of another woman.(91)

3.3.3. The Anatomical Donations and Post-Mortem Examinations Act 24 of 1970

Because the procedure in this set of circumstances involves the removal of a gonad from the body of one woman and its transplantation in fertilised form into the body of another woman it falls within the prohibition set out in section

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(88) Douglas J Cusine '"Womb-Leasing" : Some Legal Implications' (1978) 128 New Law Journal 824.

(89) Grotius Introduction to Dutch Jurisprudence 1.12.2; Voet 1.6.6; Green v Fitzgerald 1914 AD 88 at 96; Daniels v Daniels 1958 (1) SA 513 (AD) 529.

(90) W Humphreys 'Lawmaking and Science : A Practical Look at in vitro Fertilization and Embryo Transfer' (1979) Detroit College LR 433.

(91) Reilly Genetics and the Law (1975) 359 at 368.

7(1) of the Act. It is therefore necessary for the physician to obtain written consent from the Minister of Health before being allowed to proceed.

3.4. Hostess Mothers

As technology changes, lifestyles change. As needs arise, solutions are created. With advances in reproductive technologies, society's conceptions of procreation, parenthood and the family have evolved to include arrangements benefitting couples who are unable to have children. The use of hostess and surrogate mothers are two major advances in this arrangement.(92)

The most common reason for resorting to engaging the services of a hostess mother may be termed 'necessity', which results from

(a) the wife's inability to carry a child to term;

(b) the spouses' inability or unwillingness to adopt a child;

(c) the wife may feel that she is too old to safely carry a child to term.(93)

Reasons other than necessity may also motivate a couple to engage a hostess eg the wife may not want to interrupt her career to bear a child and therefore seeks a more convenient method of obtaining one.(94)

The idea of renting, or to use more sophisticated legal terminology, leasing a womb may at first blush appear to be idle science fiction speculation, but it has happened in both the United States and Britain. There are even reported cases(95) on the issue in both countries, while in the USA there is a corporation in Kentucky called Surrogate Family Services Inc which assists infertile couples to conceive a child via the surrogate procedure.(96)

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(92) Theresa Mady 'Surrogate Mothers : The Legal Issues' (1981) 7 American Journal of Law & Medicine 323.

(93) ibid; see also Mason (1982) 56 Australian LJ 347 at 355.

(94) ibid.

(95) Doe v Kelley [1980] 6 Fam. L. Rep (BNA) 3011; A v C (1978) 8 Family Law 170.

(96) Katie Marie Brophy 'A Surrogate Mother Contract to Bear a Child' (1981/2) 20 Journal of Family Law 263.

'Womb leasing' involves one woman (A) (who is infertile or unable to carry a child) obtaining the services of another woman (B) who is either prepared to carry her fertilised ovum to term or who is prepared to be artificially inseminated with Mr A's sperm and after the birth of the child to surrender it to Mr & Mrs A together with all rights she might have to such child. Mr & Mrs A would then presumably register the child as their own.(97)

The notion of 'womb leasing' raises at least three legal issues:

(a) Is such a scheme legally permissible?

(b) Would the law be prepared to enforce a 'womb lease' agreement?

(c) What would the child's status be? (98)

There are a number of potential permutations of sperm and ovum which can be utilised in a 'womb leasing' situation, depending on the circumstances of the parties, and I will proceed to discuss them and also attempt to answer the questions posed in (a) & (b) supra in regard to them. Question (c) will be dealt with in the chapter on legitimacy.

3.4.1. Wife's ovum, husband's sperm, hostess mother carries the child

In this hypothetical situation, the wife's ovum would be fertilised by the husband's sperm in vitro and the embryo transferred(99) into a third party, or 'hostess', who would carry the child for the duration of the pregnancy and then give birth to it. The resulting infant would be biologically the offspring of the woman who contributed the ovum and gestationally the offspring of the 'hostess' who bore it; in fact, such a situation may even be called an 'embryonic adoption'.(100)

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(97) Cusine (24 August 1978) New Law J 824.

(98) ibid.

(99) Edwards & Steptoe (1973) 17 Ciba Foundation 15. The transfer of the 8 or 16 celled blastocyst could almost certainly be performed through the cervix without surgery. This is the stage of development at which the blastocyst usually attaches to the uterus.

(100) Oakley (1974) 8 Family L.Q. 385 at 392; Mason (1982) 56 Australian LJ 347 at 350-351.

3.4.1.1. Consent of the parties concerned

The physician concerned should examine the wife and establish that there are sound medical reasons for her being unable to carry a child. He should then discuss the therapy and its medical implications with the parties.(101) The physician should also ensure that the spouses have consulted a lawyer and fully acquainted themselves with their legal position vis-á-vis the child.(102) He should then require them to submit to him, in writing, their informed consent to the therapy.

(a) Removal of embryo

In order to perform the laparoscopy upon the wife the physician would first require the permission of the Minister of Health in terms of section 7(1) of the Anatomical Donations and Post Mortem Examinations Act.(103)

(b) Hostess Mother

It is in the interests of the biological parents that a written agreement should be obtained from the hostess mother that the baby she will carry will be legally the child of the couple who contribute the germ cells and that her rights to the child will terminate at birth.(104)

In order to provide the hostess mother with adequate safeguards for her health, it must be clearly established that, should the pregnancy in any way endanger her mental or physical health an abortion will be performed

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(101) Reilly Genetics and the Law (1975) 368; Strauss Doctor, Patient and the Law (1980) 158.

(102) For a full discussion on the child's status see chapter 7.

(103) No 24 of 1970.

(104) For a full discussion of the validity of such a contract see page 113. infra

immediately.(105) On the other hand it is essential that the hostess should be absolutely certain that she wishes to go through with the pregnancy because she cannot change her mind once the ovum has been implanted and she is experiencing a normal pregnancy. The provisions for a lawful abortion are clearly and narrowly defined by section 3 of the Abortion and Sterilization Act.(106) Should the 'hostess' resort to an illegal abortion to terminate her pregnancy she would render herself liable to a possible action for damages for breach of contract.(107)

To protect the privacy of all the parties involved, especially that of the resulting child, the 'hostess' should remain anonymous to the couple and the couple anonymous to the 'hostess'. As in the case of AID, only the physician should know the identity of all parties concerned.(108)

3.4.2. Wife's ovum, donor's sperm, hostess mother carries child

The position regarding the precautions which the physician should take in determining the suitability of all the parties concerned is the same as in sub-heading 3.4.1. supra. The consent which he requires to perform the laparoscopy

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(105) Christian League of Southern Africa v Rall 1981 (2) SA 821 (O) at 829-830; S v Collop 1981 (1) SA 150 (AD) at 163 165. Such an agreement is in keeping with the conditions under which a lawful abortion may be performed in South Africa, cf Abortion and Sterilization Act No 2 of 1975, s 3(a) & (b). The actual agreement could be in the form of a legal waiver, or a contract between the 'hostess' and the physician with the recipient couple as third party beneficiaries. This procedure is advisable as any direct contact between the 'hostess' and the recipient couple would destroy the vital anonymity of such a procedure. See Oakley (1974) 8 Family LQ 372.

(106) In the United States abortion during the first trimester is a matter to be determined solely by the pregnant woman and her physician, see Doe v Bolton 410 US 179 (1973) and Roe v Wade 410 US 113 (1973). Only during a period roughly corresponding to the last trimester can the state interfere to protect what is then a potentially viable foetus. See also the provisions of Act 2 of 1975 and Christian League of Southern Africa v Rall supra and S v Collop supra.

(107) Oakley (1974) 8 Family L Q 392; Douglas J Cusine '"Womb-Leasing" : Some Legal Implications' (24 August 1978) New Law Journal 824 825. See page 107 infra for full discussion on the enforceability of such contracts.

(108) Oakley (1974) 8 Family L Q 392. See page 165 for discussion of the implications of intentional and negligent disclosure.

and to reimplant the transferred embryo into the uterus of the hostess mother also remains the same as in sub-heading 3.4.1.1. supra. Because the physician is not using the sperm of the wife's husband but that of a donor it is naturally necessary for him to obtain the husband's informed consent(109) for this procedure. The physician must also ensure that he matches the donor as closely as possible to the husband.(110) The donor should also be a voluntary donor who is prepared to father a child for an unknown couple.(111) The physician should furthermore ensure the donor's anonymity for psychological reasons and to protect him against potential paternity claims instituted by the biological mother.(112)

The position of the 'hostess' mother also remains the same as in 3.4.1.1. supra.

3.4.3. Wife's ovum, sperm donor and hostess mother are married

We will distinguish the parties in this situation by referring to Mrs A as the ovum donor, she is married to Mr A who is infertile. The sperm donor is Mr B who is married to the hostess mother Mrs B.

(a) Mr & Mrs A

It would again be sound medical procedure for the physician to examine the couple to establish that Mr A is infertile and that Mrs A has a sound medical reason for being unable to carry the child. It is also necessary to establish that

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(109) The husband should realise that unlike the situation in 3.4.1. supra where it is submitted (see chapter 7 p 263) that the child is the legitimate child of its biological parents viz the spouses involved, in this case, the fact that a donor's sperm is used means that the child is illegitimate unless adopted by the spouses.

(110) Joseph M Healey 'Legal Aspects of Artificial Insemination by Donor and Paternity Testing' in Genetics and the Law edited by H Milunsky and G Annas (1975) 203 at 206; Elliot L Sagall 'Artificial Insemination' (1973) 9 Trial 59 at 63.

(111) Sagall (1973) 9 Trial 63.

(112) Sagall (1973) 9 Trial 63.

Mrs A has healthy eggs which will respond to fertilization by potent male sperm.(113) He requires the informed consent (medical and legal implications) of both parties to the therapy as well as Mrs A's permission to perform the laparoscopy, permission to operate in terms of the relative Provincial Ordinance, and the permission of the Minister of Health in terms of section 7(1) of the Anatomical Donations Act(114) because the embryo is to be used for procreation in the body of another person.

(b) Mr & Mrs B

As both spouses are to be involved in the birth of the child, Mr B in a biological capacity, and Mrs B in a gestational capacity, they should be fully aware of each other's respective rôle in the birth, and convey their written consent to participate.(115)

For the reasons given above it is again vital for the physician to maintain the anonymity of the two couples so that they or the child are never aware of the true identity of the various participants.(116) It is submitted that legitimacy is determined by biological origin and on this basis the resultant child being the biological offspring of Mrs A and Mr B will be illegitimate.(117)

4. The Contract Between the Spouses and the Hostess Mother

In a situation where the biological mother does not give birth to her child but the child is carried by a surrogate or hostess mother or nurtured to maturity

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(113) Gerald George 'Creating Life in the Lab' (1974) 75 Science Digest 28 at 30.

(114) Act No 24 of 1970.

(115) Strauss & Strydom Die S A Geneeskundige Reg (1967) 205-207.

(116) Smith (1980) 11 Columbia Human Rights Review 91.

(117) Cusine (1979) New Law Journal 627 at 628. The legitimacy of children born of AID and embryo transfer will be discussed in detail in Chapter 7.

by an artificial placenta,[118] a number of potential problems might arise which would not normally be the case when a biological mother carries her own child to term. Where a married couple are thus forced to resort to the services of a surrogate or hostess mother in order to have a child of their own it would be advisable for them, their physician and their lawyer to anticipate as many of the potential problems as possible and to attempt to regulate them by way of a contract.[119]

The anonymity[120] of the host mother should be protected at all costs and to this end the choice of the host mother should be left to the physician and the drafting of the contract to the attorneys representing the respective couples. The attorney acting for the surrogate or hostess mother would do so as an agent acting on behalf of an undisclosed principal.

Where the services of a host mother or an artificial placenta are utilised to carry a child to term, there are a number of potential problems which may arise in the nine months which elapses between conception (fertilization of the egg or transplantation of the nucleus) and birth (expulsion from the host mother's womb or from the artificial placenta).

The various issues confronting the surrogate mother arrangement can be agreed to in a contract which specifies all the rights and duties of the parties.

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(118) D Rorvik 'Making Men & Women Without Men & Women' (1969) Esquire at 108; P Gorney 'The New Biology and the Future of Man' (1968) 15 UCLA Law Review 273; A Rosenfeld The Second Genesis (1969) at 102.

(119) Brophy (1981/2) 20 J of Family Law 263.

(120) G Range 'Surrogate Mother is Recruited by Ad for Artificial Insemination' (1 July 1976) 2 13 Ob Gyn News 36. In this case the physician chose the surrogate mother and liaised with the father's attorney; D Rorvik 'Embryo Transplants' (June 1975) 180 6 Good Housekeeping 78 at 126 127; Shapiro & Spece Bioethics & Law (1981) 531-537.

The terms of the contract will thus stipulate what the parties may and may not do.(121) This does not however guarantee that specifications agreed to will be judicially recognised. Any term of the contract which a court finds to be contrary to public policy will be struck down.(122) Therefore, while a detailed contract(123) may help eliminate many of the ambiguities, it cannot ensure that all specified terms will be judicially enforced. This is an inherent weakness in all attempts to structure the law through private agreement.(124) The alternative is regulation by legislation which is discussed in chapter II.

4.1. Some contractual problems relating to Hostess Mothers

4.1.1. The legality of the contract

It is important for the parties intending to enter into such a contract to know whether it is legal or whether it violates any principles of civil or criminal law which would then make them liable for their actions. On the other hand, if the contract itself is illegal it will be unenforceable. For the contract to be illegal it must infringe the provisions of existing statutory or common law.

4.1.1.1. The Children's Act(125)

In terms of section 79 of the Children's Act it is illegal for any parties involved in the adoption of a child to give or receive any valuable consideration in relation to the adoption. Chapter II of this Act makes special provision for the protection of infants(126) by instituting a system of control which regulates

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(121) E A Erickson 'Contracts to Bear a Child' (1978) California Law Review 611; Mady (1981) 7 Am J of Law & Medicine 323; Brophy (1981/2) 20 J of Family Law; Robert C Black 'Legal Problems of Surrogate Motherhood' (1981) 16 New England Law Review 373; Noel P Keane 'Legal Problems of Surrogate Motherhood' (1980/81) 2 Southern Illinois University Law Journal 147; Suzanne Paterson 'Parenthood by Proxy : Legal Implications of Surrogate Birth' (1982) 67 Iowa Law Review 385.

(122) A v C (1978) 8 Family Law 170; Doe v Kelley [1980] 6 Fam LR (BNA) 3011.

(123) Brophy (1981/82) 20 J of Family Law 266-291.

(124) Mady (1981) 7 Am J of Law & Medicine 326.

(125) Act No 24 of 1970.

(126) J R L Milton and N M Fuller South African Criminal Law and Procedure Vol (1971) 763; section 10 & section 16 of Act 33/1960.

the movement of infants and provides criminal sanctions for those who do not comply with these requirements. It would appear that the objective which this Chapter sets out to achieve is to prevent what can be described as 'baby farming'.(127) In terms of this practice mothers of unwanted children arrange for them to be removed from their custody and to be placed with persons who undertake to maintain them for a specified remuneration.(128) Because these 'foster parents' do not have the children's best interests at heart they 'usually died within a very short time, the deaths being due to negligence rather than active criminality'.(129)

The provisions of section 79 prohibiting the payment of money for the adoption of a child were designed to prevent the involuntary relinquishment of the natural mother's child through financial pressure, and to ensure that the best interests of the child are protected.(130)

4.1.1.1.1. Does 'womb-leasing' infringe Chapter two of the Children's Act?

In their contract with the hostess mother the spouses (suppliers of the ovum and sperm) undertake to pay her a sum of money for the service she provides to them viz the lease of her womb.(131) Does this contract however constitute an infringement of sections 10(1), (2) & (3) and 16(2) which are designed to prevent 'baby farming'?

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(127) T E James Child Law 63; section 16(2) Act No 33/1960.

(128) Noyes v Thrane Pasedena Court, California, reported in 'Daily News' 25 March 1981 at p 13 and 31 March at p 9.

(129) James Child Law 69.

(130) Milton & Fuller S A Criminal Law & Procedure Vol III (1971) at 774.

(131) Brophy (1981/2) 20 J of Family Law 264; Doe v Kelley supra; A v C supra.

In the situation above the biological parents are married, and they have supplied the ovum and the sperm from which the child was conceived, furthermore, if we examine the currently prevailing definitions of 'parent'[132] and 'legitimate child'[133] in our law it is submitted that the 'hostess' cannot be classed as being the mother of the child[134] and hence cannot fall foul of the provisions of section 10(1), (2) & (3).

If the object of these sections of the Act is to prevent anyone from 'profiting' from the sale of a child or from an adoption then there are also

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(132) 'Parent' is defined in s 1(xxix) of The Children's Act 33 of 1960 as follows:

> 'Parent' means the father or the mother of a child born of or legitimated by a lawful marriage, or the mother of an illegitimate child, and save in Chapter VII includes an adoptive child.

It is submitted that the hostess is not a 'mother' in the accepted sense of the word as she does not contribute to the genetic make-up of the child. She merely provides a suitable environment for its gestation. See note 134 infra.

If we accepted an alternative, more modern definition of 'parent', as being the husband and wife who have consented to the conception of the child and who have undertaken to assume all the normal parental responsibilities for it, then the 'hostess' mother is equally disqualified from claiming parental rights in regard to the child.

(133) It is submitted that the most significant aspect of parenthood is supplying the gonads from which the child develops. The moment of conception is the moment at which the sperm fertilizes the ovum. The conception in our present example can take place in the biological mother's body by normal intercourse and the fertilized ovum can then be removed and transplanted into the host mother or the conception can take place in vitro.

Boberg The Law of Persons & the Family (1977) 318 defines a legitimate child as 'one whose parents were married to each other at the time of his conception or at the time of his birth, or at any time between these dates.' In the case to which we are referring the child's biological parents were married to each other at both its conception and its birth. It is thus submitted that in the light of this definition and my submissions in note 132 supra, that the child is the legitimate child of its biological parents.

(134) C Grobstein (1979) 240 Scientific American 38-43. Fertilization of the egg initiates the process of cell division which in turn results in a series of multiple and complex changes by which the zygote begins to evolve the set of characteristics of a multicelled organism and finally into a highly organised individual. The child's genetic make-up is determined at the moment of fertilization and is thereafter immutable, furthermore the embryo has a blood system which is separate from that of the hostess mother. However the embryo does rely on the hostess mother for nutrition and the removal of waste products.

circumstances in which the payment to the carrier can be interpreted as amounting to no more than compensation for lost wages which in turn would not amount to the sale of the child.(135) Where the hostess had been in employment and earning a salary prior to the ET and her pregnancy and had resigned her job, the payment she received could be interpreted as falling into this category.

> 'There is nothing to indicate that the payment permitted the mother to profit from childbirth. To the contrary, it would seem to have been intended simply to prevent her confinement from resulting in pecuniary loss.'(136)

I further submit that the remuneration received by the hostess from the biological parents of the child was for a service which she had rendered to them viz the physical acts of pregnancy and childbirth.(137) In other words they are paying her to carry <u>their</u> child, not to sell them <u>her</u> child. The child is not hers to sell because, it is submitted, it is the legitimate child of the biological parents.(138)

4.1.1.2. <u>Waiver of Parental Power</u>

The parents of a child involuntarily, by operation of law, acquire parental power over their child at the moment of its birth(139) and this power cannot be waived, ceded or transferred by a parent to another person because such an act is deemed to be <u>contra bonos mores</u>.(140)

At the moment of birth, a child, if it is born alive, acquires legal personality.(141) In conjunction with this legal personality the child is endowed with

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(135) Keane (1980) 2 <u>Southern Illinois Univ LJ</u> 157.

(136) <u>Las Vegas Sun Inn v Franklin</u> 74 Nev 282 at 292, 329 P2d at 872.

(137) Mady (1981) 7 <u>Am J of Law & Medicine</u> 331.

(138) <u>ibid.</u>

(139) Grotius 1.6.1; Van der Linden 1.4.2; <u>Van Rooyen v Werner</u> (1892) 9 SC 425 at 428. It is generally accepted, however, that the father's rights are superior to those of the mother.

(140) <u>Van der Westhuizen v Van Wyk</u> 1952 (2) SA 119 (GW).

(141) <u>Christian League of Southern Africa v Rall</u> 1981 (2) SA 821 (O) at 827(G).

a right to freedom, which is in turn protected by the actio injuriarum[142] and the Criminal Procedure Act.[143]

The law of slavery, having been abolished in South Africa in 1835, natural persons are all born as free men and are thus not chattels which can be bought and sold. Furthermore the sale of a child would involve the transfer of parental power from the sellers (parents) to the buyers. In terms of our law one parent may not confer the parental power or its incidents on another parent[144] by private agreement, even less so may he transfer it to a third party.[145] Only a Children's Court[146] or the Supreme Court acting in its rôle as upper guardian

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(142) Prinsloo and Another v Newman 1975 (1) SA 481 (A); Malou & Others v Minister of Police & Others 1981 (2) SA 545 (ECD) at 580; N J van der Merwe & P J J Olivier Die Onregmatige Daad in die Suid-Afrikaanse Reg 3rd (1976) at 504.

(143) See sections 39 & 40 of Act No 51 of 1977.

(144) Ex parte Van Dam 1973 (2) SA 182 (W) at 185C-D. In this case the mother of an illegitimate child wanted to be deprived of guardianship at her own request. She and the child's father had had two children, the elder in wedlock and the younger out of it. The object of their application was to give effect to an agreement in terms of which the father was to be guardian and the mother custodian of both children, thereby placing the children on an equal footing vis-á-vis their father. The court reiterated the fact that:

> 'It is plainly not competent for a natural guardian to renounce guardianship in favour of a third person at will. Guardianship is a duty much more than a right' (at 185C-D).

However the court found that there were special circumstances present and that it would be in the best interests of the child that its father should continue to occupy a position of parental authority.

(145) Van der Westhuizen v Van Wyk 1952 (2) SA 119 (GW); Boberg The Law of Persons & the Family (1977) 316; Spiro Law of Parent & Child 3rd ed (1971) 33-34.

(146) See section 60 Act No 33 of 1960.

of all minors may deprive a parent or parents of their parental power.(147)

It is submitted that a parent who purports to sell his/her child has abandoned that child. This will place the child within the ambit of the definition of a 'child in need of care'.(148) Because the 'buyer' does not acquire parental power, custody or guardianship over the child he has no defendable right to the child and will be forced to surrender the child to the Commissioner of Child Welfare. The 'buyer' would also fall foul of section 10(1) of the Act(149) which prohibits a person from receiving and maintaining an infant apart from its parents for more than 30 days without informing the Commissioner of Child Welfare of the district, in writing.

However, if all the parties involved in the IVF and ET have obtained the necessary consent,(150) it is submitted that the transaction between them does not amount to the 'sale of a child'(151) and neither have they committed a criminal act.(152)

The sort of contract which it is submitted would be struck down by our courts as amounting to the 'sale of a child' and which would also be in contravention of section 79 of the Children's Act(153) which prohibits the giving or receiving of any valuable consideration for the adoption of a child, would be for surrogate mothers.(154) It is submitted that our courts would interpret a

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(147) Calitz v Calitz 1939 AD 56 at 63; Bam v Bhabha 1947 (4) SA 798 (AD); Wehmeyer v Nel 1976 (4) SA 966 (W).

(148) See section 1 (x)(a) Act 33 of 1960.

(149) No 33 of 1960.

(150) The written permission of the Minister of Health in terms of section 7(1) of Act 24 of 1970.

(151) It is submitted that the hostess mother is not in fact a 'parent' as defined in section 1. See notes 132 & 134 supra.

(152) Milton & Fuller S A Criminal Law & Procedure Vol III (1971) 763-765.

(153) No 33 of 1960.

(154) A surrogate mother is one who enters into an agreement with a husband and wife that she will be inseminated with the husband's sperm, bear a child and then relinquish the child plus all rights to it to the husband and wife. See Mady (1981) 7 Am J of Law & Medicine 323; Willey v Lawton 8 Ill App 2d 344, 132 NE 2d 34 (1956).

situation where a woman (A) contracts with a man (B) to be inseminated with his sperm, to conceive, bear, and then surrender the child and all rights to it in favour of Mr & Mrs B by way of adoption in exchange for valuable consideration as amounting to the sale of a child.(155) The parties would furthermore have committed an offence in terms of section 10(1) read in conjunction with section 16(1) of the Children's Act.(156)

The reasons, it is submitted, that our courts would take a different approach to a surrogate mother contract, is that the surrogate (A) is genetically and biologically the mother of the child.(157) Legally it is the illegitimate child of Miss A and Mr B.(158) The only way in which Mr & Mrs B can acquire full parental power over the child and legitimate it, is by adoption.(159) Where Miss A has been paid for her services this would amount to selling her child and to receiving remuneration for adoption.(160)

The sale of children in this manner would reduce human infants to the status of chattels and this is totally abhorrent to both public policy and private morality,(161) and would furthermore definitely not be considered to be in the best interests of the child.(162)

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(155) See Doe v Kelley supra and A v C supra.

(156) No 33 of 1960.

(157) Paterson (1982) 67 Iowa LR 393.

(158) A v C supra.

(159) In re McLeod 1972 (2) SA 383 (RAD). The consent of the child's natural (surrogate) mother would be necessary to validate such an adoption cf section 71(2)(d)(i) of Act 33 of 1960.

(160) A v C supra; Doe v Kelley supra; section 79 Act No 33 of 1960.

(161) Because a person, unlike a thing or chattel, is always the subject of rights and not the object of rights cf Gaius Institutes 1.8, 1.9; Digest 1.5.4.1; 1.5.4.2; R Sohm The Institutes 3rd (1907) 161; J D van der Vyver Die Beskerming van Menseregte in Suid-Afrika (1975) 19.

(162) Erickson (1978) 65 California LR 613; Keane (1980) Southern Illinois LJ 154.

4.2. The Rights and Liabilities of the Parties to the Contract

If we accept the submission that a contract between a husband (H) and wife (W) and the hostess (C) in which all the necessary consents have been obtained is legal it is still up to the parties to determine which terms and conditions they can include which have a realistic chance of being judicially enforced.

Although the written agreement of the parties may be persuasive to a court in order to establish their intent, the court is certainly not bound to enforce provisions in it which are contrary to public policy.(163) Furthermore, public policy concerns, play a vital rôle in the hostess mother arrangement, particularly where the interests of an unborn child are at stake. While attempts to contract to enforce personal services have until recently(164) been viewed unfavourably by our courts.(165)

4.2.1. The rights and liabilities of the hostess or carrier (C)

The rights and liabilities of the hostess or carrier arise from two basic promises which she makes to the H & W. First, C promises to have W's fertilised ovum inserted into her uterus and to carry the child to term. This undertaking includes the assurance that she will seek the necessary medical attention and to maintain and ensure the health and safety of the foetus. Second, C promises to surrender to H & W all rights in the child.

The pater est quem nuptiae demonstrant presumption will apply to the permutation in which the hostess (C) is also married to the sperm donor.(166) In the other permutations we will assume that (C) is unmarried. Since the

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(163) A v C supra; Doe v Kelley supra.
(164) Hayes v Kingwilliamstown Municipality 1951 (2) SA 371 (AD).
(165) ISEP Structural Engineering v Inland Exploration 1981 (4) SA 1 (AD) at 5.
(166) Mady (1981) 7 American J of Law & Medicine 333.

above presumption is rebuttable, C and her husband should state explicitly that they will not make any claim to the child which is in fact the illegitimate child of C's husband and W.(167) It is submitted that such a provision would help to eliminate emotional strain, probable litigation and would avoid harming the child by involving it in custody proceedings.(168)

4.2.1.1. Breach of contract by C

If C should commit a breach of contract by not adhering to one or both of her promises it will place the court in an extremely difficult position to devise an appropriate remedy. The remedy will in turn depend upon the type of breach of which there are 3 major possibilities viz C may wish to abort the child, C may negligently cause harm to the foetus or C may refuse to give the child up after birth.

4.2.1.1.1. Abortion

The position in South African law is clear on the issue of abortion. C can only have a legal abortion if she can justify the need for the abortion within one of the prescribed grounds in section 3(1) of the Abortion and Sterilization Act.(169) These grounds are strictly therapeutic and eugenic and if C's need for an abortion fell within these grounds it is submitted that H & W will not be justified in seeking any damages from C.(170)

If, however, C had undergone an illegal abortion, it is submitted that H & W could claim for any expenses they had incurred eg medical and legal expenses.(171) It is submitted however that our courts would decline to put a value on human life and that they would not succeed with a claim for the wrongful death of the foetus.(172)

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(167) Mady (1981) 7 American J of Law & Medicine 333.
(168) ibid.
(169) Act No 2 of 1975.
(170) Turner (1981) 58 J of Urban Law 474.
(171) Erickson (1978) 65 California LR 620.
(172) Boberg (1964) 81 SALJ at 498.

4.2.1.1.2. Inadequate Medical Care

The second type of breach which can occur is if C fails to obtain proper medical care during her pregnancy and due to her negligence the foetus suffers harm. Should this happen H & W have two possible avenues of recovery viz an action for breach of the terms of the contract, or a delictual action based on negligence.

(a) The delictual remedy

In order to succeed with this remedy H & W would have to prove that a particular activity engaged in by C (in this case failure on her part to undergo regular pre-natal care) had resulted in the foetus suffering a specific injury.(173) They would also have to prove the causality of the act(174) and result and furthermore, that a reasonably prudent pregnant woman would not have taken a risk of that nature viz refusal of proper medical care.(175) The onus of proof involved would be extremely difficult to satisfy and it is most unlikely that an action of this nature would succeed.(176)

The damages claimed by H & W would naturally depend on the nature of the injury suffered by the child.

(b) Specific performance

If the contract between H & W & C explicitly states the level of medical care which C agrees to undertake, the extent of her duty will be clear.(177) In the absence of specific terms in the contract, the standard of necessary medical

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(173) Pinchin NO v Santam Insurance Co Ltd 1963 (2) SA 254 (W).

(174) Pinchin NO v Santam Ins Co Ltd supra at 259.

(175) Pinchin NO v Santam Ins Co Ltd supra at 259.

(176) Pinchin NO v Santam Ins Co Ltd supra at 260.

(177) Tito v Waddell (No 2) 1977 Ch 306 at 321H-322B.

attention that C must observe would be the same as that which a reasonable pregnant woman[178] in the circumstances would receive. For our purposes we will assume that the exact degree of medical care required of C had been specified in the contract.

In the event of H & W discovering that during the term of C's pregnancy she had been remiss in obtaining the appropriate level of medical attention and that she refused to comply with their requests that she should adhere to her agreed programme of pre-natal medical attention, it is submitted that they can resort to an action against her for specific performance.[179]

It is submitted that this is the more appropriate action in the circumstances since the real purpose of the terms of the contract in this regard is to protect the welfare of the unborn child.[180] It is further submitted that retrospective damages obtained after the child has been born deformed are clearly inadequate since money damages will not cure the deformity which could have been prevented by timeous medical treatment.[181]

Our courts have generally been reluctant to grant interdicts to enforce specific performance of the terms of a contract 'where it would be difficult for the Court to enforce its decree'.[182] However in the case of ISEP Structural Engineering v Inland Exploration[183] the Appellate Division intimated that courts should not be reluctant to enforce the remedy of specific performance except in the following circumstances:[184]

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(178) Mady 1981 (7) American J of Law & Medicine 336.

(179) Mady ibid; Erickson (1978) 65 California LR 619.

(180) Mady op cit 337.

(181) Black (1981) 16 New England LR 379.

(182) Hayes v Kingwilliamstown Municipality supra at 378H.

(183) 1981 (4) SA 1 (AD) at 5.

(184) supra at 5E-F.

(a) where specific performance would operate unreasonably hard on the defendant or

(b) where the agreement giving rise to the claim is unreasonable, or

(c) where the decree would produce injustice, or

(d) where it would be inequitable under the circumstances.

It is submitted that in the type of contract we are considering that none of the above conditions are applicable and that an order of specific performance would be perfectly justifiable.

4.3.1.1.3. Refusal to surrender the child after birth

The third way in which C can breach the contract is by refusing to surrender the child to H & W after its birth.(185) Monetary damages are obviously an inappropriate form of compensation to H & W in this event since the whole purpose of the agreement was to provide them with what they could not otherwise obtain, viz a child of their own.(186) Since in most cases H & W are willing to pay money (for C's services) to obtain the child in dispute, giving them money as damages would be wholly inappropriate.(187) In addition there is no ethically acceptable standard by which a judge can measure the worth of the child.(188)

Although the child's genetic parents are H & W it is submitted that at this stage of our legal development it is most unlikely that a South African court would enforce specific performing viz by instructing C to surrender the child to H & W on the basis of her contractual undertaking.(189)

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(185) Erickson (1978) 65 California LR 620.

(186) Mady (1981) 7 Am J of Law & Medicine 323 at 336.

(187) ibid.

(188) Strauss Doctor, Patient and the Law (1980) 163.

(189) Ex parte Van Dam 1973 (4) SA 182 (W); Wehmeyer v Nel 1976 (4) SA 966 (W).

It is however submitted that H & W might obtain relief by instituting a claim for custody of the child.(190) This claim would be decided on the well established criterion of the best interests(191) of the child and would therefore not be against public policy.

It is further submitted that in all but the most extraordinary circumstances the best interests of the child will be served by being placed with its genetic mother and father who wanted the child desperately enough to go to such great lengths to conceive it, rather than to stay with the hostess or carrier who has no genetic link with the child and who is in fact a 'stranger' to it.(192)

It is also submitted that because of the infant's tendency to form psychological ties with the parent who has custody, that a prompt resolution of the custody dispute is a matter of urgency. It is submitted that it would be desirable if, upon prima facie proof of the 'womb-leasing' agreement, custody of the child were transferred to H & W pending a final custody decision by the court.(193)

Equity suggests that the existence of the contract freely entered into by H & W on the one hand and C on the other, should shift the custody decision in favour of the genetic parents rather than the carrier.(194)

4.2.2. The Rights and Liabilities of H & W

Assuming that 'womb-leasing' contracts are lawful and enforceable(195) their unique features would still present difficulties in the event of a breach.

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(190) Mady (1981) 7 Am J of Law & Medicine 323 at 338.

(191) Byliefeldt v Redpath 1982 (1) SA 702 (AD); Van Oudenhove v Gruber 1981 (4) SA 857 (AD).

(192) Keane (1980) 2 Southern Ill. Univ LJ 147 at 160.

(193) Black (1981) 16 New England LR 373 at 386.

(194) Paterson (1982) 67 Iowa LR 385 at 390.

(195) See p 115-116 supra.

4.2.2.1. Non payment of C's expenses and/or remuneration

H & W contract with C to pay the financial costs of her pregnancy and all necessary medical care, to pay her an additional fee for her services or an amount equivalent to her loss of earnings from her job. In addition they undertake to accept the child after birth.(196)

Since H & W have a vested interest in providing C with good medical and personal care during her pregnancy, they will presumably pay these expenses.(197) Should H & W renege on their promise to pay C's costs of pregnancy, medical care and her fee, recovery on normal contractual principles should be fairly straight forward, since these experiences will either be delineated in the contract or easily ascertainable by assessing the costs of medical care.(198)

4.2.2.2. Non acceptance of the child

Breach of the contract by H & W refusing to accept the child after birth will create a problem in determining an appropriate remedy not unlike that which occurs when C refuses to surrender the child.(199) It is submitted that specific performance is unlikely and inappropriate since it will not be in the best interests of the child to force H & W to accept an unwanted child.(200)

It is submitted that C would be justified in sueing H & W for maintenance of the child in the same way as any unmarried mother can sue the father of her child for support.(201) C should in addition be entitled to sue H for the inconvenience of having custody foisted on her on the basis that she reasonably relied

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(196) See specimen contract at p 121.

(197) Mady (1981) 7 Am J of Law & Medicine 323 at 339.

(198) Keane (1980) 2 5 Illinois U L J 147 at 167.

(199) Humphreys (1979) Detroit C LR 433-434.

(200) Mady (1981) 7 Am J of Law & Medicine 323 at 339.

(201) Lamb v Sack 1974 (2) SA 670 (T) at 673 (C-D).

on H & W's promise that they would assume custody of the child and that the child would not be in her custody after its birth.(202) Alternatively should C wish to retain custody of the child she should not be coerced into putting the child up for adoption to mitigate H & W's damages, or because she cannot afford to provide adequately for the child from her own means.(203)

It is submitted that in either case H should be estopped from denying responsibility on the basis that he admits to being the child's genetic father and has contracted to accept the child and become its father in all respects.(204)

It is submitted that if neither H & W nor C wishes to retain custody of the child, C should be free to offer the child for adoption.(205)

It is however submitted that it is most unlikely that H & W would breach their undertaking to accept the child in view of the effort, commitment and expense which they went to, to conduct the search for a suitable carrier, and to negotiate the contract. Furthermore the fact that the child is genetically theirs is also a very strong motivating factor.(206)

5. Womb-Leasing Contract Agreement(207)

THIS AGREEMENT is made this _____ day of _____, 1982 by and between _____ (hereinafter referred to as "carrier") and _____ (hereinafter referred to as Genetic).

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(202) Mady (1981) 7 Am J of Law & Medicine 323 at 339.

(203) ibid.

(204) ibid.

(205) Keane (1980) 2 S Illinois U LR 147 at 168.

(206) Erickson (1978) 65 California LR 611 at 619.

(207) The following series of agreements have been adapted from a series of similar agreements published by Katie Marie Brophy in (1981/2) 20 Journal of Family Law 263 at 266-268.

RECITALS

THIS AGREEMENT is made with reference to the following facts:

(1) The Genetic Father is a married individual over the age of twenty-one (21) years who is desirous of entering into the following agreement.

(2) The Genetic Father and the Genetic Mother desire to have a child who is biologically related to them.

(3) The Carrier is over the age of twenty-one (21) years and is desirous of entering into the following agreements in consideration of the financial remuneration incident hereto.

NOW THEREFORE, in consideration of the mutual promises contained herein and with the intentions of being legally bound, hereby the parties agree as follows:

SECTION I. The Carrier represents that she is capable of conceiving children, but agrees that she will not form or attempt to form a parent-child relationship with any child she may conceive pursuant to the provisions of this contract and shall freely and readily, in conformance with applicable statutory regulations, terminate all rights to said child pursuant to this agreement.

SECTION II. The Genetic Father is hereby entering into a written contractual agreement with the Carrier whereby the Carrier shall have the fertilised ovum of the Genetic Father, and the genetic mother implanted into her uterus by _____, M.D. The Carrier, upon becoming pregnant, shall carry said embryo/fetus(s) (hereinafter referred to as "child") until delivery. Delivery shall occur at the ..... Hospital. The Carrier agrees that she will on the fifth day after delivery of the child, or as soon thereafter as is medically possible, hand over the child to its genetic parents, who will register the child in their name in accordance with the provisions of the Births, Marriages and Deaths Registration Act 81 of 1963.

Comment

The carrier mother should be placed in a private ward which is not in the maternity division. Her file will be flagged just as in a regular private adoption, and she will not see the child. It is suggested that the genetic father and his wife should begin feeding the child as soon as it is delivered.

SECTION III. The Genetic Father and the Carrier recognize and acknowledge that the Attorney(s) for the Genetic Father shall act as agent for the Genetic Father in all matters pertaining to this agreement in order to maintain complete confidentiality.

SECTION IV. The consideration for this agreement, in addition to other provisions contained herein, shall be as follows:

(a) R_____ shall be paid to the Carrier upon delivery of the child to the Genetic Parents.

(b) The Genetic Father will pay the Carrier's pregnancy and confinement expenses beginning on the date her pregnancy is verified and continuing for one (1) month subsequent to the contemplated birth. Said pregnancy and confinement expenses shall not exceed R_____ per month in addition to the following:

(c) The consideration to be paid said Carrier shall be deposited with the attorney for the Genetic Father at the time of the signing of this agreement and held in trust until completion of the duties and obligations of the Carrier.

(d) The Genetic Father shall pay the expenses incurred by the Carrier pursuant to her pregnancy, more specifically defined as follows:

(1) All medical, hospitalization, and pharmaceutical, laboratory and therapy expenses incurred in the Carrier's pregnancy.

(2) The Genetic Father shall not be responsible for any latent medical expenses occurring six (6) weeks subsequent to the birth of the child unless the medical problem/abnormality incident thereto was known prior to the expiration of said six (6) week period.

(3) The total cost of all paternity testing.

(4) The Carrier's travel expenses incurred pursuant to this agreement. These expenses shall be defined as follows:

1. Travel expenses incurred by motor car taxi during the Carrier's trip to the hospital for delivery. Said expenses incident to the motor car travel shall not exceed 25 cents per kilometre.

Comment

Subsection (c)(2) states that the genetic father will not be responsible for any latent medical expenses occurring six weeks subsequent to the birth, unless the medical problem incident to the expense existed and was known of prior to said time. At six weeks, the carrier will have her final postpartum examination as is the case with all mothers. Medical experts believe that at the six week examination, all problems should be known. It is necessary to limit the genetic father's liability by deterring the carrier from reappearing a year after delivery, stating that she had just developed a problem which was necessarily related to the pregnancy and therefore, seeking payment for that amount. As a practical matter, if there is a problem, or abnormality known of prior to the six week period, the genetic father would probably continue payment of her medical expenses.

SECTION V. Immediately subsequent to the birth of the child, the Carrier, the Genetic Father and the child shall undergo the following tests under the direction of a pathologist designated by _____, M.D.:

(1) Blood Group

(2) Serum Proteins

(3) Red Cell Enzymes

(4) White Cell/H.L.A.

In the event that the Genetic Father is excluded by one (1) or more of the aforementioned tests, it will be sufficient proof that he is not the father of the child. This contract shall then be immediately terminated and all monies and/or all other consideration paid to the Carrier shall be immediately returned by the Carrier to the Genetic Father.

SECTION VI. The Genetic Father shall pay the cost of the term life insurance policy payable to a named beneficiary of the Carrier with a policy amount of R_____ and said policy shall remain in effect for six (6) weeks subsequent to the birth of the child. In addition, the Genetic Father shall make appropriate arrangements in his will for the support of the infant child should he die prior to the birth of said child and shall pay the cost of a term life insurance policy on his life payable in trust to said unborn child.

SECTION VII. The Carrier understands and agrees to assume all risks including the risk of death which are incident to conception, pregnancy, childbirth and postpartum complications.

SECTION VIII. The Carrier agrees to undergo psychological/psychiatric evaluation by (1) Dr _____ and (2) Dr _____, psychologist(s) designated by the Genetic Father or an agent thereof. The Genetic Father shall pay for the cost of said psychiatric and psychological reviews. The evaluations of said psychiatrist and psychological reviews. The evaluations of said psychiatrist and psychologist shall be submitted to the Genetic Father, absent any information which would tend to identify or allow identification of the Carrier. The Carrier shall sign prior to their evaluations, a medical release authorizing the Attorney for the Genetic Father to secure the release of said psychiatric evaluations prior to said evaluation.

SECTION IX. In the event that custody of the child is awarded to the Carrier or any individual or organization, not related to the Genetic Father, by any court decision or otherwise, the Genetic Father shall be indemnified by the Carrier for any and all monies he is required to pay for child support or pregnancy related expenses pursuant to said court order and shall be entitled to immediate reimbursement from the Carrier for all monies and/or other consideration paid to the Carrier pursuant to this agreement or expended on behalf of the Carrier.

SECTION X. The Genetic Father agrees that he will not seek to learn the identity of the Carrier or her family, nor advise the child of said identity if known.

SECTION XI. The Carrier agrees that she will not seek to learn the identity of the Genetic Father of the child and will not attempt to contact same if their identity is learned.

SECTION XII. In the event that pregnancy has not occurred within a reasonable time, in the opinion of the attendant physician, _____ M.D., this agreement shall terminate by written notice from the Attorney for the Genetic Father to the Carrier.

SECTION XIII. All parties hereto agree that they will not provide nor allow their agents to provide any information to the public, news media or any other individual or group which sould lead to the disclosure of the identity of the parties hereto or the child.

SECTION XIV. In the event of the Carrier violating any of the provisions contained herein, this agreement may be immediately terminated at the option of the Genetic Father without any further liability hereunder. In the event the Genetic Father does terminate this agreement, the Genetic Father shall be under no obligation to pay any monies to the Carrier or reimburse any of her expenses. In addition, the Carrier must reimburse the Genetic Father for all monies expended on her behalf pursuant to this agreement.

SECTION XV. The Carrier agrees that she will provide no interviews of any kind whatsoever, either of a public or private nature, without the prior written consent of the Attorney for the Genetic Father.

SECTION XVI. The Carrier agrees that she will not abort the child once conceived except, if in the opinion of the attendant physician, such action is necessary for the physical or mental health of the Carrier or the child has been determined by said physician to be physiologically abnormal. In the event of either of those two (2) contingencies, the Carrier desires and agrees to have said abortion.

SECTION XVII. The Genetic Father assumes the legal responsibility for any child who may possess congenital abnormalities and he has been previously advised of the risk of such abnormalities.

SECTION XVIII. In the event that the Genetic Father and Mother predecease the birth of the child, said child shall be placed in the custody of _____, for placement through a private adoption to a designated person upon consent of the appropriate social agency.

SECTION XIX. The Carrier agrees that she will not seek to view the infant child born pursuant to this contract at any time, nor will the Carrier seek to view or meet with the Genetic Father.

SECTION XX. The Carrier further agrees to adhere to all medical instructions given to her by _____, M.D. as well as her independent gynaecologist. The Carrier also agrees not to smoke cigarettes, drink any alcoholic beverages, use any illegal drugs, non-prescription medications or prescribed medications without written consent from _____, M.D. The Carrier agrees to follow a prenatal medical examination schedule to consist of no fewer visits than: one visit per month during the first seven months of pregnancy, two visits (each to occur at two week intervals) during the eighth month of pregnancy and four visits (each to occur at weekly intervals) during the ninth month of pregnancy. The Carrier

agrees to take all necessary steps to sign all necessary documents in order to have her medical records sent to the Attorney for the Genetic Father on a monthly basis.

SECTION XXI. Each party acknowledges that he or she fully understands the agreement and its legal effect and that he or she is signing the same freely and voluntarily and that neither party has any reason to believe that the other(s) did not freely and voluntarily execute said agreement.

SECTION XXII. In the event any of the provisions of this agreement are deemed to be invalid or unenforceable, the same shall be deemed severable from the remainder of this agreement and shall not cause the invalidity or unenforceability of the remainder of this agreement. If such provision shall be deemed invalid due to its scope or breadth, such provision shall be deemed valid to the extent of the scope or breadth permitted by law.

SECTION XXIII. This agreement may be executed in two (2) or more counterparts, each of which shall be an original but, all of which shall constitute one and the same instrument.

SECTION XXIV. This agreement sets forth the entire agreement between the parties with regard to the subject matter hereof. All agreements, covenants, representations, and warranties, express and implied, oral and written, of the parties are contained herein. No other agreements, covenants, representations or warranties, express or implied, oral or written, have been made by any party to the other(s) with respect to the subject matter of this agreement. All prior and contemporaneous conversations, negotiations, possible and alleged agreements and representations, covenants and warranties with respect to the subject matter hereof are waived, merged herein and superseded hereby. This is an integrated agreement.

SECTION XXV. This agreement can be amended only by a written agreement signed by all parties hereto.

SECTION XXVI. This agreement has been drafted, negotiated, executed and performed in ....., and shall be governed by, continued and enforced in accordance with the laws of ....

SECTION XXVII. No provision in this agreement is to be interpreted for or against any party because that party or that party's legal representative drafted the provisions.

_____

Prepared by:

_____

Attorney at Law

Pietermaritzburg, Republic of South Africa

I, _____ recognise that there is a signature line on the attached page for signatures by the Genetic Father and that in order to maintain confidentiality I will never see any signatures of said Genetic Father, although it is our collective intention to enter into a binding legal obligation.

_____ _____

Carrier Date

_____ _____

Attorney for Carrier Date

_____ _____

Attorney for Genetic Father Date

PIETERMARITZBURG

REPUBLIC OF SOUTH AFRICA

The foregoing instrument was acknowledged before me this _____ day of _____, 1982, by _____, and _____.

_____
NOTARY PUBLIC
PIETERMARITZBURG

My Power of Attorney expires the _____ day of _____ 19__.

I, _____, recognize that there is a signature line on the attached page for signatures by the Carrier, and that in order to maintain confidentiality I will never see any signatures of said Carrier, although it is our collective intention to enter into a binding legal obligation.

_____ _____
Genetic Father Date

_____ _____
Attorney for Genetic Father Date

_____ _____
Attorney for Carrier Date

PIETERMARITZBURG
REPUBLIC OF SOUTH AFRICA

The foregoing instrument was acknowledged before me this _____ day of _____, 1982 by _____, and _____.

_____
NOTARY PUBLIC
PIETERMARITZBURG
REPUBLIC OF SOUTH AFRICA

CHAPTER 4

THE PHYSICIAN'S ROLE

1. The Physician's responsibility

The physician who carries out donor insemination or in vitro fertilization assumes a heavy responsibility, for he alone can and must determine the eugenic fitness and the acceptability of the substitute biological father/mother in each case, as well as determining whether or not donor insemination or ET is the most suitable form of therapy for the couple involved.(1)

Consequently, physicians have a duty to exercise due care in the diagnosis(2) and treatment of patients seeking treatment for infertility. When the treatment they prescribe includes AID or ET the standard of care required of them extends to the examination of donors. Physicians and cryobanks will probably be held to be delictually liable if it can be proved that their actions fell below the required standard of care and that this deviation was responsible for injury.(3)

Although physically and mentally defective children resulting from AID and ET are rare, the physician who engages in these procedures may be civilly liable for damages should they occur. If an action for damages is brought against the physician then it is submitted that the negligence resulting from his professional conduct should be determined according to the well established legal principle governing a physician's professional conduct, viz, that it should be measured against

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(1) Guttmacher (1969) 18 De Paul LR 570.

(2) Mitchell v Dixon 1914 AD 519,

> '... a medical practitioner is not necessarily liable for a wrong diagnosis. No human being is infallible: and in the present state of science, even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect, if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in his profession' per Innes CJ at 526.

(3) Ravenis v Detroit General Hospital 234 NW 2d 411 (Mich Ct of App, August 11 1975); Frankel op cit 95.

the conduct of a '... reasonably skilled and careful practitioner in the position of the respondent ....'(4)

2. Suggested qualifications for the AID & ET practitioner

Referring to AID the British Medical Association expressed the view that 'the actual technique of insemination is of the nature of a minor surgical procedure, but ... the selection of suitable couples and donors, and their investigation for fitness, necessitates considerable knowledge in the fields of gynaecology, male infertility, psychological medicine and human genetics.'(5) It is thus submitted that a practitioner who wishes to practice in these fields should have a sound knowledge in the skills discussed below.

ET requires a considerably greater degree of medical skill on the part of the practitioner than does AID. The practitioner is required to perform a laparoscopy during which he extracts a small number of ova from the uterus by aspiration. They must then be placed in the correctly mixed culture medium and brought into contact with semen which have been capacitated. The cultured embryo must then be reimplanted in the uterine cavity at the optimum time which coincides with the development of the endometrium or uterine lining.(6) It is thus submitted that the skills required for a successful in vitro fertilization and subsequent embryo transplant places the technique beyond the scope of the average general practitioner; in fact there are currently only two skilled teams of specialists who practice the technique on a large scale viz Steptoe and Edwards at Bourn Hill Clinic in Oldham(7) and the team of gynaecologists at the Faculty of Medicine Monash University, Melbourne.(8) A practitioner who does attempt

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(4) Blyth v Van den Heever 1980 (1) SA 191 (AD) at 221; Mitchell v Dixon ibid 525; Van Wyk v Lewis 1924 AD 438 at 461.

(5) See supplement to the British Medical Journal 27 June 1959.

(6) Luigi Mastrioanni 'In Vitro Fertilization' (1978) Encyclopedia of Bioethics 1449.

(7) Sunday Tribune 4 October 1981.

(8) Cf Test-tube fertilization - the necessity of Australian legislation (1981) 55 Australian Law Journal 314.

ET without the necessary research and training would, it is submitted, be misleading his patients and his actions would certainly be negligent, unless he measured up to the standard of the reasonable practitioner with that training.

2.1. Gynaecology and Male Infertility

It is a fairly obvious requirement that the prospective AID practitioner should have a sound knowledge of male infertility and gynaecology.(9) This knowledge is essential in order to diagnose the problem and advise the typical couple who approach the practitioner and state that their marriage is involuntarily childless.(10) It is up to the practitioner to determine whether the fault lies with the husband, the wife or both.(11) Many couples seek AID before the wife's fertility and capacity to reproduce have been adequately investigated.(12) Proper medical examination reveals not infrequently, that both the husband and the wife possess a degree of infertility which points to the fact that AID is unlikely to be successful.(13)

It is rarely possible to state categorically that a male with fertility problems will be permanently incapable of begetting a child.(14) This fact should be borne in mind in the counselling and decision making process by the spouses and the physician in order to avoid utilising too quickly the AID remedy, which should be considered as a last resort.(15) This is borne out by the fact that not infrequently a couple conceive a child by natural means after having adopted one; in such a case the husband and wife stand in an equal relationship to both children, the first 'belonging' physically to neither of them and the second to both.(16) However a similar position does not arise if an AID child is followed

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(9) Guttmacher (1969) 18 De Paul LR 570 at 566.
(10) Sergeant (1970) 19 Drake LR 434.
(11) Ficarra (1967) 4 Lex & Scientia 57.
(12) Verkauf 1966 (3) Houston LR 283, 284.
(13) ibid.
(14) De Stoop (1976) 50 Australian LJ 305.
(15) Schellen Artificial Insemination in the Human (1957) 178.
(16) Feversham Report op cit 63.

by a natural child. It is thus submitted that AID should not be administered in situations where the husband only suffers from a moderate degree of oligospermia.(17)

It is also necessary for the practitioner to have some knowledge of human genetics, both in order to deal with the rare cases where an hereditary disease in the husband's family may be considered an indication for AID, and in addition so that he can recognise the minor trends which would suggest the possibility that a donor might be carrying certain hereditary diseases.(18) For the latter purpose, he would have to enquire, not only into the donor's own medical history but into that of his family for several preceding generations. If careful enquiries are made about the donor's heredity, the risk to the child is probably less than where the child is born as a result of natural conception, however with natural conception the doctor cannot be held responsible for the development of genetic abnormalities in the child.(19)

2.2. Psychological medicine

It is on his skill in the field of psychological medicine that the practitioner's selection of suitable couples and donors largely depends.(20) It is submitted that the practitioner need not be a qualified psychiatrist, but that he should be sufficiently knowledgable or have sufficient practical experience to be able to eliminate the unbalanced, either as donors or as applicants for AID and ET.(21)

In regard to the selection of donors it is submitted that an essential requirement would be the ability to recognise those who were psychologically unfitted for the task.(22) However in dealing with applicants for AID or ET a

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(17) Verkauf (1966) 3 Houston LR 283.

(18) Shaman (1979/80) 18 Journal of Family Law 348.

(19) ibid at 349.

(20) Joseph A Silvoso 'Artificial Insemination ; A Legislative Remedy' (1975) 3 Western State LR 48 at 58.

(21) Sagall (1973) 9 Trial 63.

more positive approach and more far-reaching enquiries would be needed. It is submitted that the practitioner who is approached for AID or ET treatment should try and determine not only whether the marriage is currently stable, but whether it is likely to remain so after the birth of an AID or ET child. He has to try and envisage the circumstances in which the child will grow up, five, ten or fifteen years later.(23)

2.3. Are AID and ET Therapeutic Procedures?

The above procedures are sometimes represented as being a 'cure' for childlessness.(24) AID is certainly the only cure for childlessness due to the husband's infertility.(25) One must not however lose sight of the fact that the husband remains infertile and is not cured by his wife's recourse to donated semen.(26) If the wife's infertility is the result of tubal occlusion ET will assist her to bypass this problem and produce her own child, but it must be pointed out that it will not cure the physical defect which forces her to resort to this form of conception.(27) The usual justification claimed for AID and ET is that they are procedures which fulfill an earnest emotional desire for a child to be born to the wife and not on the basis that either of them is suffering from any form of physical or mental disability.(28)

In this regard AID and ET appear to differ from most other forms of medical treatment. Certain forms of treatment however, are aimed not at treating any specific physical or mental disability but in the interests of the patient's general well-being.(29) Certain practitioners thus justify the fact that AID and ET are therapeutic on the basis that they bring happiness to the marriage. It is

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(22) Carr (1973) 26 Alabama LR 128.

(23) A W Diddle 'Rights Affecting Human Reproduction' (1973) 41 Obs. & Gyn 789 at 792.

(24) Feversham Report 64.

(25) Drumheller (1968) Illinois LF 222.

(26) Frankel Encyclopedia of Bioethics op cit 1445.

(27) Mastrioanni, Encyclopedia of Bioethics 1449.

(28) Sagall (1973) 9 Trial 63; Shapiro & Spece Bioethics & Law (1981) 529-533.

(29) Elaine Jones 'Artificial Insemination' (30 July 1960) The Lancet 247.

for this reason that AID is often referred to in the USA as 'therapeutic donor impregnation'.(30) Where the decision to resort to AID however differs from other decisions relating to medical treatment is that when the practitioner decides to use AID he takes it upon himself not only to bring 'foreign' blood into the marriage but also assumes responsibility for choosing who will be the biological father of the child. Herein lies the essential difference between AIH, ET (using the wife's ovum) and AID.(31)

In order to be in a position to make a fully informed consent as to all the possible medical implications and consequences of AID or ET it is up to the practitioner to carefully counsel the spouses on these matters.(32) This is in the practitioner's own interests lest the couple afterwards seek to lay the blame on him for consequences which they had not foreseen.(33)

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(30) Klayman (1970) Cincinatti LR 291 note 1;

> 'The term therapeutic impregnation is more commonly referred to as artificial insemination. Unfortunately, much hostility toward the practice probably derives from an automatic indelible adverse reaction evoked by the semantic symbols - artificial insemination. Rather than focus on the artificial procedure and the insemination method when advancing a name for the technique, it would be wiser to concentrate on the treatment of the condition it is intended to relieve and the remedial effects of such treatment. Thus therapeutic impregnation reveals the true spirit and motivation of the medical practice - the treatment of a matrimonial inability or inadvisability to conceive by normal intercourse for the purpose of causing pregnancy to occur, thereby relieving the otherwise sterile condition. The term may encompass a situation where a maturing ovum is transplanted into a female genital tract (therapeutic inovulation) as well as the more traditional practice of introducing semen into the tract. The term does not comprehend impregnation for purely eugenic or euthenic purposes, nor is the practice intended to replace conventional intercourse as a means of impregnation. Hopefully the new term therapeutic impregnation will succeed in dispelling much of the hostile reaction directed toward the practice.'

(31) Elliot & Sagall 'Artificial Insemination' in Medical Ethics and Liability ed Cyril H Wecht (1976) 255 at 265.

(32) G Schaad 'Medical and psychological preliminaries for artificial insemination' (1971) Published papers of the 7th Congress on Fertility and Sterility, Tokyo at 365.

(33) Feversham Report 64.

3. Suggested precautions to be observed by a 'reasonable' physician practising AID and ET.

The vast majority of candidates for IVF will be women with occluded oviducts who are physically competent to carry a foetus to term if conception did occur.(34) No biological third party would be involved in these in vitro fertilizations. Consequently a child born via this technique would not be burdened with any doubts as to its ancestry because biological and legal parenthood would coincide.(35) This is in effect the female counterpart of AIH.

3.1. Medical and Clinical Precautions for ET

In a situation where a wife's eggs are defective because they are genetically abnormal or damaged by disease or absent, a physician may decide to assist the wife to produce a child by utilising a donated ovum, fertilising it with the husband's spermatozoa and then implanting it into the wife's uterus.

The doctor must of course exercise the same degree of care in choosing the ovum donor as would be the case in choosing a sperm donor,(36)

(a) he must subject the potential donor to a thorough medical examination with particular emphasis on ensuring her freedom from any venereal disease;(37)

(b) he must thoroughly screen the potential donor and her family background to ensure that there is no transmissible disease or genetic defect in her or her family;(38)

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(34) Cf Reilly Genetics and the Law (1975) 360.

(35) A Jones & W Bodmer Our future inheritance : choice or chance? (1974) 30.

(36) Mariel Revillard 'Legal Aspects of Artificial Insemination and Embryo Transfer in French Law' (1974) International and Comparative Law Quarterly 383 at 388.

(37) ibid.

(38) ibid.

(c) he must ensure that the donor's blood is tested to ensure compatibility with that of the recipient.(39)

New and sophisticated tests allow preconception prediction of many genetic disabilities, permitting prospective parents to make an informed decision whether to conceive. Furthermore, such postconception techniques as amniocentesis(40) and ultrasonography(41) can tell prospective parents whether a foetus is actually impaired. Amniocentesis involves inserting a long needle into the uterus to obtain a sample of amniotic fluid containing both dead and living foetal cells. Living cells can be cultured to grow into colonies of cells whose chromosomes can be studied during cell division. Cultured amniotic fluid cells can be used to determine the chromosomal constitution of the foetus and to diagnose metabolic defects. More than 60 such disorders can be so diagnosed, including Tay-Sachs disease. Recent studies indicate that amniocentesis is highly accurate and increases the risk of spontaneous abortion by only 0,5%. Experts indicate that the procedure is sufficiently safe to warrant its use in pregnancies in which there is a risk factor of at least one in 200 of producing a seriously abnormal child.(42)

If the test is executed with the necessary skill and care the doctor will not incur any liability even if the foetus was damaged in the course of the procedure and is subsequently born defective. The physician is not liable by reason of the fact that there is no negligence on his part. Furthermore, the

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(39) Mastrioanni Encyclopedia of Bioethics (1978) 1450.

(40) Aubrey Milunsky 'Prenatal Diagnosis' in Encyclopedia of Bioethics (1978) 1332; J Miller 'Genetic Problems Related to Reproduction' in Counselling in Genetics (1979) 81 at 98, edited by K Hirschorn, R Silverberg and L Gadmilaw.

(41) ibid.

(42) ibid.

object of the test viz to determine the genetic soundness of the foetus is medically, socially and scientifically justified.(43)

Ultrasound appears to be harmless to both mother and foetus. It can detect such abnormalities as neural tube defects, anencephaly and dwarfism. When combined with computerised axial tomography (CAT) scanning which also provides cross-sectional views through tissue, it can in addition detect malformations of internal organs such as polycystic kidneys.(44)

However where the fertilization has been done via the in vitro process the embryo is readily available and the test could be performed before the embryo is transferred into the uterus. Since close to 20 000 infants are born in the USA each year with chromosomal defects, it is important to note that most chromosomal abnormalities can be diagnosed in the foetus sufficiently early in pregnancy for the parents to consider the option of abortion.(45)

3.1.1. Recovery of the ova

Ovum donation (OD) is the female counterpart of AID. However, for two reasons it is in practice qualitively different:

(a) Unlike sperm donation or blood donation, oocyte donation requires a surgical intervention known as laparoscopy which presupposes physical discomfort and risk.(46) Laparoscopy is a technique for visualising the abdominal contents

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(43) S A Strauss Doctor, Patient and the Law (1980) 159.

(44) Miller Counselling in Genetics (1979) 98.

(45) It is submitted that in terms of s 3(1)(c) of the Abortion and Sterilization Act No 2/1975 this would be justified:

> '3(1)(c) Where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped and two other medical practitioners have certified in writing that in their opinion there exists, on scientific grounds, such a "risk"'.

See also Boberg The Law of Persons and The Family (1977) 20-21; Van der Vyver & Joubert Persone & Familiereg (1980) 58; Strauss op cit 195 et seq. See also Milunsky Encyclopedia of Bioethics (1978) 1332.

(46) P C Steptoe & R G Edwards 'Laparoscopic Recovery of Preovulatory Human Oocytes After Priming the Ovaries with Gonadotrophins' (1970) Lancet 683.

which involves placing a telescope through a small incision in the umbilicus. It is used extensively in evaluating female infertility and for tubal sterilization.(47)

During laparoscopy a small number of ova are aspirated by needle puncture. They are then placed in a nourishing liquid culture medium.(48) If the aspiration is carefully performed by a physician trained in the technique there is no evidence that the removal of oocytes (eggs prior to maturation) causes any damage to the ovary.(49) The normal female has 400 000 to 500 000 oocytes at birth, so there is no danger of depleting the supply of eggs.(50)

For the immediate future it will be possible to secure needed oocytes from women undergoing surgery for other reasons, but it is important to realise that this source limits the size of the donor pool and consequently the latitude of choice which the donee couples can exercise.(51)

If the woman is subjected to surgery not for the purpose of maintaining or improving her health, but solely to recover occytes for culture, fertilization and transfer, the ethical and legal issues become more complex and one has to consider the merits of the operation in the light of a risk-benefit ratio affected by wider circumstances. The physician must consider amongst others the risk to the mother (inherent in the procedure itself), as well as the risk to the foetus (possibility of deformity) and weigh these against the benefits to the spouses in the form of a successful pregnancy.(52)

In the South African context we must constantly bear in mind that the removal of oocytes from one woman and their transfer into another for reproductive

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(47) ibid.
(48) Milunsky Encyclopedia of Bioethics (1978) 1332.
(49) Steptoe & Edwards (1970) Lancet 684.
(50) Mastrioanni Encyclopedia of Bioethics (1978) 1448.
(51) Reilly Genetics and the Law (1975) 369.
(52) Mastrioanni op cit 1449.

purposes can only be done with the consent of the Minister of Health in terms of section 7(1) & (2) of the Anatomical Donations and Post-Mortem Examinations Act.(53) Failure by a physician to observe the conditions in section 7(1) & (2) constitute an offence.

Advances in medical technology have improved the chances of successful in vitro fertilization eg patients are pretreated with pituitary hormones in order to obtain properly conditioned ova for fertilization.(54) Another advantage gained from the use of pituitary hormones is that it allows standardization of the menstrual cycle and simultaneous maturation of several ova containing follicles.(55) Although these hormones have been extensively used for the induction of ovulation in infertile patients, the physician must observe the greatest care and continual vigilance as one of the occasional side-effects of these drugs are ovarian cysts and multiple births.(56)

It is thus submitted that it is vital for the physician to fully inform both the husband and wife of all the potential risks and hazards of the IVF process viz the hormone administration, laparoscopy to aspirate the oocytes and then again to reimplant or transfer the blastocyst. He must also inform them of the completely unknown odds of achieving pregnancy and the unquantifiable chance that a defective child could be born.(57)

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(53) Act No 24 of 1970.

(54) Mastrioanni Encyclopedia of Bioethics (1978) 1449.

(55) G George 'Creating Life in the Lab' (1974) 75 Science Digest 28 at 30.

(56) Marc Lappe 'Ethics of In-vitro Fertilization : Risk Taking for the Unborn' The Hastings Center Report (Feb 1972) at p 2;

> 'Fertility drugs which induce super-ovulation are used without regard to the likelihood of multiple births and resulting stunting of foetal growth, prematurity, and higher risk of respiratory disease and death .... Moreover, this society has sanctioned the use of sex steroids like diethylstilbestrol to help women who are habitual aborters to have their own children, even when the safety of the artificial steroid was incompletely known.
>
> Daughters of some of the women who took this steroid eventually developed vaginal cancer. There are also couples under an increased risk of producing a child with a genetic defect who elect to take that risk.'

(57) Oakley (1974) 8 Family LQ 393.

It is submitted that the process does not create an unusual or abnormal degree of legal risk or liability for the physician but that as always the standard of skill expected from him is that of '... the reasonably skilled and careful medical practitioner in the position of the respondent ....'(58) As our law does not apply strict liability to the acts of a physician, he is by implication relieved of liability for non-negligent defects arising from IVF and ET.(59)

4. Liability of the Physician

A physician who does not possess the qualities outlined above or does not observe the precautions spelt out supra could be held liable for the damages which might occur in the circumstances described below.

A physician whose practice includes infertility therapy via the techniques of AID or IVF is vulnerable to claims for damages resulting from injury caused to one of the participants eg the instruments used in AID could infect the woman inseminated with them,(60) or a disease could be transmitted to her from the donor.(61) Laparoscopy for removing eggs has a risk of complications as well as infection.(62) Zygote transplantation may also injure the recipient and a surrogate mother could be injured in carrying the child to term.(63) Finally, the resulting child could also be injured because of the technical manipulations performed on the ova, or because the child was conceived from a 'defective' sperm or egg cell.(64)

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(58) Blyth v Van den Heever supra 221 (D).

(59) Strauss Doctor, Patient and the Law (1980) 255.

(60) John A Robertson 'Reproductive Technologies - Legal Aspects' in Encyclopedia of Bioethics 1466.

(61) ibid.

(62) ibid.

(63) ibid at 1467.

(64) ibid.

While no such litigation has yet been reported it is possible to speculate on the liability of the physician in terms of our law of delict in regard to the following categories of persons affected by his conduct, viz, the woman inseminated, her husband, the donor, the child produced, and any other individuals such as next-of-kin of the woman and her husband.

4.1. Basis of the physician's liability

There are three possible sources according to which the physician's liability can be assessed:

4.1.1. Strict liability

Acceptance by the courts of the res ipsa loquitur doctrine virtually amounts to introduction of strict liability, and although the doctrine has been applied on an inconsistent basis by English(65) and American(66) courts, South African Courts, both before and after(67) the Appellate Division's decision in Van Wyk v Lewis,(68) have consistently refused to apply the res ipsa loquitur maxim. Our courts have thus refused to deviate from the accepted principles of our law of delict when assessing professional liability viz fault in the form of culpa or dolus.(69)

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(65) John K Toulmin 'Major Current Problems [in the UK] as seen by the Lawyer' in The Influence of Litigation on Medical Practice ed Clive Wood (1977) 79.

(66) Edward J Hart 'Effect of Litigation on the Practice of Medicine in the USA - A Lawyer's View' in The Influence of Litigation on Medical Practice ed Clive Wood (1977) 45 at 48; Rubsamen 'Silverson v Weber - A Reconsideration of Res Ipsa Loquitur in Medical Malpractice (1962) 15 Stanford LR 77: Bruce v United States 167 F. Supp. 579 (SD Cal 1958).

(67) Mitchell v Dixon 1914 AD 519 at 525; Webb v Isaac 1915 EDL 273 at 276; Coppen v Impey 1916 CPD 309 at 320; Allott v Paterson & Jackson 1936 SR 221 at 226.

(68) 1924 AD 438.

(69) Blyth v Van den Heever 1980 (1) SA 191 (A); Strauss, Doctor, Patient and the Law op cit 263; Buls & Ano v Tsatsarolakis 1976 (2) SA 891 (T) at 894; Duke v Administrator, Transvaal 1957 (3) SA 710 (T) at 723.

According to the theory of strict liability, liability would be imposed on the physician without any need for the plaintiff to prove fault or negligence arising from the AID or IVF. It would merely be necessary for the plaintiff to prove that he had suffered harm caused by the physician's conduct.(70) The provisions of the res ipsa loquitur(71) principle of evidence in those jurisdictions where it is applicable to delictual claims against doctors, greatly facilitates the onus of proving the doctor's negligence which rests on the plaintiff.(72) The res ipsa loquitur doctrine is not applicable to medical treatment generally but to those situations in which it is most unusual or unlikely for the injurious result to have followed from the particular treatment administered by the doctor.(73)

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(70) Strauss, Doctor, Patient and the Law 148; Mastroianni Encyclopedia of Bioethics (1978) 1451.

(71) A literal translation is 'The thing speaks for itself'. The advantage that this doctrine has for the plaintiff is that if he can prove that the injury which he has suffered arose directly from the actions of the defendant an inference is created that the defendant was negligent. See Sardi and Others v Standard & General Insurance Co Ltd 1977 (3) SA 776 (AD) at 780 in which Holmes JA stated the approach of the SA courts to the res ipsa loquitur maxim. He held that it is only invoked in our law in situations where the only known facts relating to an allegedly negligent act consist of the occurrence itself. He also held that by invoking the maxim the plaintiff was not relieved of the onus of proof resting on him, but that it merely served to create an inference of negligence in certain circumstances. Where such an inference has been raised against a person, he/she may then give evidence to explain that the occurrence was unrelated to any negligence on his/her part. This evidence will then in turn be tested by evaluating its probability and credibility.

(72) The fact that the plaintiff has led evidence which creates a presumption of the defendant's negligence vis-à-vis his injury does not necessarily mean that the burden of proof has now been shifted to the defendant, but what it does assist in doing is to break the so-called 'conspiracy of silence' which allegedly exists in the medical profession. This is achieved because there is now a 'duty to explain' resting on the defendant, in other words, failure on his part to give an acceptable (ie reasonable) explanation for the plaintiff's condition might persuade the court to deduce that he was in fact negligent.

(73) Danville Community Hospital Inc v Thompson 43 SE 2d 282 (1947) - where burns were inflicted by a warming bottle in an unconscious patient's bed; Cho v Kemplar 2 Cal Reptr 167 (1960) - where a facial nerve had been injured in the course of a mastoidectomy.

4.1.2. Negligence

4.1.2.1. Patrimonial damages

The onus of proving negligence rests on the plaintiff. He must prove not only that the defendant was negligent but that his damage arose as a consequence thereof.(74) The delictual liability of a medical practitioner in our law is determined by testing whether he was negligent in executing the treatment which allegedly caused the plaintiff's injury, in other words, whether the reasonable skill and care required of him by the law was absent.(75) The degree of skill and the qualities which a practitioner in the field of AID & ET should, it was submitted, possess, were stated supra.(76)

The performance of IVF and ET requires a considerable degree of expertise and experience(77) and it is submitted that a physician who undertakes to provide a patient with this form of treatment without having undergone the necessary training should foresee the reasonable possibility of his conduct resulting in the birth of a defective child.(78) It is submitted that the physician's

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(74) Griffiths v Netherlands Insurance Co Ltd 1976 (4) SA 691 (AD) at 695; J C van der Walt Delict : Principles and Cases (1979) at 71.

(75) Buls and Another v Tsatsarolakis 1976 (2) SA 891 (TPD) at 893-94, where Nicholas J held:

> 'The standard of care required of a medical practitioner who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care'.

See also Esterhuizen v Administrator, Transvaal 1957 (3) SA 710 (T) at 723.

(76) At page 131-134.

(77) R G Edwards and P C Steptoe 'Physiologic Aspects of Human Embryo Transfer' Progress in Infertility 2ed (1975) edited by S J Behrman and R W Kistner at 377-409; Gerhard Schumacker et al 'In Vitro Fertilization of Human Ova and Blastocyst Transfer : An Invitational Symposium' (1973) 11 Journal of Reproductive Medicine 192-204.

(78) Robertson, Encyclopedia of Bioethics (1978) at 1467.

actions would amount to imperitia culpae adnumeratur.(79) It is thus submitted that the average general practitioner or even the average gynaecologist who has not undertaken the necessary research or undergone a course of training at Bourn Hill Clinic or the Monash Medical Faculty, should not attempt IVF and ET. It is further submitted that the skill of a medical practitioner who has acquired the necessary skill and who practises IVF and ET should be measured in terms of the standard of competence of the reasonable practitioner within the field of IVF and ET.(80)

This approach is supported by Innes ACJ (as he then was) in Mitchell v Dixon:(81)

> 'A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.'

and also by Wessels JA in Van Wyk v Lewis:(82)

> 'We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in similar circumstances would have acted or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short he is negligent.'

Should the required negligence and causality on the doctor's behalf be proved then he can be held liable to compensate the deformed AID or ET child for medical expenses, loss of earnings and pain and suffering.

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(79) Beswick v Crews 1965 (2) SA 690 (AD) at 705; Griffiths v Netherlands Ins. Co Ltd supra at 695.

(80) Robertson, Encyclopedia of Bioethics (1978) at 1467; Sonnenberg (1982) 55 Southern California LR 477 at 496.

(81) supra 525.

(82) supra 462.

4.1.2.2. Injuria

Miss X is a single girl who lives in a lesbian relationship with Miss Y. She approaches a doctor and requests AID so that she can have a child. The doctor inseminates her with the semen of a donor and a child, A, is born to her. A is naturally illegitimate.(83) A maintains that his dignitas has been infringed(84) by virtue of the mental suffering and distress he has had to endure as the illegitimate child of a lesbian mother. As a result A institutes an action to recover damages from the doctor for the alleged injuria which he has suffered.

This action differs from the claim in Pinchin's case in that the foetus has not suffered an injury. The damage only arises when the child is born illegitimate. It is only when this occurs that there is damage and consequently an actionable delict.(85)

If one examined the requirements for a successful claim under the actio injuriarum then clearly the act of insemination by the doctor amounts to intentional conduct which causally resulted in the illegitimate birth of A. It would also be required of A to prove that he had suffered social and legal handicaps because of his illegitimate status and that this had impaired his dignitas.(86) A's greatest difficulty would be to prove that the doctor had the necessary animus iniuriandi(87) viz the intention to injure when administering the AID treatment.

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(83) See chapter 7 infra.

(84) Zepeda v Zepeda 41 Ill App 2d 240, 190 NE 2d 849 (1963) at 258:

> 'It is of this the plaintiff complains. His adulterine birth has placed him under a permanent disability. He protests not only the act which caused him to be born, but birth itself.'

See also P Q R Boberg 'An Action for Wrongful Life' (1964) 81 SALJ 498.

(85) Boberg The Law of Persons and the Family (1977) 501; Williams v New York 18 NY 2d 481, 223 NE 2d 343, 276 NYS 2d 885 (1966); Stills v Gratton 55 Cal App 3d 698, 127 Cal Rptr 652 (1976).

(86) Boberg op cit 502 submits that the impairment of personality would be satisfied by the deprivation of the dignity which attends the status of legitimacy.

(87) Boberg ibid submits that it would be very difficult to link animus iniuriandi to the doctor's act of insemination.

4.1.3. Contract

The physician's liability can arise from the provisions of a contract entered into by him with the parents in terms of which he guaranteed a healthy child and a deformed child was born, or a particular technique or donor type was not used as agreed upon by the terms of the contract.(88)

The damages which the parents are likely to succeed in recovering would probably include their medical expenses, pain and suffering, and, if the child were deformed, the additional costs (over and above the costs of rearing a normal child) of raising and caring for it.(89) It is also a fact that in many instances an act can give rise to damages of a delictual and contractual nature and care should be taken in the pleadings to distinguish between them.(90)

4.1.4. Conclusion

In the light of the above principles for determining the liability of a physician which are well-established in our law, it is submitted that the same principles should be applied in determining liability arising from AID or ET.(91)

5. The Physician's liability to the various parties involved

Let us examine whether the parents of a foetus conceived by AID or ET and born defective (and subsequently the child itself) have an action for damages against the doctor or third party who allegedly perpetrated the injury, and if so, what the legal basis of such an action is. It is submitted that our law recognises such an action in favour of a defective child. Successful prosecution will naturally depend on fulfilling the requirements of such an action.

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(88) Robertson Encyclopedia of Bioethics (1978) 1467; Strauss Doctor, Patient & the Law (1980) 155.

(89) Strauss op cit 164.

(90) Van Wyk v Lewis supra.

(91) Strauss op cit 162.

5.1. Legal basis for such an action

5.1.1. Does the action depend on the extention of the nasciturus fiction?

It is submitted that it is unnecessary to rely on an extention of the nasciturus fiction in order to fashion an action for damages for an AID or ET child which is born with defects causally linked to negligent or intentional acts involved with their conception.(92)

When the defective child is born one is dealing with a person not a foetus and a person has rights which came into existence at the moment of birth and it is thus irrelevant to examine an injury caused before its birth. As Van der Merwe & Olivier(93) put it:

> 'Van belang is nie die oomblik van handeling nie, maar wel die kousale verband tussen handeling en regskrenking .... 'n Regskrenking wat 'n kind eventueel ondergaan as gevolg van byvoorbeeld die optrede van 'n ouer nog voor eersgenoemde se verwekking, kan prinsipieel tot 'n aksie ex delicto lei'.

The defective child is a person, a persona iuris, and the action which the child institutes is for the injury which it has to endure as a living person and has nothing to do with its erstwhile position as a foetus.(94) All the child need prove is that it has suffered an injury due to the dolus or culpa of the doctor and that there is a causal link between the doctor's act and his injury.(95)

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(92) Pinchin & Ano NO v Santam Insurance Co Ltd 1963 (2) SA 254 (W); Christian League of Southern Africa v Rall 1981 (2) SA 821 (OPD); N J van der Merwe 1963 (26) THRHR 291; W A Joubert 1963 (26) THRHR 295; Susan Bedil 'Can a Foetus be protected from its Mother?' (1981) 98 SALJ 462 at 463; P C Smit 'Die Geneeskunde en die Reg' (1976) De Iure 107 at 115.

(93) N J van der Merwe & P J J Olivier Die Onregmatige Daad in die Suid-Afrikaanse Reg 2ed 1975; See also the opinion of Boberg (1963) Annual Survey of South African Law at 219, where he disagrees with the approach of W A Joubert which is in turn endorsed by Van der Merwe & Olivier. It is submitted that the approach of the latter authors is the correct view of our law.

(94) Christian League of Southern Africa v Rall supra at 830, where Steyn J held:

> 'Waar die ongebore vrug nie lewend gebore word nie is daar geen sprake van enige regte wat hom toeval nie en kleef geen regte aan hom, op grond waarvan gesê kan word dat hy 'n regsubjek is nie.'

(95) Pinchin v Santam supra at 255.

5.1.2. Do children born alive, but defective, have an action?

A wrongful life claim as formulated in American litigation is one which is brought on behalf of a severely defective infant against a physician. The claim is based on the fact that the physician negligently failed to inform the child's parents of the possibility that they could produce a severely defective child, thereby preventing parental choice to avoid the child's birth. A wrongful life action is thus not based on the defendant's harmful acts per se, but on conduct which prevents parents from making a meaningful choice between completing and terminating a pregnancy. Where the physician concerned has inseminated the wife or performed the IVF and ET he is under a duty to inform the prospective parents of all the reasonably probable facts[96] required by them to make a conscious choice not to become parents if they so desire.[97] It is

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(96) Esterhuizen v Administrator Transvaal 1957 (3) SA 710 (TPD) at 716; M A Millner 'The Doctor's Dilemma' (1957) 74 SALJ 384 at 389.

(97) Curlender v Bio-Science Laboratories 106 Cal App 3d 811, 165 Cal Rptr 477 (2d Ct App 1980). The following were the facts which gave rise to this action: Mr & Mrs Curlender were of Ashkenazi Jewish descent. They were aware of the fact that one in 25 Jews of Eastern European origin were carriers of the Tay-Sachs gene. They therefore consulted their doctor on the advisability of them having children. He arranged for blood tests to be performed and analysed by Bio-Science Laboratories. Based on the results of their tests and analysis their doctor assured them that they were not carriers of the recessive genes. Relying on this inaccurate assessment of their risk, the Curlenders conceived a child which was born in May 1978 with Tay-Sachs disease. Shauna was given a life expectancy of three to five years.

On 17 August 1978 Shauna filed an action for wrongful life alleging that the laboratory and the doctor were negligent in performing and analysing the blood tests performed on her parents and thus causally responsible for the injuries she had suffered. She further alleged that the defendants had previously been warned by a leading authority on Tay-Sachs that their testing procedures were insufficient and would lead to disastrous consequences. She claimed damages for pain and suffering and for the special care she would require.

The California Court of Appeal, Second Appellate District, reversed the trial court's order of dismissal, and held that a genetically defective child has a wrongful life cause of action '... based upon negligently caused failure by someone under a duty to do so to inform the prospective parents of facts needed by them to make a conscious choice not to become parents' (at 829). She was awarded damages for pain and suffering but denied damages based on her actuarial life expectancy had she been born without disease (at 830).

This case is currently the only one in the USA in which an appellate court has allowed a wrongful life cause of action on behalf of the injured infant plaintiff.

submitted that the decision in the Curlender case infra would not be possible in South African law, in which at this stage of its development, it is only possible for a person to claim for injuries actually suffered, but not for wrongful life.(98)

It is submitted that on the strength of the decisions in the cases of Pinchin v Santam Ins Co Ltd and Christian League of Southern Africa v Rall(99) that if a foetus is born alive, but with defects which can be causally linked to the negligence of the doctor who performed the AID or ET then, it is submitted, the child has an action to recover damages from him for his pain and suffering and loss of earnings,(100) while the parents can recover for the medical expenses which they have had to incur because of the child's defects.(101)

The courts in the United States have had to adjudicate on numerous so-called 'wrongful life' cases where the child born defective and/or its parents claim damages from the doctor or hospital involved on the basis that their

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(98) Christian League of SA v Rall supra 830; Van der Merwe & Olivier Die Onregmatige Daad in die SA Reg 2nd ed (1975) 57; Joubert (1963) THRHR 295.

(99) Pinchin v Santam supra at 255; Christian League of South Africa v Rall supra at 830.

(100) Pinchin v Santam supra at 260(A) where Hiemstra J held,

> 'I hold that a child does have an action to recover damages for pre-natal injuries.'

(101) Gildener v Thomas Jefferson University Hospital 451 F Supp 692 (SD Pa 1978); In the case of Curlender v Bio-Science Laboratories 106 Cal App 3d 814, 165 Cal Rptr at 479 the court held that a genetically defective child has an action for wrongful life.

> '... based upon negligently caused failure by someone under a duty to do so to inform the prospective parents of facts needed by them to make a conscious choice not to become parents'. The court then ruled that Shauna Curlender (the defective child) could recover damages for the pain and suffering which she endured during her lifetime. (at 829-831 and Cal Rptr at 488-489).

negligence was responsible for its defective condition.(102) Their courts have tended to distinguish these cases on the basis of whether the negligence occurred at the preconception or postconception stage.(103)

Preconception injuries are those which occur before conception and result in the birth of defective children.(104) The children are born in this state because their parents were not adequately advised of their risk of bearing such a child.(105) In Renslow v Mennonite Hospital(106) a 13 year old girl with Rh negative blood was given a transfusion of Rh positive blood. This act increased tremendously the risk that any Rh positive foetus she might someday carry would have a fatal, or near fatal, reaction to her blood.(107) Eight years later she gave birth to a daughter who as a result of the transfusion was born premature, jaundiced and suffering permanent damage to various organs, her brain and her nervous system.(108) The court recognised the child's right to recover damages on the basis that the interest protected is a potential child's right to be born in a whole and healthy condition,(109) and that there is thus a duty of care imposed on other persons (eg the hospital and its officials in this case) to protect that interest.(110) As far as proof of negligence was concerned it was a well known medical fact apparent from this quotation from a medical textbook, predating the transfusion, which was accepted by the court,

> 'It must be an absolute rule that Rh-positive blood is never transfused to an Rh-negative female who is below the age of menopause'.(111)

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(102) Horace B Robertson 'Toward Rational Boundaries of Tort Liability for Injury to the Unborn : Prenatal Injuries, Preconception Injuries and Wrongful Life' (1978) Duke Law Journal 1401.

(103) Maxine Sonnenberg 'A Preference for Nonexistence : Wrongful Life and a Proposed Tort of Genetic Malpractice' (1982) 55 Southern California Law Review 477.

(104) Sonnenberg op cit 488.

(105) ibid.

(106) 67 Ill 2d 348, 367 NE 2d 1250 (1977).

(107) Renslow supra at 349, 367 NE 2d at 1251.

(108) A Milunsky, Know Your Genes (1977) 70, 72.

(109) Robertson (1978) Duke LJ at 1438.

(110) ibid.

(111) P Millinson Blood Transfusion in Clinical Medicine (1961) 418, quoted in Renslow 67 Ill 2d at 353-54.

Furthermore the injury was causally linked to the act, it was tangible and compensable under 'the traditional delictual measure of damages viz by comparing the condition of the injured plaintiff to his condition had the injury not occurred.(112

In the case of Park v Chessin(113) the New York Supreme Court, Appellate Division, upheld the claim for damages against that doctor by the parents, and their child, born with fatal polycystic kidney disease that resulted in her death 2½ years later.(114) The parents were awarded damages for their medical and maintenance expenses.(115) Their claim for mental anguish and emotional distress was disallowed.(116) The child, Lara Park, was awarded damages for her pain and suffering.(117) The wrongful act of the physician which formed the basis of the action was negligently advising the parents, after the birth of an earlier child suffering from the same disease, that the chances of a subsequent baby being similarly diseased were 'practically nil'.(118) The doctor did not perform any specific act which resulted in injury to the parents or the child. Rather, the injury flowed from a genetic condition of the parents themselves.(119) The doctor's wrongful act was negligently allowing the conception to take place under circumstances in which the act of conception which creates life also causes the injury.(120)

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(112) Robertson (1978) Duke LJ at 1438.

(113) 60 AD 2d 80, 400 NYS 2d 110 (1977), modified in Becker v Swartz 46 NY 2d 401, 386 NE 2d 807, 413 NYS 2d 895 (1978).

(114) Park 60 AD 2d at 88, 400 NYS 2d at 114.

(115) Park 60 AD 2d at 86, 400 NYS 2d at 113.

(116) Park 60 AD 2d at 88, 400 NYS 2d at 114.

(117) Park supra 88, 400 NYS 2d at 114.

(118) Park 60 AD 2d at 83, 400 NYS 2d at 111.

(119) Robertson (1978) Duke LJ at 1442.

(120) ibid.

The victory by the parents and child was short lived, however. The next year, in a decision combined with the postconception wrongful life case Becker v Swartz,(121) the New York Court of Appeals rejected the idea that a child has a right to be born as a whole, functioning person. The court disallowed the Park child's claim and limited her parents to recovery of pecuniary damages.(122)

In the most recent wrongful life case viz that of Turpin v Sortini,(123) the Fifth District California Court of Appeal similarly repudiated the proposition that a child has a 'fundamental right ... to be born as a whole, functional human being'.(124)

Postconception wrongful life actions are based on harm to a foetus after conception but before birth, harm that should have been discovered and communicated to the parents so that they could consider the possibility of abortion.(125)

The landmark postconception wrongful life case brought by a child is Gleitman v Cosgrove.(126) In this New Jersey case, a foetus was damaged by the rubella its mother had contracted during pregnancy.(127) The doctor failed to warn the parents of the risk to the foetus caused by the rubella, and assured them that the disease would have absolutely no ill-effects on the child who was subsequently born blind and deaf.(128) The court denied recovery by either the parents or their son on two grounds viz (a) the impossibility of measuring damages and (b) that public policy in 1967 prevented the court from sanctioning abortion or attempting to evaluate the relative values of 'life with defects against the utter void of nonexistence.'(129)

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(121) 46 NY 2d 401, 386 NE 2d 807, 413 NYS 2d 895 (1978).
(122) 46 NY 2d at 415, 386 NE 2d at 814, 413 NYS 2d at 900.
(123) 119 Cal App 3d 690, 174 Cal Rptr 128 (5th Ct App 1981).
(124) 119 Cal App 3d at 695, 174 Cal Rptr at 131.
(125) Sonnenberg (1982) 55 Southern Cal. LR at 486.
(126) 49 NJ 22, 227 A 2d 689 (1967).
(127) 49 NJ at 25-26, 227 A 2d at 690-91.
(128) 49 NJ at 24, 227 A 2d at 690.
(129) 49 NJ at 28, 227 A 2d at 692.

Twelve years later in Berman v Allen[130] the parents and their Down's syndrome child instituted an action against a doctor who had failed to suggest that the mother undergo amniocentesis, even though her age increased her risk of giving birth to a child so impaired.[131] The parents recovered damages for emotional distress caused by having a child with Down's syndrome,[132] the child's claim, however, was rejected on the basis of public policy considerations rather than on the difficulty of measuring damages.[133]

In Speck v Finegold[134] a Pennsylvania court awarded pecuniary expenses to the parents of a child born after a negligently performed vasectomy and abortion.[135] The child was born with neurofibromatosis, a genetic defect that the parents were aware they could transmit.[136] The court rejected the child's claim, however, on the following grounds:

> 'There is no precedent ... that holds a child has a fundamental right to be born as a whole, functional human being. Whether it is better to have never been born at all rather than to have been born with serious mental defects is a mystery more properly left to the philosophers and theologians ....'[137]

A final example of a postconception injury case is Gildener v Thomas Jefferson University Hospital.[138] Like Curlender, this case involved a child

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(130) 80 NJ 421, 404 A 2d 8 (1979).

(131) 80 NJ at 425, 404 A 2d at 10. For a woman under 30, the risk of giving birth to a child with Down's syndrome is one in 1500, by the time a woman is 38, as Mrs Berman was, the risk is one in 300. Cf L Karp Genetic Engineering : Threat or Promise? (1976) 71.

(132) 80 NJ at 434, 404 A 2d at 15.

(133) 80 NJ at 429-30, 404 A 2d at 12-13.

(134) 268 Pa Super Ct 342, 408 A 2d 496 (1979).

(135) 268 Pa Super Ct at 349, 408 A 2d at 500.

(136) 268 Pa Super Ct at 348, 408 A 2d at 499. Neurofibromatosis is a condition in which there are tumours of various sizes on peripheral nerves. It is a crippling disease of the fibrous structures of the nerves of the spinal cord, mouth, pleura or stomach cf Taber's Cyclopedic Medical Dictionary N - 18 11th ed (1970).

(137) 268 Pa Super Ct at 364-65, 408 A 2d at 508.

(138) 451 F Supp 692 (SD Pa 1978).

afflicted with Tay-Sachs, but unlike Curlender the negligence in Gildener occurred postconception, when the results of an amniocentesis test were inaccurately reported to the parents.(139) Following the pattern of earlier cases, the court allowed the parents to recover damages for the child's medical treatment, but refused to extend its ruling to the disabled child.(140) The case also contains an interesting reflection on the public policy of 1978:

> 'Tay-Sachs disease can be prevented only by accurate genetic testing combined with the right of parents to abort afflicted fetuses ....
> Society has an interest in insuring that genetic testing is properly performed and interpreted ....'(141)

5.1.3. Cases where no live birth occurs

In terms of South African law legal personality is acquired at birth.(142) Parents of a still-born AID or ET child or one which has been aborted because of gross defects which became apparent during the pregnancy can sue the doctor for medical expenses which they have incurred if the foetus's defects are causally attributable to the doctor.(143)

It is submitted that if the parents institute a claim for the loss of a 'potential child' basing their claim on the provisions of the actio legis Aquilia their claim will fail because our law does not recognise a right of 'ownership' of a child nor does it put a value on life per se. The parents would only succeed with an action for the wrongful death of their child if they could prove that the doctor's actions were causally connected to the child's death and as a result caused them pecuniary loss eg they incurred hospital expenses as a result of the abortion or funeral expenses for the still-born child.(144) Although

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(139) 451 F Supp 694, 696.

(140) 451 F Supp at 694.

(141) 451 F Supp at 696.

(142) Christian League of Southern Africa v Rall supra at 829-830; Pinchin v Santam supra at 260.

(143) Pinchin v Santam supra 256.

(144) Strauss Doctor, Patient and the Law at 163-164.

their chances of proving it would be very slim indeed, theoretically at least the parents might succeed with a dependant's action in regard to the death of their child.(145)

In the United States actions for so-called 'wrongful life' have been recognised and damages have been awarded to children who have been born with defects.(146) In effect the child's action amounts to a claim that it should not have been born.(147) No such 'wrongful life' action would, it is submitted, succeed in South African law because there is no basis for such a claim because if the action is instituted by the parents they are claiming damages for a non-person, a legal personality that never existed as such.(148) If the child institutes an action for 'wrongful life' he is in effect seeking damages on the basis that he should not have been born. If the child had not been born he would not have enjoyed legal personality and again he would find himself in a position where he had no locus standi to claim or receive damages.(149) The following passages from the judgment of the Supreme Court of New Jersey in the case of Gleitman v Cosgrove,(150) in which it dismissed an action for 'wrongful life' by an infant born blind and deaf, are particularly apposite:

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(145) Anthony v Cape Town Municipality 1967 (4) SA 445 (A); Van Vuuren v Sam 1972 (2) SA 633 (A); H Per 'A Child's Duty of Support' (1968) 85 SALJ 4.

(146) Curlender v Bio-Science Laboratories supra.

(147) Gleitman v Cosgrove supra.

(148) Boberg (1964) 81 SALJ at 498.

(149) Christian League of Southern Africa v Rall supra 830.

(150) 49 NJ 22, 227 A 2d 689 (1967).

'The infant plaintiff is therefore required to say not that he should have been born without defects but that he should not have been born at all .... Damages are measured by comparing the condition plaintiff would have been in, had the defendant not been negligent, with plaintiff's impaired condition as a result of the negligence. The infant plaintiff would have to measure the difference between his life with defects against the utter void of non-existence .... This court cannot weigh the value of life with impairments against the non-existence of life itself. By asserting that he should not have been born, the infant plaintiff makes it logically impossible for a court to measure his alleged damages because of the impossibility of making the comparison required by compensatory remedies.'

'Ultimately, the infant's complaint is that he would be better off not to have been born. Man, who knows nothing of death or nothingness, cannot possibly know whether that is so.'(151)

The following constitutes an analysis of the rights, duties and liabilities of a physician who artificially inseminates a woman or impregnates a woman by way of in vitro fertilization and ET.

5.2. To the mother of the child

5.2.1. In vitro fertilization

A physician who brings about a pregnancy in a woman by IVF or ET is required to exercise the same degree of care in regard to this procedure as a reasonable practitioner of those procedures would be expected to exercise. If he fails to exercise due care, and she or the baby(152) suffers any ill effects from his negligence, it is submitted that he will be liable for damages in the same way and on the same principles as for any other professional negligence.(153)

Where the ET technique is used the problem of causation is complicated by the fact that as a certain number of conventional births result in defective infants,(154) it might be difficult to prove that the extraordinary process itself

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(151) 49 NJ 22 at 63, 227 A 2d at 711; Shapiro & Spece Bioethics & Law (1981) 466

(152) Insofar as the injury to the child affects any of the mother's rights.

(153) Oakley (1974) 8 Family LQ 393; Tallin (1956) Canadian Bar Review 175.

(154) About 2-3% of all children have defects which are readily identifiable at birth. If a group of children is followed for 10 years after their birth, about 10% are eventually determined to be defective. Cf Leek et al 'The Incidence of Malformations in Birmingham, England 1950-1959', (1968) 1 Teratology 263.

is responsible for a deformed child.(155) If the parents have been informed in advance of the risks involved and have consented in an informed manner to the procedure knowing full well the risks involved, the physician has a stronger defence.(156)

What would the physician's position be where he has fertilised a woman's ova in vitro and a perfectly formed blastocyst is developing, but prior to implantation he loses his resolve and destroys the cleaving blastocyst? It is submitted that the physician's liability should be determined by the question of consent viz if the parents consent to the destruction of the conceptus then naturally he incurs no civil liability.(157) Should he destroy the conceptus without their consent, the parents should be entitled to recover damages(158) at least equal to the costs incurred in attempting to conceive the child via IVF in addition to damages for emotional distress.(159)

Because of the ability of modern medical science to detect defects of the foetus in utero during the early weeks of foetal development, the question will doubtless arise as to whether or not the parents have the right to refuse to abort an obviously defective foetus.(160)

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(155) Edwards & Steptoe, 'Biological Aspects of Embryo Transfer' in Ciba Foundation op cit (1970) at 13:

> 'All the evidence obtained from transfers has consistently pointed to one conclusion: there are no induced anomalies attributable in any manner whatsoever to the culture and transfer of embryos. Neither has there been any indication of an increase in the incidence of malformations of any kind ....'

(156) Oakley (1974) 8 Family LQ 393.

(157) Robertson Encyclopedia of Bioethics (1978) 1466.

(158) The damages referred to would be recoverable on the basis of a breach of contract. Damages for emotional distress would not however be recoverable on this basis. It is submitted that the latter form of damage could probably not be recovered in delict either unless the requirements for the actio injuriarum were proved, or there was nervous shock (which would be highly unlikely).

(159) Paula Diane Turner 'Love's Labor Lost : Legal and Ethical Implications in Artificial Human Procreation' (1981) 58 Journal of Urban Law 459 at 472; Del Zio v Presbyterian Hospital 74 Civ 3488 (SDNY Apr 12 1978).

(160) Reilly Genetics and the Law 371. The parents' right to decide whether to continue the pregnancy if the foetus is defective, or to terminate it, is granted to them by s 3(1) of the Abortion and Sterilization Act 2 of 1975 viz

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Oakley submits[161] that it is advisable for a physician in these circumstances to protect himself by obtaining a written undertaking from the parents that they would agree to an abortion of a defective foetus as a precondition to the AID or ET. The writer however submits that in our law a physicain does not require such protection if he has advised the parents at an early stage that the foetus is defective, but they insist on continuing the pregnancy to term. The physician would only possibly incur liability if his initial negligence gave rise to the foetus's defect and thus the need to consider an abortion.

It is submitted that although these steps are necessary at present because IVF and ET are still in the pioneering stage of development, that the proliferation of these techniques will also lead to medical science perfecting them, so much so that the level of risk involved in these techniques will eventually be considerably lower than that in a natural pregnancy and birth.[162]

5.2.2. Artificial Insemination

A physician undertaking AID would be advised to observe a number of special precautions, over and above anything agreed to in the contract with the parents. He will have to be certain that the donor from whom the semen is taken is of an appropriate blood group, that he has racial and physical characteristics similar to those either of the woman or her husband and that he has no heritable diseases or defects.[163] Even if the physician is not held to a higher standard of care than he would be in regard to other forms of treatment it would seem that he should take all reasonable precautions to ensure beyond

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(160) (continued from the previous page)

'[if] there is a serious risk that the child will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped.'

(161) Oakley (1974) 8 Family LQ 394.

(162) ibid.

(163) Klayman (1970) 39 Cincinnati LR 291 at 323.

doubt that the semen presented to him by the donor is indeed his semen and no one else's.(164)

While it is hardly appropriate to liken a physician's position to that of a vendor who is liable for the latent defects in his product, there may be, apart from any express undertaking which he has given to the parents, an implied undertaking on his part that the semen is fit for the purpose for which it is to be used.(165) Furthermore, the physician could not escape liability by submitting that he was ignorant of the purpose for which it was to be used or that he was unaware that the spouses had relied on his judgment.(166)

The nature of AID and ET is such that it can hardly be described as falling within the normal scope of a physician's function viz to preserve the life and health of his patient.(167) AID and ET therapy is not used to cure any ailment the recipient woman might suffer from nor does it rectify any physical defect.(168) Instead it produces a condition (pregnancy) which would not have occurred in the normal way, and which is furthermore not necessary for any curative purpose.(169) Despite the fact that AID does not fall within the normal scope of a physician's recognised function, it is submitted that it is unlikely that our courts will require a higher degree of care than normal from him in relation to the AID.(170)

It will be difficult to assess the extent of the damages recoverable from the physician where the AID child is born an idiot or imbecile or has physical characteristics which according to the law of heredity the woman and the donor could not have produced.(171) Where the child is an idiot or imbecile or has a

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(164) Silvoso (1975) 3 Western State LR 48 at 58; Tallin (1956) Canadian Bar R 175.

(165) Reilly Genetics and the Law (1975) 365; Knoppers (1978) 2 Family LR 112.

(166) Tallin op cit 175.

(167) Tallin op cit 176.

(168) ibid.

(169) ibid.

(170) Strauss op cit 148.

(171) Robertson Encyclopedia of Bioethics (1978) 1467; Berman v Allen 80 NJ 421, 404 A 2d 8 (1979). In this case the parents and their Down's syndrome child brought an action against a doctor who had failed to suggest that the mother undergo amniocentesis even though her age, 38, increased the risk of giving

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definite physical defect a portion of the total damages are quantifiable viz the increased costs involved in caring for the afflicted child.(172)

If the circumstances were such that the physician had misrepresented the nature of the treatment, and on that basis induced the woman to submit to it, he might become liable in an action based on fraud if it could be proved that the misrepresentation was intentional at least in the sense of dolus eventualis.(173) The damages recoverable may include those for any injury or physical or mental pain suffered by the woman in addition to recovery of expenses incurred by her or her husband arising from the AID therapy.(174)

If a physician gave any undertaking in the nature of a warranty as to the success of the treatment or the character of the donor he might become liable for a breach of contract if the treatment ended up being unsuccessful or the character of the donor was not precisely as he had represented it.(175)

The physician may also be liable for a breach of an undertaking on his part to maintain secrecy as to the fact that the woman has been artificially insemi-nated, or of his undertaking not to reveal her identity to the donor of the semen.(176) A breach of the former undertaking might subject her to ridi-cule or mental suffering, a breach of the latter to attempts at blackmail or

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(171) (continued from the previous page)
birth to a child so impaired from one in 1500 for women under 30, to one in 300. The parents recovered damage for emotional distress caused by having a child with Down's Syndrome but the child's claim for wrongful life was dismissed.

(172) Becker v Swart 46 NY 2d 401, 386 ne 2d 807, 413 NYS 2d 895 (1978). The facts were similar to those in Berman's case; the court allowed the parents to recover their pecuniary losses but refused to grant damages for emotional distress. The result was thus diametrically opposite to that in Berman's case. It is submitted that Becker's case is more in accord with the current position in SA law.

(173) Tallin (1956) Canadian Bar R 176.

(174) Strauss Doctor, Patient and the Law (1980) 164; Shaman (1979/80) 18 J of Family L 347; Dame Cataford et al v Docteur Moreau June 1978; District of Terrebonne No 66, 320 not yet reported but discussed by Robert P Fouri under Comments in (1979) 1 Canadian Bar Review 89 at 98.

(175) Robertson Encyclopedia of Bioethics (1978) 1467; Knoppers (1978) 2 Family LR 112. Frankel (1979) 3 Legal Medical Q; Strauss op cit 148; Oakley (1974) 8 Family LQ 365; Shaman op cit 348.

(176) Silvoso (1975) 3 Western State LR 59; Guttmacher (1969) 18 De Paul LR 570; Sagall (1973) 9 Trial 65.

other demands by the donor. It is submitted that the plaintiff is more likely to recover damages if his/her claim is based on a breach of contract, because it would only be possible to recover in a delictual action if it could be proved that the physician had acted intentionally. This would naturally be very difficult.(177)

5.3. To the Husband

5.3.1. AID

Where a husband had consented to his wife being inseminated his grounds of action against the physician would be the same as those of his wife.(178) However, in terms of our present law a child born as a result of AID would be the illegitimate child of the wife and the donor.(179) The husband would thus have no responsibility for its care, maintenance and education.(180) Consequently any expenses which he voluntarily incurred in this regard could not be recovered by him,(181) whereas his wife, on whom the burden of maintenance would fall, might be able to recover amounts in excess of normal maintenance expenses which she has had to incur because the child has been born deformed as a result of the physician's negligence.(182)

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(177) Tallin (1956) Canadian Bar R 177; Reilly Genetics and the Law (1975) 369; Robertson Encyclopedia of Bioethics (1948) 1467.

(178) Tallin op cit 177; Strauss Doctor, Patient and the Law (1980) 147-148.

(179) V v R 1979 (3) SA 1006 (TPD) at 1015.

(180) The duty to support a child arises from the act of procreating it. The father's duty of support flows from paternity, see R v Swanepoel 1954 (4) SA 31 (O); Moodley v Gramani 1967 (1) SA 118 (N); Van Lutterveld v Engels 1959 (2) SA 699 (AD); Lamb v Sack 1974 (2) SA 670 (T); Tate v Jurado 1976 (4) SA 238 (W); Sager v Bezuidenhout 1980 (3) SA 1005 (O). However in V v R supra at 1015, F S Steyn J held as follows regarding the husband's duty to support his wife's illegitimate AID child:

> '... dat geen ander man as die gewaande vader onderhoudspligtig is jeens so 'n kind nie.'

(181) V v R supra 1015.

(182) Speck v Finegold 268 Pa Super Ct 342; 408A. 2d 496 (1979); Berman v Allan supra at 15; Curlender v Bio-Science Laboratories supra 830-831; Strauss op cit 163-164.

A person who impregnates a woman by way of natural sexual intercourse without her husband's consent is likely to be faced with a claim for damages for adultery(183) which may include patrimonial aspects eg for medical and hospital expenses(184) and non-patrimonial aspects eg for the injuria he has suffered by the infringement of the consortium.(185) There is no reason to believe that the patrimonial liability of the doctor would be different where the pregnancy was artificially produced.(186) AID does not constitute adultery(187) however and the nature of the injuria suffered would be different. The basis of the action is the fact that marriage creates a very special relationship, a consortium omnis vitae,(188) which is protected against interference by the law.(189) It is thus submitted that a physician who proceeds with AID or ET knowing that his patient is married and that her husband has not consented to the procedure or to having a stranger's child thrust upon him in this way, infringes the consortium and thus the husband's personality rights.

Where the couple were married in community and the AID occurred without the husband's consent, medical and hospital expenses arising from the pregnancy and paid for out of the joint estate could be recovered from the physician.(190) If they were married out of community the husband could refuse

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(183) Viviers v Kilian 1927 AD 449; Rosenbaum v Margolis 1944 WLD 147 at 156; Smit v Arthur 1976 (3) SA 378 (AD).

(184) Van Lutterveld v Engels supra 702-703; Sagar v Bezuidenhout supra.

(185) Smit v Arthur supra at 386.

(186) Smit v Arthur ibid; Anonymous v Anonymous supra 886; People v Sorenson supra 495.

(187) V v R supra 1015; Strauss Doctor, Patient and the Law (1980) 148.

(188) Rohloff v Ocean Accident & Guarantee Corp Ltd 1966 (2) SA 291 (AD) at 303; T v T 1968 (3) SA 554 (R) at 558; Rosenbaum v Margolis 1944 WLD 147 at 151; Hahlo Husband and Wife 4th,(1975) at 109, 122.

(189) Pearce v Kevan 1954 (3) SA 910 (D); Hahlo Husband and Wife 4th (1975) at 419.

(190) Becker v Swartz supra 807; Hahlo op cit 239.

to meet the expenses from his estate and insist that the wife should pay for them from her own estate.(191) As far as non-patrimonial damages are concerned it is submitted that the actions of his wife and the physician in acting without his consent certainly constitute an injuria for which he could claim damages.(192)

5.3.2. In Vitro fertilization

The legal relationship between the physician, the couple who choose IVF and the child born via this technique is regulated largely by consent.(193) In other words as long as the wife and the husband were fully informed of the known risks involved with laparoscopy, hormone administration, the reimplantation of the blastocyst, the completely unknown odds of achieving pregnancy and the unquantifiable chance that a defective child could be born, then no unusual legal liability will be attributed to the physician, and the standard of care expected of him will be the normal standard expected of a physician.(194)

However, it is submitted that if the parents have not been informed of the risks attendant on IVF, and the foetus has to be aborted because it is defective, they should be entitled to recover damages equal to the costs they incurred in attempting to conceive a child through IVF.(195)

If the blastocyst is negligently or intentionally destroyed prior to implantation by the physician he would be liable for damages at the suit of the father.(196)

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(191) Van Lutterveld v Engels supra 702; Park v De Necker 1978 (1) SA 1060 (N) 1061.

(192) Strauss Doctor, Patient and the Law (1980) 148.

(193) Robertson Encyclopedia of Bioethics (1978) 1466.

(194) A M Capron 'Tort Liability in Genetic Counselling' (1979) 79 Columbia Law Review 618 at 660.

(195) Turner (1981) J of Urban Law 459 at 479.

5.4. Liability of the physician to the donor

A physician might incur liability to an egg or semen donor when he has in breach of an undertaking permitted the identity of the donor or the fact that he/she has donated semen/oocytes to become known.(197) It is however submitted that a doctor/patient relationship is not privileged in the sense that a doctor can withhold evidence in a court of law regarding the AID or ET if he is questioned about it. If he reveals the donor's identity under cross-examination the compulsion would be a defence to any claim of breach of confidence instituted by the donor.(198)

In order to succeed with an action the donor would of course have to prove that the breach had resulted in damage to him/her.(199) The damage may result in two ways. First, it may result in an affiliation and maintenance order being made against him/her.(200) Secondly, the donor might have lost business, position, husband/wife or suffered psychological injury, when his/her customers, clients, employer or husband/wife learned of his/her part in the practice.(201)

If the breach of confidence by the physician was not justified in any way it could, it is submitted, give rise to damages of both a contractual and a delictual nature. The affiliation and maintenance expenses arising from the breach of confidence could be classified as being contractual damages(202) while claims for the infringement of his dignitas would be a delictual action based on the actio injuriarum for which the animus injuriandi must be established.(203)

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(197) Reilly Genetics and the Law (1975) 479.

(198) Parkes v Parkes 1916 CPD 702; L H Hoffman & D T Zeffertt The South African Law of Evidence 3rd ed (1981) 212.

(199) ibid.

(200) Tallin (1956) Canadian Bar R 179.

(201) ibid.

(202) Whittaker v Roos & Bateman 1912 AD 123; Sambo v Milns 1973 (4) SA 312 (T).

(203) Moaki v Reckitt & Coleman (Africa) Ltd & Ano 1968 (3) SA 98 (A) at 104.

Patrimonial loss via the loss of clients and/or job would be recovered in terms of the actio legis aquilia for which proof of negligence on the doctor's part would be sufficient.(204)

Purchasers of sperm/oocytes/zygotes from a cryobank would also have claims against the bank for improper handling, spoilage, insufficient disclosure or use without consent subject to particular contractual arrangements.(205)

5.5. Physician's liability to the Child

Where a doctor has foreseen the possibility of a defective child being born as a result of an AID or ET pregnancy and performed an amniocentesis(206) and/or ultrasonography(207) test but has been negligent in the execution, analysis or diagnosis of the test then the doctor might incur liability on the basis that he ought reasonably to have foreseen that had he performed these tests with the necessary skill he would have detected the fact that the foetus was defective(208) and in the light of this knowledge the parents could have chosen to have the defective foetus aborted.(209) If the mother could convince the

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(204) Matthews v Young 1922 AD 504; Perlman v Zoutendyk 1934 CPD at 155.

(205) Robertson Encyclopedia of Bioethics (1978) 1466.

(206) Maxine A Sonnenberg 'A Preference for Non-Existence : Wrongful Life and a Proposed Tort of Genetic Malpractice' (1982) 55 Southern California Law Review 477 at 483; Gildiner v Thomas Jefferson University Hospital 451 F Supp 692 (SD Pa 1978). In this case the parents and the child afflicted with Tay-Sachs sued the hospital for damages on the ground that their negligence in assessing the results of an amniocentesis test had resulted in the birth of the defective child. Had they been correctly informed they would have exercised their right to have the child aborted. The court allowed the parents to recover damages for the child's medical treatment but refused the child's claim. The court held as follows on the doctor's laibility:

> 'Society has an interest in ensuring that genetic testing is properly performed and interpreted .... The recognition of a cause of action for negligence in the performance of genetic testing would encourage the accurate performance of such testing by penalizing physicians who fail to observe customary standards of good medical practice'
> cf at 696.

(207) ibid.

(208) Strauss Doctor, Patient and the Law (1980) 164.

(209) ibid.

court that she would have opted for an abortion the doctor might then be causally responsible for the birth of the defective child.(210) Should a court make such a decision the doctor would then be liable for pecuniary damages to the extent that the child requires special medical treatment, education and maintenance beyond that of a normal child.(211)

It is an established principle in South African law that a child who is born defective as a result of injuries suffered in utero due to the negligence of a third party may sue the guilty party for damages. In order to succeed with his action he will have to prove that a causal connection existed between the negligent act of the third party and the defect with which he was born.(212)

It is submitted that this principle can be extended to apply to injuries suffered before conception(213) again with the proviso that the necessary causal connection can be established.(214) In other words, if the doctor concerned uses sperm which has not been tested for defects or oocytes which are defective or damaged during manipulation or in the laparoscopy process and a deformed child is subsequently born, it is submitted that such child will have an action against the doctor.(215)

It is possible that a physician might incur liability to a child resulting from AID when its mother or her husband failed or became unable to support it. The only hope that an action on behalf of the child would succeed against the

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(210) Strauss Doctor, Patient and the Law (1980) 164.

(211) Shapiro & Spece Bioethics & Law (1981) 466-475.

(212) Pinchin NO v Santam Insurance Co Ltd 1963 (2) SA 254 (W).

(213) Strauss Doctor, Patient and the Law (1980) 162; see also Van der Merwe & Olivier Onregmatige Daad in die SA Reg 2nd (1975) at 56-57. They submit that it is not necessary to extend the nasciturus fiction to cover cases of this nature because the damage occurs at the moment of the action but that the action to recover the damages can only be instituted if and when the child is born defective.

(214) Jorgensen v Meade-Johnson Laboratories Inc 483 F 2d 237 (10th Cir, 1973). In this case the mother had taken contraceptive pills manufactured by the defendant, but despite using the pills as prescribed she had given birth to a child suffering from Down's Syndrome.

(215) Pinchin v Santam Ins Co Ltd supra at 256; Christian League of Southern Africa v Rall supra 829-830; Van der Merwe & Olivier op cit 56, 57; Strauss loc cit 162-163).

physician would depend on a finding by the court that the position of the physician was analogous to that of a father in that without his wilful act the child would not have been born. It is a well-established fact that the basis of a father's liability to support his child is the nexus sanguinus, the fact that he was responsible for bringing it into the world. However, it is submitted that there is no chance of such an action succeeding in South African law or of fatherhood being thrust on the physician, because there is no such tie of blood between the physician and the AID or ET child. He merely performs a clinical procedure using the gonads of a male and female.(216)

If a defective child is born after IVF it is submitted that it would be very difficult to prognosticate a right of action against the physician based on the mode of its conception. If one assumed that the appropriate consent had been secured and that foetal monitoring(217) had been employed it would be difficult to succeed with a claim for damages based on the physician's negligence eg how would the plaintiff (child) ever succeed in demonstrating the causal connection between the mode of conception and the birth defect from which he suffers? All conceptuses face a high statistical risk of defects; indeed a very large percentage abort spontaneously.(218)

Risk to the test-tube blastocyst is not easily quantified, but few people would dispute the probability that many blastocysts will fail to implant,(219)

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(216) See s 39 of the Draft Child Care Bill and V v R supra 1010.

(217) Cf Mastroianni Encyclopedia of Bioethics (1978) 1450 states that although genetic screening in mid-trimester of the pregnancy will allow an evaluation of the chromosomal integrity of the foetus it will only serve to reveal the most obvious genetic diseases.

(218) Cf Mastroianni op cit 1450 who states that under normal conditions foetal wastage is in excess of fifty percent.

(219) Turner (1981) 58 J of Urban Law 459 at 473; Edwards & Steptoe attempted approximately 100 implantations before the first test tube babe was achieved.

that some will abort[220] and that some will come to term as deformed children. The IVF process involves deliberate embryo wastage ie the destruction of multiple blastocysts to achieve the implantation of only one.[221] Some theologists and philosophers who believe that human personhood begins with fertilization reject IVF on that ground alone viz that it involves the deliberate destruction of human life to achieve a pregnancy.[222] Other ethicists argue that there is genuine doubt about whether a human person exists at this stage of development.[223] Edwards submits that in discarding embryos, experimenters are doing nothing more than women who use intrauterine contraceptive devices.[224]

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(220) If tests reveal that the foetus is abnormal a decision would have to be made by the parents, in conjunction with the physician as to whether the defective foetus should be aborted or not.

(221) Reilly Genetics and the Law (1975) 369.

(222) P Ramsay, Fabricated Man : The Ethics of Genetic Control (1970) 39.

(223) J Fletcher The Ethics of Genetic Control : Ending Reproductive Roulette (1974) 88.

(224) F P Grad 'New Beginnings in Life' in The New Genetics and the Future of Man (1972) 64 at 68.

CHAPTER 5

AID, ET AND THE CRIMINAL LAW

1. Is AID or ET a crime per se?

Perhaps the first question which we should determine is whether the practice of AID and ET constitute an offence per se in S.A. law.

AID is neither a criminal offence at common law[1] nor in terms of any existing statute.[2] Furthermore section 39 of the Child Care Bill[3] deems a child born of AID to be the legitimate child of its mother and her husband. Should this Bill become law in unaltered form the AID child would then enjoy the status of legitimacy with the blessing of the legislature and AID would enjoy the reputation of being a lawful therapeutic activity.

The position regarding ET is, however, somewhat different in the light of the provisions of section 7 of the Anatomical Donations and Post Mortem Examinations Act, which regulate the use of oocytes very carefully. The only method in which an oocyte can be obtained is by means of laparoscopy which involves a surgical process. The removal of the oocyte must thus be done by a skilled surgeon, and because the availability of the oocyte is vital to the success of ET, the whole process is indirectly regulated by the provisions of section 7. In other words unless the consent of the Minister of Health is sought and obtained before the laparoscopy is performed, fertilization of the oocyte, and its subsequent reimplantation in the hostess mother or recipient mother, an offence is committed in

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(1) Steyn J in V v R 1979 (3) SA 1006 (TPD) examined the SA law appertaining to AID without making any allusion to the fact that it might in fact constitute a criminal act.

(2) Section 7(1) of the Anatomical Donations & Post-Mortem Examinations Act No 24 of 1970 deems it to be an offence to use a gonad (sperm) in the body of a person other than the spouse of the person from whose body it was removed without prior permission of the Minister. All AID therapy in SA takes place without such permission. However it is submitted that it does not constitute an offence because the semen is not removed by a medical practitioner see V v R supra at 1009. See also S A Strauss Doctor, Patient and the Law 1980 at 147.

(3) (28 October 1981) Government Gazette No 7864 at 28.

terms of the Act.(4) A prerequisite to obtaining the Minister's consent is obtaining the consent of the spouses. However section 9 of the Act exonerates the doctor from any civil or criminal liability if he has removed an oocyte and the consent on which he has relied proves to be legally invalid '... for ... any reason' unless the doctor was aware of its invalidity at the time of performing the laparoscopy.(5)

2. Sexual Offences

2.1. Where intercourse is a requisite

2.1.1 Incest(6)

The interest which incest seeks to protect is to eliminate or prevent the inherent genetic risk of an abnormal child being born to parents who are too closely related by blood. The law thus sets out to obviate such defective children being born by prohibiting intercourse between ascendants and/or descendants.

The definition of incest unambiguously states that sexual intercourse is a requirement of this crime.(7) It is thus submitted that acts of sexual intimacy

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(4) See section 15(2) Act No 24 of 1970.

'Any person who is found guilty of an offence specified in ... s 7(1) ... shall be liable to a fine not exceeding fivehundred rand or to imprisonment for a period not exceeding six months.'

(5) Act No 24 of 1970; Strauss Doctor, Patient and the Law (1980) 130 131.

(6) P M A Hunt South African Criminal Law and Procedure Vol 2 2nd ed by J R L Milton (1982) 257, defines incest as follows:

'Incest consists in unlawful and intentional sexual intercourse between two persons who on account of consanguinity, affinity or adoptive relationship may not marry one another.'

See also C R Snyman Strafreg (1981) at 333 and J C de Wet Strafreg 3rd ed (1975) at 264. See also Van Leeuwen R-H 4.37.9; R v Botes and Botha 1945 NPD 43; Ex parte Roets 1952 (2) SA 520 (C); R v Mulder & Ano 1954 (1) SA 228 (E).

(7) S v A 1962 (4) SA 679 (E). Sexual intercourse in turn requires that the private parts of the female must be penetrated by the male organ cf H R Hahlo 'Some Legal Aspects of Human Artificial Insemination' (1957) 74 SALJ 167 at 175; R v Giles 1926 WLD 211 at 212-3; Hunt op cit 258.

between persons within the ambit of the definition which stop short of intercourse do not amount to incest, but might depending on the circumstances amount of an attempt to commit incest.(8) It is furthermore a well-established fact that AID does not constitute an act of intercourse.(9) In the light of the above it is submitted that Masters' statement(10) that a medical practitioner who inseminates a woman with the semen of a donor related within the prohibited degrees may be guilty of incest is very wide of the mark if measured against the current definition of the crime. It is hardly necessary to state that the transplanting of a fertilised oocyte into a female's uterus also fails to fulfil the requirements for incest, because ET does not constitute an act of intercourse.

If one concentrated on the interest which incest seeks to protect viz to prevent the genetic risks involved to offspring of parents who are too closely related by blood, then it is submitted that the definition of incest should be extended to cover the very real possibility of 'inbreeding' via AID and ET eg if a brother donates semen which is then used to inseminate his sister or if a daughter donates an oocyte which is fertilised with her father's sperm.

It is thus submitted that although AID and ET do not in themselves constitute the crime of incest, they can give rise to situations in which incest can unwittingly be committed by the unknowing offspring of these practices.(11) This can come about because of the cloak of secrecy which surrounds AID and ET and particularly the fact that the identity of the donors (the genetic parents) is not revealed to the offspring.(12) It is thus possible for two children of the

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(8) R v Botha 1916 TPD 365; see also S v A 1962 (4) SA 679 (E).

(9) V v R supra at 10 15B-C.

(10) N C Masters 'Artificial Insemination' (1953) SALJ 375 at 379.

(11) A A Levisohn 'Dilemma in Parenthood Socio-Legal Aspects of Human Artificial Insemination' (1957) 4 Journal of Forensic Medicine 147 at 167.

(12) Hoffer (1979) Modern Medicine 27; Curie-Cohen et al (1979) New England J of Med 589; W J Finegold Artificial Insemination (1964) at 32.

same donor[13] to marry and unknowingly live in an incestuous relationship, or to unwittingly have an affair. However it is submitted that if this did happen a prosecution would be most unlikely since the required mens rea would be lacking.[14]

The excessive use of the sperm or oocytes of a single donor will increase the risk of an accidental incestuous relationship being entered into by siblings. It is thus further submitted that a strict limit be placed on the number of inseminations or embryo transplants from a single donor.[15]

2.1.2. Rape[16]

The crime of rape sets out to protect a woman's physical integrity against intercourse without her consent. It is difficult to imagine circumstances in which a physician or some other person performing AI on a woman could commit rape thereby. Would the insemination of a woman without her consent while she is under an anaesthetic or asleep constitute rape? A sleeping woman obviously cannot consent to AID (or intercourse) and unless she has given the physician a prior consent the AID would constitute an assault upon her.

It is submitted that AID without the woman's consent does not fulfil the requirements for rape[17] because first, AID is a clinical medical technique which

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(13) V M Berger 'Artificial Insemination' (1965) Brooklyn Law Review 302 at 321 submits that

> '... The semen obtained from one donor could be used to successfully initiate two hundred artificial inseminations. To carry this to extremes one donor might contribute his semen five, six or X number of times, which if multiplied by two hundred shows the physical possibility of one donor being the biological father of 1000, 12000 or 200X number of children. Such state of affairs could, and not inconceivably, result in marriages being unwittingly entered into between relatives within the degrees of consanguinity which constitute incest.'

(14) Hunt Vol 2, 2nd ed (1982) 258; R v Pieterse 1923 EDL 232.

(15) Berger (1965) Brooklyn LR 302 at 321.

(16) Hunt Vol 2, 2nd ed (1982) at 435, defines rape as follows:

> 'Rape consists in intentional unlawful sexual intercourse with a woman without her consent.'

(17) See also R v Mosago 1935 AD 32 at 34; Hahlo (1957) 74 SALJ 167 at 175; Spiro Law of Parent and Child 3rd ed (1971) at 216; Verkauf 1966 (3) Houston LR 301; R v C 1952 (4) SA 117 (O).

cannot by any stretch of the imagination be equated with sexual intercourse which in turn requires penetration of the female organs by the male private parts.(18) This does not occur in the course of the AID procedure. Secondly the physician who is dispassionately performing the insemination cannot be said to have formed the necessary intent to rape in the process of performing a medical technique which is not entirely unlike certain gynaecological examinations performed upon women daily.

2.1.3. Offences under the Immorality Act(19)
(Where sexual intercourse is a requirement)

Section 16 of the above Act prohibits sexual relations between persons of the white(20) and coloured(21) races in South Africa. Section 16(1)(a)(i), (b)(i), 2(a)(i) and (b)(i) makes it an offence for a white person of either sex to have unlawful carnal intercourse with a coloured person.(22) Because neither AID nor ET amounts to sexual intercourse it is submitted that they do not constitute an offence in terms of the above sections of the Act.(23) The question

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(18) Hahlo loc cit; R v V 1960 (1) SA 117 (T); R v E 1960 (2) SA 691 (FC); S v K 1972 (2) SA 898 (AD) at 900; R v K 1958 (3) SA 420 (A) at 421.

(19) Act No 23 of 1957.

(20) A white person is defined in section 1(xi) as

> '... any person who in appearance obviously is, or who by general acceptance and repute is a white person.'

(21) A coloured person is defined in section 1(ii) as,

> '... any person who is not a white person'.

The test of race is thus simply appearance and repute and proof of birth or descent is not the major factor eg the mere fact that a person is obviously not a white person would be evidence that he is a coloured.

(22) In section 16(1)(a)(ii) the Act further prohibits persons of the white and coloured races from performing with each other any immoral or indecent acts of a sexual nature which do not necessarily culminate in sexual intercourse between them. See R v H 1959 (4) SA 427 (AD) at 431.

(23) Hahlo (1957) 74 SALJ 175; Spiro Law of Parent & Child 3rd ed (1971) 216; On the other hand Masters' submission in (1953) SALJ at 378 that,

> 'On the assumption that governs the present discussion viz that artificial insemination constitutes sexual intercourse, a medical practitioner who used the semen of a non-European to artificially inseminate a European - or the semen of a European in the case of a non-European patient - would conceivably be contravening these criminal provisions',

is clearly incorrect in the light of the universal acceptance of the fact that AID does not amount to sexual intercourse, see notes 9 & 17 supra.

now arises whether a white doctor who inseminates a coloured woman and in the process touches her genitals thereby commits an offence in terms of section 16(1)(a)(ii) of the Act. It is submitted that the doctor's act of insemination if performed with her consent is analogous to that of delivering a coloured woman's baby viz it is not an offence but merely a therapeutic act that cannot be described as immoral or indecent.

Section 14(1)(a) makes it an offence if 'any male person has or attempts to have carnal intercourse with a girl under the age of 16 years'.(24) We have established that AID does not amount to sexual intercourse therefore it is submitted that AI performed on a girl under 16 with her parents' consent is not a contravention of section 14(1)(a). It would however constitute an offence in terms of section 88 of the Children's Act(25) if the doctor performed the AID on the girl without her parents' consent.(26)

In terms of section 15(a) of the Immorality Act it is an offence(27) if any person 'has or attempts to have unlawful sexual intercourse with any female idiot or imbecile in circumstances which do not amount to rape', provided, 'such person knew that such female was an idiot or imbecile'.(28) Thus in the most unlikely event of a doctor inseminating such a female he would not be guilty of

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(24) Hunt Vol 2, 2nd ed (1982) 452; R v T 1960 (4) SA 685 (T) at 686; R v M 1959 (3) SA 332 (A).

(25) Act No 33 of 1960.

(26) In terms of section 20(8A) of the Act a child of 18 years may consent to any medical treatment of himself/herself without the assistance of his parent or guardian. See Boberg The Law of Persons and the Family (1977) 444; Strauss Doctor, Patient and the Law (1980) 130 131.

Section 30(6) of the Act specifies that where the parents refuse to give their consent to a particular type of treatment the medical officer must refer the matter to the Minister for his consideration and consent if he deems it necessary and justified.

(27) The maximum penalty is 6 years imprisonment, with or without a fine, not exceeding R1 000, in addition to such imprisonment.

(28) R v K 1951 (4) SA 49 (O) at 52; R v V 1957 (3) SA 633 (O) at 634; R v M 1958 (2) PH H 324 (N).

an offence in terms of section 15(a),[29] but would in all likelihood incur liability on a charge of assault or indecent assault.

In terms of section 66(1) of the Mental Health Act[30]

> 'Any person who has carnal intercourse with a female person who is detained under the provisions of this Act or who is under care or control as a mentally ill person, shall be guilty of an offence.'

Again, it is submitted, that in the unlikely event of a doctor performing AID on such a female he is not committing an offence in terms of section 66(1) because AID does not constitute carnal intercourse.[31] Nor, it is submitted, would it be an offence in terms of the Act if he transplanted a fertilised oocyte into her womb, because ET is also not an act of intercourse.

2.2. Where intercourse is not a requisite

In terms of section 16(1)(a)(ii), (b)(ii), 2(a)(ii) and (b)(ii) of the Immorality Act it is an offence for a white female person to commit an immoral or indecent[32] act 'with' a coloured male person and vice versa. The offences referred to in the above sections are not dependent upon an act of carnal intercourse,[33] but are indicative of the legislature's intention to extend the scope of the Act to prohibit sexual contacts of a lesser degree than sexual intercourse as well. It is submitted that in determining whether an act is indecent or immoral the test should be an objective determination of the nature of the sexuality in dispute and that the test should not hinge on the race of the participants.[34]

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(29) Because, it is submitted, that the requirement of sexual intercourse is not met; see also Hunt Vol 2, 2nd ed (1982) 457; C R Snyman Strafreg (1981) at 348.

(30) Act No 18 of 1973.

(31) According to section 66(4) of the Act the consent of the female will not serve as a defence to any such charge.

(32) In R v H & Ano 1959 (4) SA 427 (A) at 432F the AD, per Ogilvie Thompson JA (as he then was), declined to venture a comprehensive definition of acts which were regarded as 'immoral or indecent'.

(33) J R L Milton South African Criminal Law and Procedure Volume III (1971) 330; Spiro Law of Parent & Child 3rd ed (1971) 216.

(34) S v S 1965 (4) SA 405 (N); G M Hardie & G F Hartford Commentary on

(continued on the next page)

It is thus submitted that in the event of eg a coloured person donating semen or an oocyte, which is then utilised in the body of a white person for purposes of procreation, that an offence in terms of the provisions of the above sections of the Act has not been committed, because, although such an act might contravene Government policy, such a prohibition cannot be construed from the Act.(35) The techniques of AID & ET are therapeutic acts which cannot under any circumstances be interpreted as falling within the definition of 'sexual intercourse' or an 'indecent or immoral act'.(36)

Apart from the required mens rea, proof of the offence will rest on the facts of each case eg where the semen of a coloured man is negligently issued by a cryobank instead of that of the white donor, considerable difficulty will arise in proving an offence against the spouses or the donor. If a criminal act was committed it is possible that the medical practitioner who performed the AID or ET might also be involved.(37)

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(34) (continued from the previous page)
the Immorality Act (1960) at 63. In R v H 1959 (1) SA 803 (T) is was suggested that acts which in themselves were not immoral or indecent could become so when performed between white and coloured persons.

(35) Spiro op cit 217. This submission should be studied in conjunction with the Population Registration Act No 30 of 1950 and the Prohibition on Mixed Marriages Act No 55 of 1949 in which the legislature's clear intention is to preserve the racial or ethnic purity of the white racial group in South Africa. The practice of AID and ET across the 'colour line' would probably be viewed as an attempt to circumvent the provisions of these Acts and would thus be in conflict with the government's aim to preserve white racial purity. It is submitted that AID across the colour line is not currently an offence, and that section 15 would have to be amended to include AID before it could be prohibited. Because section 7 of Act No 24 of 1970 requires Ministerial permission in order to transplant an oocyte from one person to another this would effectively prevent donations across the colour line occurring. It is not however, expressly prohibited in terms of Act 24 of 1970.

See also Snyman's criticism op cit 350, of this section in the Act.

(36) See supra at page 176, 181, 182.

(37) Spiro Law of Parent and Child 3rd ed (1971).

3. Perjury

In terms of the Births, Marriages and Deaths Registration Act[38] any person who wilfully makes or causes to be made for the purpose of being inserted in the births register a false statement relating to information required for registration, is guilty of an offence and liable for the crime of perjury.[39]

The children born from AID, and as a result of most of the permutations possible in ET, are illegitimate.[40] Yet because of the secrecy surrounding the practice and in view of the protection afforded the spouses by the pater est quem nuptiae demonstrant[41] rule it is relatively easy for the spouses to falsely register the child as their legitimate child. In view of their collusion in the matter there is little chance of the true facts being revealed and of them exposing themselves to a prosecution for perjury. The decision to prosecute or not to prosecute is at the discretion of the Attorney-General and depends on the Registrar of Births, Marriages and Deaths lodging a complaint with him. There is no reported sequel of a prosecution for perjury following the case of V v R[42] in which it was quite obvious that the AID child in question had been registered as the legitimate child of his mother and putative father.

Can the doctor who performed the AID or ET and was aware of the false registration effected by the spouses be viewed as an accomplice to their perjury? It is submitted that in terms of our law of criminal participation mere

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(38) No 81 of 1963.

(39) See section 46 Act 81 of 1963; see also Strauss Doctor, Patient and the Law (1980) 149; Spiro op cit 217.

(40) See chapter 7 supra.

(41) Spiro op cit 217; Strauss op cit 149.

(42) 1979 (3) SA 1006 (T).

participation by the doctor in AID or ET, neither of which is per se a criminal offence, cannot in addition render him criminally liable for a subsequent act of perjury committed by someone else.(43)

The position would obviously be different if the doctor himself were to report the birth and then do so in fraudulent terms. This would clearly be an act of perjury on his behalf.(44)

If the provisions of the Draft Child Care Bill(45) became law, the difficult position in which AID parents currently find themselves when registering their child viz whether to commit perjury and register the child as their legitimate child or to reveal its source of conception and adopt it, or to register it as their illegitimate child, will be solved. Section 39 declares the AID child to be legitimate for all purposes. This Bill, if it becomes law, will remove any vestige of responsibility which might be placed at the doctor's door. It is perhaps premature at the moment, because the practice of in vitro fertilization is currently limited to utilization of the genetic materials of married couples only,(46) but it is submitted that when donated oocytes are used and implanted into infertile wives, the provisions of section 29 should be extended to cover this category of illegitimate children as well and to decriminalize the registration of such children, so that they become the legitimate children of their 'mother' and father.

4. Assault

Mrs A approaches a doctor and consents to a gynaecological examination to determine whether she is suffering from a certain ailment. In the course of

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(43) Strauss Doctor, Patient and the Law (1980) at 149.

(44) Section 19(1) of the Births, Marriages & Deaths Registration Act 81 of 1963.

(45) (28 October 1981) Government Gazette No 7864.

(46) Reilly Genetics and the Law (1975) 370.

the examination, unbeknown to her, the physician inseminates her or transplants a fertilised ovum into her uterus and she subsequently conceives a child. Does such an act amount to assault?(47)

The three elements of assault are that it should be unlawful, intentional and that there should be an application of force or an apprehension that it would be applied.(48) In the matter now under consideration these elements should naturally have been directed against the person of the female complainant alleging the assault via unauthorised AID/ET.

It is submitted, that in the example above, the physician's act meets the first two requirements, viz that his act is both unlawful and unjustified. Mrs X consented to a gynaecological examination not to AID or ET treatment. It is impossible to imagine that the doctor could have performed such treatment in any way other than intentionally.

As far as the third element is concerned viz the application of force, Hunt(49) is of the opinion that:

> '... it has now become accepted in South African law that there is an indirect application of force where X administers some substance which will cause the drinker bodily harm, albeit internal harm instead of external harm. This covers the administration of poison, drugs and excessive alcohol and the fact that Y himself drinks the substance, perhaps as a result of fraud, does not mean that force has not been applied.'

In the light of the above it is submitted that the AID/ET described above constitutes the crime of assault in that the unsolicited insemination or transplantation of the fertilised embryo is analogous to X administering a noxious substance

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(47) Hunt Vol 2, 2nd ed (1982) 467 defines assault as follows:

> 'Assault consists in unlawfully and intentionally:
> (1) applying force to the person of another, or (2) inspiring a belief in that other that force is immediately to be applied to him.'

(48) Hunt op cit 468.

(49) Hunt Vol 2, 2nd ed (1982) 476; R v Jack 1908 TS 131; R v Matthews 1950 (3) SA 671 (N); R v Sophi 1961 R & N 358 (FC) at 361; M J Strydom 'State v Morse 1962 (1) SA 848 (N)' (1962) 25 THRHR 214; A V Lansdown 'Assault by Administering Noxious Substance' (1962) 79 SALJ 133.

which causes Mrs Y internal harm and discomfort in the form of an unwanted pregnancy, thereby infringing her physical integrity and constituting an assault. It is further submitted that should the physician concerned impregnate an unmarried woman and as a consequence of doing so he infringes her dignitas by causing her shame and embarrassment amongst her family and friends, he would in the alternative render himself liable to a charge of crimen injuria.(50) This would be in line with Hunt's submission that:

> '... if an act impairs only reputation or bodily security and not dignitas it is not correct to charge it as crimen injuria; it should be charged as defamation or assault.'(51)

5. Indecent Assault(52)

Mr B plies Mrs A with liquor and when she is intoxicated he clinically inseminates her with his own semen or that of a donor, or performs an ET upon her. Does his act constitute an indecent assault upon her physical integrity?

In terms of the essential elements of the crime, Mr B's act is unlawful because it occurs without Mrs A's consent.(53) It is also submitted that the act of insemination or ET would involve handling Mrs A's private parts. Such an act is in itself indecent(54) because it is not justified by consent as it would have been had Mrs A requested and consented to AID or ET. The element of

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(50) Hunt op cit 525 defines this crime as follows:

> 'Crimen injuria consists in unlawfully, intentionally and seriously impairing the dignitas of another.'

(51) R v Xabanisa 1946 EDL 167 at 169.

(52) Hunt Vol 2, 2nd ed (1982) 494 defines an indecent assault as follows:

> 'Indecent assault consists in an assault which is itself of an indecent character.'

In R v Abrahams 1918 CPD 590 at 593 the court held that,

> '... for an indecent assault, the violence constituting the assault must in itself be indecent; there must be some handling of the complainant.'

See also R v Z 1957 (2) PH H 240 (N) at 434.

(53) Hunt op cit 495.

(54) R v Curtis 1926 CPD 385 at 389-90.

the allegedly indecent assault which would be most difficult to prove would be the mens rea element[55] viz that B intended his act to consitute an indecent assault per se and not an insemination or ET pure and simple. It is submitted that this would be a very difficult onus to satisfy and that it would be wiser for the complainant to rely on a charge of assault instead of indecent assault.

6. Extortion[56]

The secrecy surrounding the practice of AID/ET exists in order to protect, for example, the donors against claims for maintenance on the one hand, and on the other hand, to protect the parents from the unwelcome publicity that one or both of them is sterile. There certainly is merit in this practice but it does expose the parents and even the AID/ET child to extortion if the donor somehow finds out who the 'parents' of his/her child are. It is also possible for a third part to attempt to gain an advantage against the parents, child or donor, or for the parents to attempt to gain an advantage from the donor.

Thus although AID/ET do not eo nomine constitute the crime of extortion the secrecy and individual circumstances of the persons involved create a favourable climate for an unscrupulous donor to extort some advantage from the 'parents' who wish to maintain the secrecy of their child's origin.

7. Income Tax

In terms of Section 6(3)(a) of the Income Tax Act[57] a taxpayer may deduct an amount of R100 as an abatement in respect of each child or stepchild. The clear implication is that this abatement is only allowed for legitimate

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(55) Hunt op cit 495.

(56) Milton Vol 2, 2nd ed (1982) 691 defines the crime of extortion as follows:

> 'Extortion consists in taking from another some advantage by intentionally and unlawfully subjecting him to pressure which induces him to submit to the taking'.

(57) No 58 of 1962.

children,[58] and that illegitimate children fall[59] under the definition of dependants[60] for whom the abatement allowed is R30 if an amount equal to at least R200 was spent on the child,[61] and R50 if an amount of R350 was contributed to its maintenance.[62]

It is thus submitted that since the AID child and most permutations of the ET child result in the children being classed as illegitimate it would constitute an offence in terms of section 104 of the Act[63] for their 'father' to claim an abatement of R100 for them as though they were legitimate children[64] as envisaged by the Act. Their father would have to content himself with the lesser deduction of R 50 as though they fell into the category of dependants.

8. The Population Registration Act[65]

In South Africa the political economic and social status of every individual is conditioned, if not pre-determined, by his/her race.[66] The differentiation

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(58) See section 1 of Act 58 of 1962.

(59) AID children and most E/T children are in terms of current law illegitimate. The AID child is not a child of its putative father (the taxpayer in our example).

(60) See section 1 of Act No 58 of 1962:
'Dependent' in relation to any taxpayer means –
(b) 'any child (other than a child or stepchild of such taxpayer) under the age of eighteen years on the last day of assessment'.

(61) Section 6(3)(b) of Act No 58 of 1962.

(62) Section 6(3)(c) of Act No 58 of 1962.

(63) Act No 58 of 1962.

(64) In V v R 1979 (3) SA 1006 (T) at 1016 it was held that the AID child is illegitimate. The Draft Child Care Bill however deems them to be legitimate for all purposes. See further, chapter 7.

(65) Act No 30 of 1950 as amended.

(66) A Suzman 'Race Classification and definition in the Legislation of the Union of South Africa 1910-1960' (1960) Acta Juridica 339.

between the races is implemented and enforced by a vast web of racially orientated legislation which determines who a person may marry,[67] where he may live,[68] which amenities[69] he may use, where he may exercise his vote[70] etc. However, fundamental to all other so-called 'apartheid legislation' is the Population Registration Act[71] which defines and categorises the various racial groups constituting the South African population. Once an individual is registered as a member of a particular racial group in terms of this Act his/her fate is sealed. He/she is then issued with an identity document[72] reflecting his/her racial group which in turn is prima facie proof of his/her membership of that group. From then onwards every facet of that person's life is regulated by some piece of racially orientated legislation.

The Population Registration Act can thus have a vital effect on the lives of both AID/ET children and their parents and may give rise to various problems illustrated by the following two hypothetical situations: (i) husband and wife, members of the coloured racial group, persuade a white man to donate his semen which they use to inseminate the wife, and the child subsequently born is in appearance obviously white; (ii) a coloured female acts as hostess mother to the child of a white husband and wife.

In the first example, the donation of the semen is not per se illegal, nor is the act of insemination, which, let us say, is performed by the coloured

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(67) Prohibition of Mixed Marriages Act No 55 of 1949.

(68) Group Areas Act No 36 of 1966.

(69) Reservation of Separate Amenities Act No 49 of 1953.

(70) Promotion of Black Self-Government Act No 46 of 1959; National States Citizenship Act No 26 of 1970; S A Indian Council Act No 31 of 1968; South Africa Act Amendment Act No 9 of 1956.

(71) Act No 30 of 1950.

(72) Population Registration Amendment Act No 29 of 1970.

woman herself. The child's appearance and general acceptance(73) are important factors in determining in which racial group it will be registered, but descent(74) is the ultimate determining factor. Here the parents are hampered in establishing its true line of descent by an oath of secrecy not to reveal the donor's identity. If this is in fact the case they will be unable to prove otherwise than that the child was descended from them and that he is thus a member of the coloured racial group and thereby subjected to many of the restrictive racial laws on our statute book. To register him otherwise would constitute an offence.

In our second example if the coloured hostess mother surrenders the child to its genetic parents there will be no problem, the child is theirs and they will register it accordingly as their legitimate child. However if the hostess mother refuses to hand over the child and insists on keeping it, how is that child to be registered so as not to commit an offence in terms of the Act?

The child is her illegitimate child; but is its racial group white or coloured? The criterion of descent(75) is the determining factor in ascertaining a person's racial group and descent is in turn established by determining the preponderance of blood of a particular racial group(76) contained in the veins of that person. In our example the child is of entirely white descent(77) and it is submitted that it should therefore be registered as a member of the white racial group despite the fact that it has been born to a coloured mother.

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(73) Population Registration Amendment Act No 61 of 1962; De Bruin v Sekretaris van Binnelandse Sake 1973 (2) SA 546 (WLD).

(74) R v Radebe 1945 AD 590; Population Registration Amendment Act No 64 of 1967; Felton v Secretary for the Interior 1972 (3) SA 886 (AD); Pinkey v Race Classification Board & Ano 1972 (3) SA 631 (AD).

(75) Ibid note 72.

(76) R v Radebe supra; Felton v Secretary for the Interior supra; Pinkey v Race Classification Board & Ano supra.

(77) See section 5(5)(a) of Act 30 of 1950,

'In the application of this section and notwithstanding anything to the contrary contained in this Act -

(a) a person shall be classified as a white person if his natural parents have both been classified as white persons ...'.

9. Abortion

9.1. Common law

The question which we must attempt to answer in this regard is whether a doctor who destroys a foetus (blastocyst) which is still at the in vitro stage of its development prior to implantation in the mother's uterus, commits the crime of abortion or not.

Abortion was defined as follows in our common law:

'Abortion consists in unlawfully and intentionally killing and causing expulsion from the uterus of a human foetus'(78)

or

'Vrugafdrywing bestaan in die wederregtelike, opsetlike afdrywing van die lewende vrug van 'n swanger vrou'.(79)

The interest which the law intends to protect is the potential life of the foetus. Both definitions place a strong emphasis on the fact that the act of the abortionist must be directed at a live(80) foetus in the uterus of a woman and that the foetus must be expelled(81) from the uterus. The requirements specified in the above definitions are understandable since at the time they were formulated medical technology had not yet attempted, let alone perfected, in vitro fertilization.(82)

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(78) Hunt Vol 2, 2nd ed (1982) 320.

(79) J C de Wet Die Suid-Afrikaanse Strafreg 3rd ed (1975) at 217.

(80) R v Davies 1956 (3) SA 52 (AD) at 59 where the court held:

'For the completed common law crime of procuring abortion the foetus must have been alive at the time of the act' (per Schreiner JA).

(81) Voet 47.11.3.

(82) Strauss Doctor, Patient and the Law (1980) 156.

9.2. The Abortion and Sterilization Act(83)

This Act was passed in 1975 and was to a large extent based on the common law as it had developed at that time.(84) We must also bear in mind that medical technology had not perfected *in vitro* fertilization and ET at that time.

Abortion is defined in the Act in the following terms:

> Abortion means the abortion of a live foetus of a woman with intent to kill such foetus'.(85)

Would the decantation of a cleaving blastocyst *in vitro* constitute the crime of abortion?

The mere fact that the blastocyst is only a few days or weeks old would not, in the light of the decision in *S v Collop*,(86) exonorate the doctor from potential liability. The blastocyst constitutes a potential life and the court in the above case rejected the submission that abortion was only a crime after the embryo had completed two months of uterine existence(87) at which stage it is

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(83) Act No 2 of 1975.

(84) Report of the Commission of Enquiry into the Abortion and Sterilization Bill RP 68 of 1974; Hunt Vol 2, 2nd ed (1982) 325.

(85) Section 1 'Abortion'.

(86) 1981 (1) SA 150 (A).

(87) *S v Collop supra*, where this submission was struck down by the court, per Diemont JA, in the following terms:

> 'I can find no *indiciae* in the Act to give support to the inference that the legislature intended to distinguish between an embryo and a foetus and for the further inference that the time of transition should be after two months or any other defined period. Moreover to adopt the interpretation contended for, must result in the spread of evil which the lawgiver sought to control and prohibit'. (at 163G-H)

and at 165(F):

> '... at no time did any of the Roman-Dutch writers suggest that the foetus must have reached a certain degree of maturity before a crime could be committed. There is, therefore, no foundation for the proposition that at common law the crime of abortion could be committed only on a woman whose pregnancy has advanced beyond what counsel was pleased to describe as the "embryonic stage". Nor have I found any support for that proposition in the South African case law ....
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> The writers on criminal law are unanimous in their view that it is not necessary that any period of time should have elapsed after fertilization on the ovum; it is enough that it is proved that there was a 'foetus' which was not dead at the time of the *actus reus*'.

medically classified as having changed from being an embryo to a foetus. The doctor's act of decanting the foetus thus meets the requirements of killing a live foetus(88) with the necessary intention.(89)

If the act of decantation was performed after, for example, an amniocentesis test which revealed that the blastocyst was defective, the doctor's act would not be unlawful because it could be justified in terms of section 3(1)(c) of the Act.(90)

It is submitted however, that the area in which the act of decantation falls short of fulfilling the requirements for the crime of abortion is in the following provisions, first, the definition in the Act refers to the '... foetus of a woman ...' (my italics) and this, it is submitted, in turn means that the foetus should be part of a woman, in other words, attached to her uterus.(91) I make this submission on the strength of the fact that the Act was based on our common law which was never called upon to adjudicate upon an IVF/ET situation. Furthermore the present Abortion and Sterilization Act was passed in 1975, but Lesley Brown, the first child conceived by the IVF/ET method was only born in 1978. The blastocyst cradled in a glass container is thus not part '... of a woman ...'. Secondly, the act of abortion implies that the foetus should be expelled(92) from the woman's uterus. Where the blastocyst (foetus) was conceived in vitro it was never part of its genetic mother's uterus and could thus never have been expelled from the environment. It is thus submitted that the act of decanting and killing the foetus does not constitute the crime of abortion.

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(88) S v Collop supra 165 (H); R v Davies supra at 59.

(89) S v Collop supra.

(90) Act No 2 of 1975.

(91) De Wet Strafreg 3rd ed (1975) at 221,
'Dit spreek vanself dat vrugafdrywing slegs op 'n swanger vrou gepleeg kan word. Swanger is die vrou vanaf bevrugting tot by geboorte van die kind.'

(92) S v Kruger 1976 (3) SA 290 (O); P C Smit (1976) TRW 156; F F W van Oosten (1977) De Jure 376 at 377; Hunt Vol 2, 2nd ed (1982) 322-23 howeve criticises the emphasis placed on the requirement of expulsion.

CHAPTER 6

AID - ITS RELATIONSHIP TO ADULTERY, DIVORCE AND ANNULMENT OF A MARRIAGE

1. General

The question as to whether or not AID amounts to an act of adultery is no longer an issue in the law relating to artificial insemination. I will, however, discuss the effect of AID on the marriage relationship in order to illustrate how and why the courts and lawyers changed their position from a point of vehement insistence that AID constituted an act of adultery(1) to a position diametrically opposite viz tolerance of AID and decisions which held that AID did not constitute an act of adultery.(2)

1.1. Society's interest in imposing the sanction of adultery

1.1.1. Preservation of the family system

One of the most persistent reasons for society's continuous attempts to control the voluntary sexual expression of its members is its goal of preserving the family system and of reducing the potential conflict between rivals for sexual partners.(3) No successful human society has ever existed for any length

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(1) Orford v Orford 58 DLR 251 (1921); Archbishop of Canterbury's Commission at p 37: "We entertain no doubt at all that the act both of a married donor, and a married recipient constitutes adultery"; G P R Tallin 'Artificial Insemination' (1956) 34 Canadian Bar Review 1 at 11-27; Doornbos v Doornbos No 54 s 14981 Superior Crt Cook County 13 Dec 23 U.S.L. Week 2308 (1954)

(2) MacLennan v MacLennan 1958 Sess Cass 105 1958 Scots L.T.R. 12; V v R 1979 (3) SA 1006 (T); Hoch v Hoch No 44-5 9307 (Cir Crt Cook County Ill 1945); People v Sorensen 68 Cal 2d 280 437 P 2d 495; J D van der Vyver 'V v R' (1980) 43 Tydskrif vir HRHR 89 at 90.

(3) J May Social Control of Sex Expression (1931) ix; D W Fullerton 'Artificial Insemination' (1979) Family Law Review 31.

of time without some type of family structure,(4) since it was the social form within which man evolved and is still today basic to his continued existence.(5) It is thus not surprising that the family system being as old as man himself is not so much a product of his development as his development is of it.(6) The family and social system to which I refer is the Western-Christian monogamous family structure with its strict condemnation of sex outside the marriage. Our Western legal systems have obviously reflected these Christian norms in their exposition of family law eg in relation to adultery.(7)

Attempts by society to control adultery by making it a crime,(8) forbidding adulterers to marry(9) and preventing an adulterine child from inheriting ab intestato from its mother(10) and stigmatizing the children of adulterers as illegitimate even after the subsequent marriage of their parents(11) were all motivated by the desire to preserve the family system and to subjugate the women

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(4) W Friedman Law in a Changing Society 2nd (1972) 237.

(5) Ibid.

(6) Editorial, 'The Socio-Legal Problems of Artificial Insemination' (1952/3) 28 Indiana LJ 620 at 624.

(7) Friedman op cit at 173, 191-194.

(8) Hahlo Husband and Wife 4th ed 368; P J J Olivier The S A Law of Persons and the Family Law 2nd ed (1980) 332; In Green v Fitzgerald 1914 AD 99, the Appellate Division decided that adultery, which had been a common law crime, was no longer a crime in S A Law because prosecutions for adultery had fallen into disuse.

(8) In Estate Heinamann & Others v Heinamann 1919 AD 90 the AD decided that since adultery was no longer a crime, the other penalties and impediments coupled to it had likewise fallen away. Consequently the prohibition imposed upon the subsequent marriage of adulterers, introduced by the Egtreglement of 18 March 1656 and the Placaat of 1674 was abrogated.

(10) Voet 38.17.19. In Green v Fitzgerald supra Lord de Villiers, having decided that adultery was no longer a crime, held that the lesser penalties for adultery had also fallen away and that the adulterine child could inherit ab intestato from its mother.

(11) Hoffman & Others v Estate Mechau 1922 CPD 179 upheld the harsh old common law sanction, but later cases have decided, in keeping with more modern concepts, that an adulterine child is legitimated by the subsequent marriage of his or her parents, see eg Ex parte J 1951 (1) SA 665 (O) and F A de Villiers (1970) 87 SALJ at 98.

in society,[12] by what amounted to an instinct of self-preservation.

Man's traditional form of procreation within the family unit is however being challenged by new biological techniques like AI coupled with cryobanking which has rendered the man-father's biological function as procreator virtually redundant. Cryobanking renders the need for large numbers of men redundant since one male can produce billions of spermatazoa which may be preserved indefinitely by refrigeration while the technique of cloning renders man superfluous altogether.[13] The success of Steptoe and Edwards is with the process of in vitro fertilization of a human ovum which foreshadows artificial wombs.[14]

The depth and complexity of human emotions are employed (either by God, by nature or by natural selection, according to individual beliefs) to assist and encourage man to follow a course aimed at the preservation of his race. These emotions have become, from man's point of view, ends in themselves and as such are protected by law whether they are still necessary for self-preservation or not.[15] One of the earliest emotions which was protected by the control of voluntary sex expression was comparable to the feeling of ownership that comes from the sole possession of any chattel, accompanied by the feeling of dispossession and pain felt at the loss of a personal possession.[16] This approach was prevalent in many primitive societies where according to custom wives were 'purchased' eg the lobolo custom still practised amongst the tribal blacks in

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(12) Leo Kanowitz Sex Roles in Law and Society (1973) 15-24; John Stuart Mill 'The Subjection of Women' in Essays on Sex Equality edited by Alice S Rossi (1970) at 1125.

(13) James D Watson 'Moving Toward Clonal Man' (May 1971) Atlantic 30 at 31.

(14) D W Fullerton 'Artificial Insemination' (1979) 2 Family Law Review 31; R Francoer Utopian Motherhood : New Trends in Human Reproduction (1970) 51.

(15) Editorial (1952/3) Indiana LJ 620.

(16) May Social Control of Sex Expression (1931).

South Africa.[17] In this type of society adultery was viewed in the light of an economic loss rather than an act of marital infidelity.[18]

1.1.2. Social stigma

Civilised men, however, rated their wives as being more valuable than mere property rights, for as civilised man developed more sensitive feelings and emotions an act of infidelity branded the husband with a social stigma not normally associated with the loss of a chattel.[19]

However, these secondary ends were still closely related to the basic goal, viz, the preservation of the race through maintenance of a family structure. Because the family was more dependent upon the woman, who kept the home and cared for the children, adultery was limited, by custom and law, to extra-marital intercourse by or with her. A man was allowed sexual freedom as long as he did not defile another man's wife.[20] This situation existed in ancient times,[21] throughout the Roman Empire,[22] and was adopted in English common law.[23] Canon law attempted to eliminate this double standard by incorporating the provisions of I Corinthians 7,4. The penalties however remained more severe for

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(17) J C Bekker & J J J Coertze Seymour's Customary Law in South Africa 4th ed 1982 149. According to Seymour the main effect of a lobolo contract is '... to transfer the reproductive capacity of the woman ... from her guardian husband' (at 149).

(18) Seymour op cit 353 'A Husband is entitled to claim a full fine or penalty for each separate act of adultery with his wife ...'. In the light of Seymour's submission the husband's economic loss and hence his right to a fine is based on the fact that the adulterer is using or abusing his exclusive right to his wife's reproductive capacity, secured by the payment of the lobolo.

(19) H Kay Sex-Based Discrimination in Family Law (1974) 125; J Blenkinsopp Sexuality and Christian Tradition (1970) 39.

(20) (1952/3) Indiana LJ at 625.

(21) G Ohlson 'Adultery : A Review' (1937) 17 Buffalo University LR 328 at 330.

(22) D 48.5.34, according to this text adultery was limited to a married woman or to a man who had sexual intercourse with a married woman. Its objective was to prevent an illegitimate child being foisted on the unsuspecting husband.

(23) F Wharton Criminal Law and Procedure Vol 2 (1966) para 281. The English ecclesiastical courts recognised motives even further removed from the original purpose of preserving the family. They said that marriage created personal rights in both parties that were ordained by God and guaranteed by

(continued on the next page)

the offending wife than the husband.(24) The provisions of Canon law were in turn received into the Netherlands.(25) These equalising measures were in turn included in The Political Ordinance of 1580.(26) The fact that both the husband and the wife who have sexual intercourse with a third party are committing adultery and that damages can be recovered by both the husband or the wife from the co-respondent via the actio injuriarum was upheld by our AD in Foulds v Smith.(27)

1.1.3. Alienation of Affection

A further harm to a husband whose wife has extra-marital intercourse, is the alienation of her affection.(28) The husband (or wife) thus has an action for damages under the actio injuriarum.(29)

To sum up thus, the prohibition against adultery which was part of the Judeo-Christian religious norms and through which it was introduced as a ground for divorce throughout the Western world had far reaching and effective consequences. It provided a sanction against the alienation of affection, the breach of marriage vows, the risk of burdening a husband with a spurious heir, the social stigma resulting from marital infidelity, and, eventually, the extinction of the race through the breakdown of the family system.(30)

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(23) (continued from previous page)
His church. Consequently they considered adultery to be essentially a breach of the marriage vows and defined it as the intercourse of any married person with someone other than his spouse.

(24) Van Leeuwen Cens For 1.5.26.1.

(25) J Cos Over de oorzaken door welke Boedelmenging Eindigt sect(iv) and authorities there quoted; De Groot Inleiding 1.5.1.

(26) 1 G.P.B. 330.

(27) 1950 (1) SA 1 (A).

(28) Diemer v Solomon 1982 (4) SA 13 (C).

(29) Viviers v Killian 1927 AD 449; Woodiwiss v Woodiwiss 1958 (3) SA 609 (D); Olivier Persons and Family Law 2nd ed (1980) 318; Van der Berg v Jooste 1960 (3) SA 71 (W); Fraser v De Villiers 1981 (1) SA 378 (D) at 382.

(30) J C Sonnekus Die Privaatreqtelike Beskerming van die Huwelik LL.D thesis Leiden (1976); J Church 'Consortium Omnis Vitae' (1979) 42 THRHR 376 at 378.

2. Definition of Adultery

To ordinary people adultery occurs when a married person engages in coitus with someone to whom he or she is not married.(31) Since AID precisely avoids personal intimacy between the man who provides the sperm and the woman who receives it, and is acceptable to many couples for this very reason, the term adultery seems peculiarly misapplied to AID.(32) It would be difficult to convince a layman that the therapeutic injection of donor seed into his wife (with his consent) was adultery, not to mention the possibility of it being sexual intercourse.(33)

In order to solve this impasse it is essential to determine how S A law (and other legal systems) define adultery and then see whether AID falls within the scope of the definition or not. It is also necessary to consider the husband-wife relationship.(34)

Hahlo(35) defines adultery in S A law as follows:

> '... voluntary sexual intercourse between a spouse and a person other than the offender's husband or wife.'

This definition has however been extended so as to include perverted forms of sexual intercourse such as sodomy and bestiality.(36)

The emphasis in the above definition falls on the requirement of an act of sexual intercourse and in this regard our courts have demanded proof of penetration.

> '... our courts have always required a plaintiff spouse seeking a divorce on the ground of adultery to prove ... that carnal connection has actually occurred: that is to say that there has been penetration .... Penetration is required to establish adultery.'(37)

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(31) Hahlo Husband and Wife 4th ed (1975) 366.

(32) Klayman (1970) 39 Cincinnati LR 291 at 308.

(33) P Creighton Artificial Insemination by Donor, A study of ethics, medicine and the law in our technological society (1977) at 11.

(34) Fullerton (1979) 2 Family LR 31 at 33.

(35) Husband and Wife 4th ed (1975) at 366. See also Brouwer 2.18.2; Van Leeuwen Roomsch-Hollandsch Recht 1.15.1; Voet 24.2.5.

(36) McGill v McGill (1926) 47 NLR 398; Kat v Kat 1910 TPD 436; Hahlo Husband and Wife 4th ed (1975) at 366-367.

(37) Stated by Ogilvie Thompson J (as he then was) in Cunningham v Cunningham 1952 (1) SA 167 (C) at 170; Louw v Louw 1946 CPD 117 at 127.

Sexual intercourse can in turn be defined as being

'sexual or carnal connection involving penetration of the female organ by the male organ.'(38)

As I will outline infra, recent authority in most Anglo-American legal systems is to the effect that AID is not adultery. Let us now however look at both sides and analyse how and why the present opinion prevails.

2.1. Cases upholding AID as adultery

The usual concept of adultery requires that sexual intercourse take place, and at one time the great wrong of adultery was the introduction of a false strain into the blood line of the husband.(39) It is submitted that this idea led to the definition that adultery was the surrender of the reproductive capacity to a person other than a spouse.(40)

2.1.1. Orford v Orford

This case,(41) decided by the Supreme Court of Ontario actually involved an alimony action, but in the course of his decision Mr Justice Orde pronounced by way of an obiter dictum that artificial insemination was adultery. The case is important because it has been much quoted and discussed particularly in decisions in the USA.

The facts were that the couple were married in Canada in August 1913. After a honeymoon and a three month visit to England, Mr Orford left his wife to return to Canada. Apparently the marriage had not been consummated due

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(38) R v V 1960 (1) SA 117 (T) at 118-119; R v Giles 1926 WLD 212-13; State v McCall 63 NW 2d 874 876 (1954) 24; American Jurisprudence 2d Divorce and Separation para 24 (1966).

(39) T A Shell 'Artificial Insemination - Legal and Related Problems' (1955) 8 Univ of Florida LR 304 at 308; Grad (1968) 15 UCLA Law Review 480 at 503; Orford v Orford (1921) 49 OLR 15.

(40) Fullerton (1979) 2 Family LR 31 at 36.

(41) (1921) 49 OLR 15.

to a physical defect suffered by the wife. In 1919, the wife, who was still in England, gave birth to a child allegedly conceived by artificial insemination and without her husband's knowledge or consent. Mrs Orford subsequently brought an action for alimony, and in response to her husband's defence that she had committed adultery, contended that AID with or without his consent was not adultery. Her counsel argued that for adultery, there must have been "sexual intercourse in the ordinary natural way".

Mr Justice Orde found, as a fact, that Mrs Orford was guilty of adultery in that she had had intercourse "in the ordinary way" with one Hodgkinson, but went on by way of obiter dictum to pronounce that artificial insemination was adultery. He said that he could not agree that the essential element of adultery rested in the moral turpitude of the act.

> 'The sin or offense of adultery, as affecting the marriage-tie, may, without going farther back, be traced from the Mosaic law down through the canon or ecclesiastical law to its present date .... In its essence, adultery was always regarded as an invasion of the marital rights of the husband or wife. When the incontinence was that of the wife, the offence which she had committed rested upon deeper, more vital ground than that she had merely committed an act of moral turpitude, or had even seen fit to give to another man something to which her husband alone was entitled. The marriage-tie had for its primary object the perpetuation of the human race.'(42)

Though incapable of finding a judicial precedent for the phenomenon of artificial instemination, Mr Justice Orde went on to state that the essence of adultery consists:

> '... not in the moral turpitude of the act of sexual intercourse, but in the voluntary surrender to another person of the reproductive powers or faculties of the guilty person; and any submission of those powers to the service or enjoyment of any person other than the husband or wife come within the definition of "adultery" .... Sexual intercourse is adulterous because in the case of the woman it involves the possibility of introducing into the family of the husband a false strain of blood.'(43)

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(42) Supra at 22.

(43) Supra at 22-23.

Following this line of reasoning, Mr Justice Orde concluded

> 'If it were necessary to do so, I would hold that [AID] in itself was "sexual intercourse". It is conceivable that such an act performed upon a woman against her will might constitute rape."(44)

Although not entirely without merit this statement is not in agreement with well recognised common law definitions,(45) and leads to some rather anomalous results.(46) For example, where the doctor performing the operation is a woman or where the woman uses the syringe herself, can one in all honesty say that an act of sexual intercourse has taken place?(47) One cannot but, I submit, answer in the negative. However before dismissing Justice Orde's reasoning altogether, let us evaluate it in greater depth by examining a few apposite English cases.

2.1.2. Russell v Russell(48)

There was at one time in the United Kingdom a tendency to find that an act of adultery had been committed even when no sexual intercourse had occurred, a fact which was totally at variance with the common law notion of adultery.(49)

In the Russell case the appellant had conceived without penetration due to her indulgence in sexual intimacies. Lord Dunedin in his dictum stated that fecundation ab extra by the woman's paramour was adultery. The proponants of the argument that AID is adultery used this obiter, divorced from its context, to the effect that if fecundation as it occurred in the Russell case was adultery, then

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(44) Supra at 23.

(45) Hahlo Husband and Wife 4th ed (1975) at 366; Cunningham v Cunningham supra at 170; V M Berger 'Artificial Insemination' (1965) Brooklyn Law Review 302 at 305 312; J R Valeri 'Donor Insemination - No Clear Legal Future in Prospect' (1968) Portia LJ 235 at 237.

(46) A Koerner 'Medicolegal Considerations in Artificial Insemination' (1948) 8 Louisiana LR 484 at 495; Weinstock (1971) 5 Family LQ 369 at 380; C P Kindregan 'State Power over Human Fertility and Individual Liberty' (1972) 23 Hastings LJ 1401 at 1409.

(47) Klayman (1970) 39 Cincinnati LR 291 at 310; J L Spiegel 'Seed of Doubt' (1956) Univ of Pittsburgh LR 659 at 669.

(48) [1924] AC 689 at 720.

(49) K R M Hennessy 'Artificial Insemination' (1967) 10 Canadian Bar Journal 514 at 519.

it didn't matter if the fecundation was at short or long range, and AID was thus merely a case of long-range fecundation.(50)

2.1.3. Rutherford v Richardson(51)

The genesis of the suggestion that something less than penetration, or at least full penetration constituted adultery is found in a dictum of Viscount Birkenhead in Rutherford v Richardson where his lordship said:

> '... some suggestion was made in argument in this House that this condition even though inconsistent with penetration, was not inconsistent with some lesser act of sexual gratification. If there were evidence of such an act, it cannot be doubted that ... a decree based upon adultery might issue.'

2.1.4. Sapsford v Sapsford(52)

This case followed a line of reasoning similar to that in the Russell case equating adultery with blatant sexual infidelity, though clearly no physical 'connection' had taken place.

Karminski J commented(53) on Viscount Birkenhead's opinion noted supra, in the following terms:

> '... if I understand those words of the Lord Chancellor, he had in mind that particular case where there had been at any rate an attempt at sexual intercourse, that is, by the introduction of the male organ into the female, but for one reason or another the attempt had not fully succeeded.'

It is submitted that Karminski J was equating Lord Birkenhead's "lesser act of sexual gratification" with an attempt at sexual intercourse.

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(50) S Lang 'Does Artificial Insemination Constitute Adultery?' (1966) 2 Manitoba Law Journal 87 at 93; Editorial, 'Medicolegal Aspects of Artificial Insemination' (30 April 1955) JAMA 1638 at 1639; A P Massey 'Artificial Insemination : The Law's Illegitimate Child?' (1963) 9 Villanova LR 77 at 79.

(51) 1923 AC 1 at 11.

(52) [1954] 2 All ER 373.

(53) Supra at 399.

2.1.5. Dennis v Dennis[54]

In this case the English Court of Appeal clearly stated that adultery cannot be proved unless there is some penetration;

> 'It is not necessary that the complete act of sexual intercourse should take place. If there is penetration by the man of the woman, adultery may be found, but if there is no more than an attempt, I do not think that a finding of adultery would be right.[55]
>
> A man may commit adultery in his heart, but what the courts are dealing with is the physical act which has to be proved in order that a divorce may be obtained, and I think that all the authorities, including the writers on canon law and ecclesiastical law ... are speaking of the physical act ... [which] has not been extended to include such a form of what may be described as lesser sexual gratification ....'[56]

Although the degree of penetration is not relevant to determining whether AID is adultery, I submit that Lord Singleton LJ's views supra are the most acceptable in regard to adultery as they are in keeping with some of the underlying reasons for which South African law proscribes adultery viz that it constitutes an infringement of the sanctity of a marriage.[57]

I submit that there is little difference between a successful attempt and an unsuccessful attempt at penetration for the spouse is equally betrayed when it comes to marital fidelity,[58] but the court is considering physical matters that must be capable of precise definition. A man may rape a woman in his mind, but the court is dealing with the physical act that must be proved in order that a divorce may be obtained, and I submit that the physical act must be the ultimate act, carrying with it the usual conception of mutual intercourse between the sexes.[59]

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(54) [1955] AC 153.

(55) Supra at 160 per Singleton LJ.

(56) Supra at 163 per Hodson LJ.

(57) Diemer v Solomon supra at 16.

(58) Carroll v Carroll 1947 (4) SA 37 (N) at 45; Kleinwort v Kleinwort 1927 AD 123 at 124.

(59) Thomson v Thomson 1949 (1) SA 445 (AD) at 456; Smit v Arthur 1976 (3) SA 378 (AD) at 384.

2.1.6. Doornbos v Doornbos[60]

The Illinois court in this case granted a divorce to a wife on the ground of her husband's habitual drunkenness. During the course of the divorce action, Mrs Doornbos petitioned the court for a declaratory judgment concerning the status of the child. According to her uncontradicted testimony, the child was conceived via AID with her husband's consent. She also asked the court to determine whether AID was adultery, whether it was contrary to public policy, and whether the child was legitimate.

In a declaratory judgment Gorman J held that the minor child conceived by AID was illegitimate and that AID constituted adultery.

> 'Heterologous artificial insemination ... with or without the consent of the husband is contrary to public policy and good morals, and constitutes adultery on the part of the mother. A child so conceived is not a child born in wedlock and therefore illegitimate. As such it is the child of the mother, and the father has no right or interest in said child.'[61]

2.2. Cases holding that AID is not adultery

2.2.1. Hoch v Hoch[62]

According to the facts, the husband, a soldier, sued his wife for divorce, on the grounds of adultery, after returning from military duty and finding her pregnant. She claimed that she had been impregnated by AID. She did not however have his consent for this step. Feinberg J rejected the wife's allegation, but stated expressly in his judgment that AID with or without the husband's consent was not adultery. Unfortunately this decision was never officially reported, and is, therefore of dubious value as a precedent.[63]

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(60) Unreported No 54-5-14931 23 USLW 2308 (Super Ct Cook County Ill 13 Dec 1954).

(61) 23 USLW 2308 at 2309; G J van Emden 'Artificial Insemination and the Problem of Legitimation and Adultery' (1955) Univ of Illinois Law Forum 759 at 760.

(62) Unreported Cir Ct Cook County Ill (1945).

(63) H S Chandler 'A Legislative Approach to Artificial Insemination' (1968) 53 Cornell LR 497 at 500; J S Sherman 'People v Sorensen : Artificial Insemination Gives Birth to Real Legal Problems in California' (1968) 4 California Western LR 177 at 180; R S Jacobs & J P Luedtke 'Social and Legal Aspects of Human Artificial Insemination' (1965) Wisconsin LR 859 at 875.

2.2.2. Maclennan v Maclennan[64]

This case deserves a good deal of attention and respect since it faces the issues raised by artificial insemination squarely and furthermore, it is submitted, Lord Wheatley's decision that AID is not adultery is well reasoned.

2.2.2.1. Facts

In 1958, the High Court of Sessions of Scotland was presented with a petition for divorce brought by Mr Maclennan, who had been separated by circumstances from his wife for a period of 14 months. When he returned home, he discovered that his wife was pregnant and consequently brought divorce proceedings against her. To rebut the inference of adultery which arose from her husband's non-access, Mrs Maclennan adduced evidence to establish that she had been artificially inseminated, although admittedly without her husband's consent.

2.2.2.2. Culpability for AID not a moral issue

Lord Wheatley conceded that the wife's act was a 'grave and heinous breach of the marriage contract'[65] but decided quite correctly that the issue was not one of moral culpability, but simply of whether AID was adultery or not:

> 'This problem ... must be decided by an objective standard of legal principles as these have been developed and must be confined to the narrow issue of whether this form of insemination constitutes adultery in the eyes of the law ....
>
> The idea that a woman is committing adultery when alone in the privacy of her bedroom she injects into her uterus by means of a syringe the seed of a man she does not know and has never seen is one which I am afraid I cannot accept.'[66]

It is submitted that Lord Wheatley's reasoning was logical and followed the modern definition of adultery which requires voluntary sexual intercourse and

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(64) 1958 Scots LTR 12; Verkauf (1966) 3 Houston LR 277 at 300.

(65) 1958 Scots LTR 12 at 14; C T Dienes 'Artificial Insemination : Perspective on Legal and Social Change' (1968) 54 Iowa Law Review 253 at 288.

(66) Supra at 17.

penetration. There must be two parties physically present and engaging in a sexual act with some degree of penetration.(67) AID does not fulfil these requirements and it is submitted that it should not be deemed to be adultery whether it takes place with or without the husband's consent.(68) There can be no destruction of the faith in the chastity or loyalty of one's spouse since there is no act of sexual intercourse to destroy that chastity.(69)

2.2.2.3. Impregnation refuted as a test for sexual intercourse

This was one of the key points of Lord Wheatley's judgment. His finding on this issue was as follows:

> 'While the primary purpose of sexual intercourse is procreation, in the eyes of the law surrender of the reproductive organs is not necessary to consummate the act of intercourse. Expedients may be used by the parties to secure birth prevention ....'(70)

2.2.2.4. Impregnation not a necessary element of every act of sex

The following argument advanced by the petitioner viz that:

> '... all cases of penetration of the female organ by the male organ were adultery ... so too all cases of impregnation were adultery even if there was no penetration.'

was dismissed by Lord Wheatley as being a 'non-sequitur'.(71)

This argument he observed was a confusion of the method with the result for clearly impregnation was not a necessary element of every act of sex.(72)

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(67) R v Giles supra at 212-213; R v V supra at 118-119.

(68) V v R supra at 1013 (B).

(69) Sergeant (1970) 19 Drake LR 409 at 420.

(70) 1958 Scots LTR at 15.

(71) Supra at 16.

(72) Supra at 16.

2.2.2.5. Fecundation ab extra

His Lordship also saw fit to distinguish the fecundation ab extra situation in Russell v Russell[73] (which Lord Dunedin found to be adulterous) from the present circumstances of artificial insemination:

> '... there was a close conjunction of the bodies even although there was no penetration of any sort of the female organ by the male organ, but the close juxtaposition of the respective organs enabled an ejaculation of semen ... to enter into the female organ and fertilise ... there was a mutual surrender of the bodies to an illicit passion ... it did not preclude the act from being an adulterous one merely because there had been no penetration .... As there can be penetration without emission (which would be adultery) and emission following penetration without fertilisation (which would likewise be adultery) it seems to me that these factors are merely incidentals or accidentals of the adulterous act which consists of the mutual surrender of the bodies and is evidenced by the degree of familiarity thereby occasioned, which is a complete transgression and violation of the marriage contract.[74]

Accordingly, Lord Wheatley advanced four propositions which totally refute Mr Justice Orde's dictum in Orford v Orford namely:

(1) For adultery to be committed there must be two parties physically present and engaging in the sexual act at the same time.

(2) To constitute the sexual act there must be an act of union involving some degree of penetration of the female organ by the male organ.

(3) It is not a necessary concomitant of adultery that male seed should be deposited in the female's uterus.

(4) The placing of the male seed in the female uterus need not necessarily result from the sexual act, and if it does not, but is placed there by some other means, there is no sexual intercourse.[75]

Perhaps the most lucid distinction with regard to AID is Lord Wheatley's statement:

> "Just as artificial insemination extracts procreation from the nexus of human relationships in or outside of marriage, so does the extraction of the nexus of human relationship from the act of procreation remove artificial insemination from the classification of sexual intercourse."'[76]

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(73) [1924] AC 687 at 720.

(74) Maclennan supra at 16.

(75) Supra at 17.

(76) Supra at 17.

2.2.3. People v Sorensen(77)

The trend towards liberalization of AID case law continued in the above 1968 California decision. This case dealt with a husband's obligation to support a child conceived by AID with the husband's consent. The court stated that in the absence of legislation prohibiting AID, a child so conceived is not the result of an adulterous affair since adultery is, by California statute, defined as voluntary sexual intercourse of a married person with one not a husband or wife. The court criticized the suggestion that the doctor and wife may commit adultery as being 'patently absurd' since the doctor may be a woman or the husband himself may make the injection.(78) It is also absurd, the court said, to consider the donor as committing adultery since he may, at the time of the injection of his semen, be miles away or even dead.(79)

2.2.4. V v R(80)

The facts in this, the first AID case in S A law were that while the applicant was married to the respondent she gave birth to an AID child. The conception took place with respondent's consent. They were subsequently divorced and the applicant remarried. She and her second husband wanted to adopt her minor son W J R. In terms of the Children's Act,(81) before a court will grant an adoption order it must be satisfied that consent to the adoption has been given

> 'by both parents of the child, or, if the child is illegitimate by the mother of the child ....'.(82)

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(77) 68 Cal 2d 280 437 P 2d 495 66 Cal Rptr 7 (1968); B J Davies 'Consent for adoption of AID child' (1974) 23 Buffalo LR 548 at 550.

(78) In response to Sorensen the California legislature amended the Penal Code by adding:

> 'The husband of a woman who bears a child as a result of artificial insemination shall be considered the father of the child for the purposes of this section, if he consented in writing to the artificial insemination.'

(79) Sorensen supra at 501; Kamlet (1975) 24 Cleveland State LR 341 at 346; Sergeant (1970) 19 Drake LR 409 at 420.

(80) 1979 (3) SA 1006 (T).

(81) Act No 33 of 1960.

The respondent (applicant's first husband) refused to give his consent to the adoption. She therefore applied to the TPD for an order declaring that her first husband was neither the natural nor the legal father of W J R, her AID son. A decision in her favour would in effect reduce her son to the status of an illegitimate and circumvent the statutory requirement of her erstwhile husband's consent to the proposed adoption.(83)

In order to decide the narrow issue of adoption raised in the application Steyn J had perforce, to look more widely at the legitimacy of the AID child and hence at whether AID constituted adultery or not.(84) Steyn J had little hesitation in deciding that AID did not constitute adultery in S A law.

> 'Ek bevind --- dat die getroude moeder nie die vergryp van owerspel begaan het met die ontvangs van die kind deur middel van kunsmatige bevrugting nie ....'(85)

In coming to this conclusion he considered and rejected Orde J's decision in Orford v Orford that AID was adultery because it amounted to the surrender of the wife's reproductive powers to a third party.(86) He held instead, that if the wife had surrendered her reproductive capacities to anyone it was to her husband who had consented to the AID taking place.(87) He justified his finding by stating that in AID the '... wellus van die partye en hulle emosionele aanraking en bevrediging ...'(88) and the '... onregmatige wellus ...'(89) normally associated with an act of adultery were missing.

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(83) Van der Vyver (1980) 43 THRHR 89 at 94.

(84) 'Die enigste grondslag waarop so 'n kind buite-egtelik beskou kan word is op ground daarvan dat die moeder owerspel sou gepleeg het deur die ontvangs van 'n onbekende skenker se saad in 'n nie-natuurlike proses van bevrugting' at 1013(A).

(85) V v R 1979 (3) SA 1006 (T).

(86) Supra at 1014(C).

(87) Supra at 1013(B).

(88) Supra at 1013(B).

(89) Supra at 1015(C).

Although I agree with Steyn J's decision that AID is not adultery, I submit that he has failed to give the most compelling reason for his decision, viz that according to our law's definition of adultery,(90) the act of sexual intercourse requires penetration of the female organ by the male organ.(91) By no stretch of the imagination can the penetration of the female organ by an AID be equated with the penetration effected by the male organ in an act of sexual intercourse.(92)

2.3. Summary of Academic arguments which have been submitted on the Issue of AID and adultery

2.3.1. Time factor

Every action takes place at a moment in time. Thus if AID did in fact amount to adultery and the wife had committed adultery by submitting to the insemination, then the donor must likewise have done so, because adultery cannot be committed without a partner; but at which moment in time and in relation to the sequence of events was the act of adultery executed? There are three alternatives which we can consider.(93)

2.3.1.1. At the moment the semen was collected

If it occurred at this moment in time, it does not necessarily follow that adultery took place at this moment, since the semen so collected may have been frozen, stored and never used.(94)

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(90) See references notes 26 & 27 supra.

(91) Van der Vyver 'V v R' (1980) 43 THRHR 89 at 90; Cunningham v Cunningham supra at 171(A); Schnellen Artificial Insemination in the Human (1957) at 300.

(92) It is however conceded that our law has extended the scope of adultery in our law to include sodomy and bestiality which do not fall precisely within the requirements of the definition viz a penetration of the female organ by the male organ cf McGill v McGill (1926) 47 NLR in which the court held that husband's intercourse with a bitch was adultery and Cunningham v Cunningham 1952 (1) SA 167(C) in which the court held that sodomy amounted to adultery.

(93) H A Hubbard 'Artificial Insemination : A Reply to Dean Tallin' (1956) 34 Canadian Bar Review 425 at 433.

(94) Fullerton (1979) 2 Family LR 31 at 36.

2.3.1.2. At the moment of injection

If this is assumed to be the moment at which adultery took place, a situation may arise where the donor might have been dead for years, and the woman would then be guilty of necrophilism.(95)

2.3.1.3. Over a period of time

If the alleged adultery took place over a period of time between and including the collection and impregnation the results are equally absurd. The wife might then have committed adultery not only during the donor's lifetime but also after his death.(96)

It is obvious from the very nature of sexual intercourse that it cannot commence with the ejaculation of semen and have subsisted continuously qua act until the impregnation. This would in fact not be one act, but two separate acts, and logically sexual intercourse cannot continue as an act after the conclusion of the activity by one of the actors. The only reasonable conclusion to the arguments advanced above is that AID is not adultery.(97)

2.3.2. Surrender of reproductive powers

The much vaunted argument that the test for adultery involves the surrender of the reproductive powers(98) cannot, it is submitted, be correct, because it would follow that the use of contraceptives would preclude adultery. Similarly a man who was impotentia seminalis or a woman who had undergone a hysterectomy could never commit adultery.(99) This is clearly absurd.

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(95) Fullerton (1979) 2 Family LR 31 at 36.

(96) Fullerton (1979) 2 Family LR 31 at 36.

(97) Hubbard (1956) 34 Canadian Bar Review 425 at 433.

(98) Orford v Orford supra.

(99) Fullerton op cit 36.

2.3.3. Consummation of a marriage

The use of contraceptives by a healthy young couple of child bearing age may give rise to divorce as a result of the irretrievable breakdown of the marriage,(100) but does not give rise to an action for nullity as a result of non-consummation of the marriage.(101) The simple fact that birth control techniques can prevent pregnancy does not prevent consummation of a marriage. On the other hand, impregnation alone does not suffice since fecundatio ab extra is not consummation. Impregnation, therefore, is not the test for consummation of a marriage. Since consummation demands deeper penetration than adultery (which requires only the slightest penetration) a fortiori, adultery does not require impregnation.(102)

2.3.4. Artificial insemination is a species of sexual intercourse

By tampering with the definition of sexual intercourse,(103) which is indisputably a prerequisite of adultery, Tallin is able to delineate adultery in such a way that it encompasses AID.(104) However this submission is refuted by Hubbard who argues that virginity is a factual condition present in a woman who

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(100) W V H 1965 (3) SA 740 (O): '... when voluntary and self-imposed sterilisation in some form or other, whether by surgical means or to the use of contraceptives, is brought about stante matrimonio, by one spouse contrary to the wishes of the other and without good cause .... [T]his would in my view be a wilful refusal by a spouse of the normal marital privileges of marriage to which the other is entitled. The procreation of children is one of the main objects of marriage, and to deny the wife stante matrimonio, the right to motherhood without good cause, is a wrongful refusal of marital rights and is as much a desertion of the wife as a wrongful refusal to have sexual intercourse is' (per Smith JP at 741). See also Baxter v Baxter [1948] AC 274.

(101) W v H supra.

(102) H v M 1936 CPD 377; Hunt v Hunt 1940 WLD 55; Fullerton (1979) 2 Family LR 31 at 36; Hubbard (1956) 34 Canadian Bar Review 425 at 432.

(103) G P R Tallin 'Artificial Insemination' (1956) 34 Canadian Bar Review 1 at 24, '... "Sexual intercourse" might be defined as any conduct between persons involving use of, or direct contact with, the primary sex organs of at least one of them.'

(104) Tallin (1956) 34 Canadian BR 1 at 25.

is '... completely innocent of carnal knowledge of a person of the opposite sex'.(105) Conversely, however, a virgo intacta can be impregnated by AID. Hubbard thus draws the following logical conclusion:

> 'If artificial insemination is sexual intercourse it is ipso facto "carnal knowledge", hence, artificial insemination would, if it be sexual intercourse, deprive a woman of her virginity (if she had not already lost it).(106)

A fortiori, artificial insemination is not a species of sexual intercourse.

It is further submitted that were a definition of sexual intercourse as wide as Tallin's to be accepted it would cut across and blur the distinction between crimes such as rape and indecent assault.(107)

2.3.5. Summary and Conclusion

In the light of the facts set out in the chapter above it is submitted that it is highly unlikely that an authoritative court of final jurisdiction faced with the specific issue of whether artificial insemination was adultery would find in favour of such a proposition. Although it is conceded that AID performed without the husband's consent constitutes a heinous assault on the marital bond,(108) in order for a court to hold that it was adultery it would have to twist the usual definitions of that offence into unrecognizable shapes and violate long standing principles of statutory construction and interpretation in order to do so.(109)

It is thus further submitted that since AI is neither illicit nor immoral,(110) and since sexual penetration, the necessary prerequisite to adultery, is absent,

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(105) Hubbard (1956) 34 Canadian BR 425 at 432.

(106) Fullerton (1979) 2 Family LR 31 at 37.

(107) P M A Hunt South African Criminal Law & Procedure Vol II 2nd ed by J R L Milton (1982) at 440 and 494.

(108) It would, however, have been difficult to obtain a divorce on the ground of AID under the 'old' divorce laws as it did not constitute either adultery or malicious desertion.

(109) G P Smith 'Through a Test Tube Darkly : Artificial Insemination and the Law' (1968) 67 Michigan LR 125 at 141; Chandler (1968) 53 Cornell LR 497 at 501.

(110) Smith (1968) 67 Michigan LR 125 at 141.

it is anomalous to consider the AID process as anything but an attempt to compensate for an unfortunate physical obstacle[111] and in this way to complete the matrimonial union with the blessing of a child where otherwise the only alternative would have been an adoption.[112]

3. AID and Divorce

In terms of the Divorce Act No 70 of 1979 the only grounds for divorce in our law now are irretrievable breakdown of the marriage and mental illness or continuous unconsciousness.[113] Adultery per se is no longer a ground for divorce in South African law[114] but will in future serve only as evidence that the marriage has broken down irretrievably.[115] Hard on the heels of this Act came the decision in V v R[116] which held that AID is not adultery. It is thus abundantly clear that in a situation where a wife has given birth to an AID child, with her husband's consent, that this does not per se give rise to a ground for divorce.[117]

It is however submitted that AID without consent which was characterised by Orde J in Orford v Orford[118] as being a 'heinous offence to the marriage' can be deemed to fall within the scope of section 4(1) of Act 70 of 1979, viz, that it constitutes a breach of faith which is grave enough to bring about the irretrievable breakdown of the marriage. If this can be proved then it would support an action for divorce on this ground.[119]

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(111) G P Smith 'A Close Encounter of the First Kind : Artificial Insemination and an Enlightened Judiciary' (1978/79) 17 J of Family Law 41 at 45.

(112) Shell (1955) 8 Univ of Florida LR 304 at 309.

(113) Section 3 of Act No 70 of 1979.

(114) Section (4)(2)(b) Act No 70 of 1979.

(115) Kruger v Kruger 1980 (3) SA 283 (O) at 287.

(116) Supra at 1015.

(117) Pauw (1980) TSAR 192 at 194.

(118) Supra at 251.

(119) John A Robertson 'Reproductive Technologies - Legal Aspects' Encyclopedia of Bioethics (1978) at 1468.

4. Artificial Insemination and Annulment

Having decided that AID does not constitute adultery essentially because an act of artificial insemination cannot be equated to sexual intercourse,(120) it is submitted that where a marriage has not been consummated in the normal way because the husband is impotent and he consented to his wife submitting to AID, the marriage can be annulled upon the application of either spouse if neither spouse was aware of the husband's impotence prior to the marriage.(121)

Since an impotent (but not sterile) husband can father a child by AIH,(122) it is further submitted, that his wife can annul the marriage after AIH has been

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(120) V v R supra at 1015.

(121) In South African law impotence or the inability to consummate a marriage is sufficient reason for the marriage to be declared a nullity (cf Hahlo Husband and Wife 4th ed (1975) 500; Smith v Smith 1963 (4) SA 729 (SR); Joshua v Joshua 1961 (1) SA 455 (GW); Van Niekerk v Van Niekerk 1959 (4) SA 658 (GW)), if the impotence is permanent and incurable and if neither party was aware of the husband's impotence at the time of the marriage. In W v W 1959 (4) SA 183 (C) and B v B 1964 (1) SA 717 (T) the court upheld the claim of the impotent spouse to have his marriage annulled.

A spouse forfeits his/her right to have a marriage annulled if he/she ratifies it (Wells v Dean-Willcocks 1924 CPD 89 at 91). The question now arises whether it amounts to approbation if the wife with the knowledge and consent of her husband allows herself to be inseminated with the semen of a donor (AID).

In the English case of Slater v Slater [1953] 1 All ER 246 a wife was granted an annulment on the ground of her husband's failure to consummate the marriage. The spouses had unsuccessfully resorted to AID to conceive a child. The court based its decision summarily on the fact that had the wife known that prior to the use of AID the marriage could have been annulled due to her husband's impotence, such conduct would have amounted to approbation of the marriage.

In Gursky v Gursky 39 Misc 2d 1083 242 NYS 2d 406 (Sup Ct 1963) the wife was allowed an annulment based on the ground that the marriage was not consummated even though she had given birth to a child by AID with her husband's consent.

(122) Schellen Artificial Insemination in the Human (1957) at 37.

utilized, whether a child has subsequently been born or not.(123) The reason, it is submitted, is that consummation is interpreted as being an act of sexual intercourse, and the latter is a right which young, healthy spouses are entitled to expect in a marriage:

> 'Both parties to a marriage are entitled to expect sexual intercourse as one of the fundamental incidents of a marriage.'(124)

AI does not amount to intercourse.(125)

The above submissions are based on the current legal interpretations of such vital terms as adultery, sexual intercourse and consummation. However it must be remembered that our courts when defining the words impotence, annulment and consummation never contemplated that a wife could conceive a child by her husband without having intercourse with him. It is thus submitted that if legislation is contemplated in this regard it should stipulate that where a husband is impotent and he and his wife consent to having a child by AIH, their consent should be deemed to constitute a waiver of their rights to annul the marriage on the ground of non-consummation.(126)

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(123) The court in the English case of Re L v EL [1949] All ER 141 held that a wife who had utilized AIH may subsequently annul the marriage. The facts were that the marriage had never been consummated due to her husband's impotence but a child had been born to her following AIH. The husband defended his wife's petition for annulment on the ground that she had approbated the marriage by her use of AIH. The court held that the wife's conduct in using AIH showed a determination and dominant intention to establish a normal relationship rather than an acquiescence or approbation of an abnormal marriage. Since there was no consummation of the marriage the court ordered the annulment of the marriage.

In Q v Q (reported in 'The Times' 12 May 1960) it was held that the fact that the wife had given birth to a child as the result of AID did not amount to approbation of the marriage by her, since at the time of receiving AID she had no knowledge of the legal remedy open to her in view of the husband's incapacity: a decree of nullity was therefore granted.

(124) W v W 1959 (4) SA 183 (C) at 186.

(125) V v R supra at 1013.

(126) Hahlo Husband and Wife 4th (1975) 502; 'AIH and Nullity' (1961) 5234 British Med J 60; C P Jones 'AID Not Necessarily Approbation of Marriage' (1966) I Lancet 1187.

5. IVF and ET in relation to Divorce and Annulment of a marriage

Because of the nature of IVF viz an oocyte which is removed from the female donor, fertilised in glass outside the human body, and then reimplanted in either the wife or a hostess mother the issue of adultery and what constitutes sexual intercourse does not become an issue in this regard.

It is submitted, however, that certain of the permutations of ovum and sperm (discussed infra) can give rise to an action for divorce by the husband on the ground of irretrievable breakdown if the wife has proceeded without her husband's consent. Having herself impregnated without her husband's consent is naturally a grave breach of marital fidelity, and will, I submit, substantiate an action for divorce.(127)

5.1. Wife's ovum, donors sperm

If a wife has an ovum removed by laparoscopy, fertilised in vitro and then has the resulting blastocyst reimplanted in her uterus without her husband's knowledge or consent she has committed a grave breach of marital fidelity. She has in effect attempted to fraudulently foist a child upon her unsuspecting husband. Her action, when discovered by her husband, could result in bringing about the irretrievable breakdown of the marriage, and it is submitted, her husband would succeed in a divorce action brought on this ground.

5.2. Wife's ovum, donor's sperm, hostess mother

In this situation it will not be possible for the wife to deceive her husband into believing that he is the father of the child. It will, however, it is submitted, be a grave injuria to him when the hostess mother surrenders the child to his wife and she then confronts him with a child which will presumably now be part of the family of which he is the head, and yet for which his consent was not obtained.

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(127) Section 4(2) Act No 23 of 1979:

'Subject to the provisions of subsection (1) and without excluding any facts or circumstances which may be indicative of the irretrievable break-down of a marriage ....'

It is submitted that the wife's conduct could bring about the irretrievable break-down of the marriage and entitle the husband to a divorce.

5.3. Donated ovum, donated sperm, wife carries the child

The position will be basically the same as in 5.1. supra. The fact that the wife proceeds on a course of action, without her husband's consent, which results in the introduction of a child into their family, could result in the irretrievable breakdown of the marriage and a divorce for the injured husband.

5.4. IVFD - wife acts as the donor

In this procedure the oocyte is fertilised in the uterus of the donor by means of artificial insemination. The resulting embryo is then transferred to the recipient within a few days of fertilisation.(128)

If Mrs A should agree to act as a donor for the purposes of this procedure, without obtaining her husband's informed consent it could, it is submitted, result in irretrievable breakdown of the marriage and a divorce for the slighted husband.

5.5. Annulment of the Marriage

A marriage can be annulled if it has not been consummated.(129) Consummation is effected by sexual intercourse with complete penetration.(130) Sexual intercourse is not an issue in IVF and ET, therefore it is submitted that annulment is not an issue in this situation.

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(128) Rosettenstein (22 October 1981) New Law Journal 1095 at 1096.

(129) W v H 1965 (3) SA 740 (O).

(130) H v M 1936 CPD 377; Hunt v Hunt 1940 WLD 55.

CHAPTER 7

THE LEGAL STATUS OF THE AID AND IN VITRO CHILD - LEGITIMATE OR ILLEGITIMATE?

1. Introduction

The legal problems arising from artificial insemination are neither new nor confined to any particular country, they are in fact universal, and reported cases date back a century.(1)

It was thus inevitable that sooner or later the courts of a country with advanced medical techniques like South Africa would likewise be seized of the problem.(2) However, because science has outstripped the law in this regard it has placed the Courts at a serious disadvantage when having to give judgment on matters concerning AID. The reason being that the Courts lack the usual guidance which they receive from legislation, precedent and the principles of our common law. Because our old authorities did not even contemplate AID when framing our definitions of legitimacy and illegitimacy it is well-nigh impossible to extend these well established concepts to deal effectively and equitably with the status problems arising from AID.

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(1) The earliest legal reference to artificial insemination was made by the Tribunal of Bordeaux in 1882 when a French physician brought forth a claim for fees owed to him for performing AIH on one of his patients. In 1905 a case arose in Germany in which a woman had scooped up semen ejaculated by her husband on the bedsheets and inserted it into her vagina. The child born, presumably as a result of this act, was ruled to be legitimate. The first case in North America, Orford v Orford [1921] 49 Ont L R 15, was decided in the Ontario Supreme Court in 1921 while 3 years later in England a somewhat similar set of circumstances was presented in Russell v Russell [1924] AC 687. The first case dealing with artificial insemination in the United States was Hoch v Hoch Cook County Ill Cir Ct (1948). The above cases are discussed by B S Verkauf in (1966) 3 Houston Law Review 277 at 294.

(2) V v R 1979 (3) SA 1006 (TPD).

The education of public opinion to accept AID and to adopt an enlightened approach to the status of the AID child has not been assisted by the attitudes of the major Western religions to the practice of AID. The Commission appointed by the Archbishop of Canterbury[3] concluded that AID contravenes the personal character of procreation, the essential nature of marriage and of the family as well as the best interests of society. The Roman Catholic Church is totally opposed to AID. Their position was stated by Pope Pius XII in 1949 before an international convention of Catholic doctors.[4] He stated that it violated the marriage covenant wherein exclusive, non-transferable, inalienable rights to each other's bodies and generative acts were exchanged by the spouses. The Jewish approach to AID is expressed as follows:

> 'By reducing human generation to stud-farming methods, AID severs the link between the procreation of children and marriage, indispensable to the maintenance of the family as the most basic and sacred unit of human society. It would enable women to satisfy their craving for children without the necessity to have homes and husbands.'[5]

Despite the rejection of AID on ethical and religious grounds by the major western religions, public opinion has largely accepted this form of fertility therapy. This is reflected by the fact that twenty American states[6] have enacted statutes which create a legal presumption of legitimacy for AID children when the mother and her husband have given their written consent to the procedure. Public opinion in South Africa,[7] it would seem, must also be ready to accept

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(3) The Report of a Commission Appointed by His Grace The Archbishop of Canterbury, Artificial Human Insemination (1948) at 11.

(4) (1949) 41 Acta Apostolicae Sedis 559.

(5) I Jakobovits Jewish Medical Ethics : A Comparative and Historical Story of the Jewish Religious Attitude to Medicine and its Practice (1959) 248.

(6) Listed in note 68 of Turner (1981) 58 J of Urban Law 459 at 468.

(7) The issue was debated and certain guidelines established at the first S.A. Medico-Legal Congress held in Johannesburg in 1958 cf Editorial (1959) 6 Journal of Forensic Medicine 1. It is submitted that, despite the objections voiced by the churches the reason that AID has become acceptable to public opinion as it exists today is that basically it does not constitute a radical interference with the family structure as it exists today. IVF & ET are less acceptable because, when they involve a hostess mother giving birth to the child it does constitute a radical departure from the normal family pattern.

AID as our legislature has published a Bill which likewise would legitimate an AID child born to a couple who have consented to such birth.(8) The practice is certainly becoming more popular in South Africa and current estimates are that between 350 and 400 women give birth to AID children in Johannesburg each year and that a total of about 1 500 AID children have already been born in South Africa.(9)

The dilemma facing our courts can perhaps be summarised in the following words:

> 'Something will have to be done in order to fit this medical innovation into our social structure so that justice is done to all and no one will be hurt or made to suffer as the result of its use. The medical profession has developed a technique and now the legal profession must try to adjust it for the welfare of society'.(10)

In order to arrive at a solution for the problem posed supra I propose to examine the common law position regarding the legitimacy of AID children in South Africa, critically analyse the only judgment on the issue in S.A. law and also examine the way the problem has been dealt with in other jurisdictions.

2. Status of the AID Child in South African Law

2.1. The problem created by modern medical science

Because the practice of AID is neither officially sanctioned(11) nor outlawed, it exists in limbo, in the shadowy periphery of the law where existing legal principles must perforce be adapted to the legal consequences of a technique which was not even contemplated by the law when the definition of 'legitimacy' and 'parent' were formulated. To allow this condition of uncertainty

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(8) See Section 39 of Draft Child Bill (28 Oct 1981) 7864 Government Gazette.

(9) Report (8 Nov 1980) SA Mediese Tydskrif 781 at 782.

(10) A D Holloway 'Artificial Insemination : An Examination of the Legal Aspects' (1957) 43 ABAJ 1089 at 1090.

(11) Supra note 8.

and ad hoc adaptation to continue is an undesirable position for the law to be in. It is thus submitted that a number of bold decisions in regard to the law relating to AID generally, and its effect upon legitimacy in particular, need to be taken.(12)

In a nutshell, the legal issue to be decided is whether a child becomes the legitimate issue of a married couple where the husband is not its natural father.

2.2. Definitions vital to determining a child's status

Although the spouses can hide behind the presumption of pater est quem nuptiae demonstrant and thus give their child a de facto legitimacy, they cannot confer de iure legitimacy on him because the presumption is rebuttable.(13) Should the spouses' marriage break up they might end up embroiled in a custody dispute over the child in which its AID origins and hence illegitimate status would be revealed.(14)

If the concept of legitimacy for the AID child is to be accepted, it will in turn affect the meaning of the term 'parent'. It is thus clear that either the courts or the legislature need to take positive action to clarify the legal status of the AID child.

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(12) As for example the decisions in the American cases of People v Sorensen 68 Cal 2d 280, 437 P 2d 495 66 Cal Rpt 7 (1968) and In Re Adoption of Anonymous 74 Misc 2d 99, 345 NYS 2d 430 (Surr C 1973).

(13) Van Lutterveld v Engels 1959 (2) SA 699 (AD) at 702.

(14) V v R 1979 (3) SA 1006 (TPD); Frank P Grad 'Legislative Responses to the New Biology : Limits and Possibilities' (1968) 15 UCLA Law Review 480 at 503-504; S Mason 'Abnormal Conception' (1982) 56 Australian LJ 347 at 351.

2.2.1. Legitimacy

In terms of South African law legitimacy in its narrowest sense is defined as follows:

'Legitimate children are those born from parents united in wedlock'.(15)

2.2.2. Definition of 'parent'

'Parent' is defined in our law as:

'... the father or the mother of a child born of or legitimated by a lawful marriage, or, the mother of an illegitimate child.(16)

It is submitted that the following definition of 'parent' be considered in order to cope with the increasing popularity of AID as a mode of conception:

'A parent is the mother or father of a child born to lawfully married spouses or who is legitimated by a lawful marriage, including a child conceived within wedlock by donated semen and to whose birth both the mother and her husband had consented in writing.'

This definition, it is submitted, would cope with both existing parenthood situations and in addition it would include and legitimate AID children.

2.2.3. Definition of 'father'

'Father' is defined in our law as:

'One who has begotten a child, a male parent, the nearest male ancestor'(17) A husband who has consented to his wife begetting a child by artificial insemination with the semen of a donor.

Furthermore a rebuttable presumption exists that a child is legitimate if his parents were married to each other at the time of his conception or birth, or at any time between these two dates.(18)

If the above principles are applied to a child born by AIH (semen obtained from the mother's husband) it would be legitimate.(19) However, if these same

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(15) Grotius, Introduction to Dutch Jurisprudence 1.12.2 (Maasdorp's translation). See also Voet 1.6.6; V d Keesel 1.6.9; Van Leeuwen 1.7.2.

(16) The Children's Act No 33 of 1960.

(17) The Shorter Oxford English Dictionary.

(18) Boberg The Law of Persons & the Family (1977) 318.

(19) E Spiro 'Artificial Insemination and the Law' (1972) Acta Juridica 213 at 214.

principles, coupled with a narrow interpretation of the word 'parent'[20] are applied to an AID child[21] (semen obtained from a donor other than the mother's husband) then the child is illegitimate,[22] regardless of the fact that the husband had consented to his wife being inseminated with the semen of a donor.[23] On the basis of equity and modern legal trends such a decision is extremely harsh and more flexibility has been displayed in U.S. decisions.[24]

The reason for our law adopting such a narrow interpretation of legitimacy was to protect the husband against having a bastard unwittingly foisted upon him and thus introducing a false strain into his bloodline.[25] This approach is no longer necessary because with the aid of blood tests and the HLA tissue typing tests the paternity of a child can be established with absolute certainty.[26]

The fact of the matter is that our courts have very little room in which to maneouver being tied as they are to legal concepts conceived in an age when AID was undreamt of.

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(20) V v R supra at 1016 (D).

(21) N C Masters 'Artificial Insemination' (1953) 10 SALJ 1953 377 at 379.

(22) V v R supra at 1016(D).

(23) Spiro (1972) Acta Juridica 213 at 214.

(24) People v Sorensen supra at 498; In Re Adoption of Anonymous supra at 433.

(25) F P van den Heever Breach of Promise and Seduction in South African Law (1954) 58.

(26) Van der Harst v Viljoen 1977 (1) SA 795 (C) at

2.3. Legitimation of illegitimate children in SA Law

2.3.1. Legitimatio per subsequens matrimonium

If the natural parents of a child marry each other subsequent to his/her birth, the child is legitimated by this marriage in terms of the doctrine legitimatio per subsequens matrimonium.(27) It should be emphasised that the child will only be legitimated by the marriage of its natural parents to each other. Marriage to a third party will not improve its status.(28)

An AID child may be legitimated in accordance with this principle if its mother subsequently married the donor. If she was married to someone other than the donor at the time of conception she would naturally first have to terminate that union.(29)

2.3.2. Legitimatio per rescriptum principis

Our common law(30) recognised a form of legitimation in terms of which an illegitimate child could be legitimated by an administrative act of the Executive.(31) This form of legitimation has been abrogated by disuse, and by the fact that there is no machinery currently available to practically implement this form of legitimation.(32)

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(27) Voet 1.6.5; 36.1.14; Howes v Howes 1958 (4) SA 41 (C); Ex parte Godden NO 1962 (2) SA 360 (SR).

(28) Boberg The Law of Persons and the Family (1977) 345 note 67 and Estate de Klerk v Rowan 1922 EDL 334 at 337; Park v De Necker 1978 (1) SA 1060 (N); Nokoyo v A A Mutual Insurance Co Ltd 1976 (2) SA 153 (E).

(29) Spiro The Law of Parent & Child 3rd (1971) at 16.

(30) Grotius 1.12.9; Van Leeuwen 1.7.5.6.

(31) Spiro The Law of Parent and Child 3rd (1971) 17.

(32) H R Hahlo (1959) 76 SALJ 237ff and (1960) 77 SALJ 106-7 contra D Pont (1958) Acta Juridica 112-34 and (1959) 76 SALJ 448; Potgieter v Bellingan 1940 EDL 264 at 267.

2.3.3. Legitimation by Parliament

It is within the power of Parliament to pass legislation legitimating a child. It has however to date not exercised this prerogative and it is submitted it is unlikely ever to do so.(33)

2.3.4. Children of putative marriages

A putative marriage is the exception to the rule that a marriage which is void results in none of the consequences of a valid marriage. A putative marriage can be defined as one in which the parties, at least one of whom was in good faith and reasonably believed that there was no impediment to the marriage, went through a ceremony of marriage in which all the prescribed formalities were observed and which purported to solemnize the union.(34)

Although our courts are not empowered to validate invalid marriages they do attach to a putative marriage certain of the consequences of a valid marriage. According to this principle and the fact that as upper guardian of all minors they always act in 'the best interests' of that minor they invariably declare the child of such a marriage to be legitimate.(35)

The marriage of the applicant and the respondent in V v R was a valid marriage (it was dissolved by a decree of divorce) and could in no way be construed as a putative marriage,(36) but Steyn J, obiter, proceeded to apply the analogy of the putative marriage to the case. He first postulated the applicant's husband as the 'putative father' of the AID child and then argued that

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(33) Spiro ibid. See also P J Conradie (1947) 64 SALJ 385.

(34) Hahlo The SA Law of Husband and Wife 4th (1975) 494; Boberg The Law of Persons and the Family (1977) 319; Vather v Seedat 1974 (2) SA 389 (N); M v M 1962 (2) SA 114 (GW).

(35) Spiro Law of Parent & Child 3rd (1971) at 60-63; Hahlo The S A Law of Husband & Wife 4th (1975) 494-5; Boberg The Law of Persons and the Family (1977) 318-9; Prinsloo v Prinsloo 1958 (3) SA 759 (T); Vather v Seedat supra at 389.

(36) Supra at 1008(B).

if the children of a bigamous or incestuous marriage, which is deemed to be putative, can enjoy the advantages of legitimacy in regard to maintenance and succession vis-á-vis its natural father then surely the AID child should not be held to have inferior rights(37) where it is born to a 'putative father' (who consented to his conception) and a natural mother(38) who are lawfully married to one another.

Relying on his creation of a new category of parent viz the 'putative father'(39) Steyn J used this as a device to justify holding the applicant's husband or the 'putative father', and no one else, liable for the maintenance of the AID child. Steyn J again in an obiter dicta at 101, prompted no doubt by feelings of justice and equity, referring to an AID child, said:

> '... die korrekte maatskaplike en wetlike beoordeling behoort te wees dat so 'n kind nie as buite egtelik gebore aangesien behoort te word nie ....'

Having been denied the means to legitimate an AID child by the provisions of our common law, Steyn J cast around to find a legal device which would justify his inherent sense of equity and enable him to pronounce the child legitimate. To this end he attempted to equate the AID child with a child born of a putative marriage. He suggested that since a child born of an invalid putative marriage is regarded as legitimate, an AID child should equally be so regarded.

It is however submitted, with the utmost respect, that Steyn J's analogy is most inappropriate. Where a marriage is putative the parties to the union are, in normal circumstances, both biological parents of the child. The child in turn

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(37) Namely that it should be declared illegitimate (which was the decision in V v R) and suffer all the consequent disadvantages of illegitimacy.

(38) Steyn J held further at 1015 (B) that AID did not constitute adultery.

(39) This term is also used by C T Dienes 'Perspectives on Legal and Social Change' in (1968) 54 Iowa Law Review at 283. Steyn J justifies his creation of this new class of parent by stating at 1016 (E) that:

> 'Daar is na my oordeel geen gesag in ons reg wat verhinder dat die instemmende eggenoot van 'n vrou wat 'n kind in die wêreld bring deur middel van kunsmatige inseminasie van 'n skenker, geplaas word in 'n spesiale verhouding tot die aldus gebore kind nie.'

derives his legitimate status from a concession to it by the law, providing its parents were unaware of the invalidity of their marriage at the time of conception. On the other hand in the AID situation in V v R the parties were validly married but only the wife was a biological parent.

Legitimacy in our law as it now stands depends on the relationship of the biological parents to each other (ie married or unmarried or 'putatively married') at the time of conception or birth or any time between these dates, not on the acceptance of the child by a person other than its biological father.(40)

Having stated his opinion, obiter, on what the law regarding the legitimacy of AID children ought to be Steyn J had to give a judgment based on the present realities of the law. Faced with a dearth of precedent, no legislative guidelines and a common law which clearly did not contemplate the existence of artificial insemination, he opted for a cautious approach(41) and held, albeit reluctantly,(42) that in regard to the application before him the AID child was illegitimate for purposes of section 71 of the Children's Act.(43)

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(40) June Sinclair Annual Survey of South African Law (1979) at 65.

(41) '... dit [sou] buitensporig wees dat 'n enkele regter van hierdie Provinsiale Afdeling 'n beslissing vel in stryd met die geboekstaafde gemeenregtelike siening van die ou skrywers en teenswoordige regsgeleerdes oor die onderwerp' at 1016(C). Referring to the modern authorities cited by Steyn J, I submit little weight should be attached to the bald unmotivated statements of Gordon, Turner & Price, Medical Jurisprudence 3rd 1953 at 67, while Hahlo's opinion that AID children are illegitimate in our law was voiced in (1957) SALJ at 174, and was based essentially on a negation of the finding of the court in Strnad v Strnad 78 NYS 2d 390 (Sup Ct 1948). He did thus not have the benefit of the arguments advanced in People v Sorensen supra and In re Adoption of Anonymous supra. In the (1968) SALJ at 85 and 319 (neither article is referred to by Steyn J) Hahlo does outline the decision in the Sorensen case without, however, applying its consequences to South African law.

Masters, writing in the (1953) SALJ at 379 was of the same opinion as Hahlo supra. He substantiates his statement that the AID child is illegitimate by referring to a 1945 article in the New York Law Journal. It is submitted that his views are also dated and not abreast of the latest developments, and thus little persuasive value should be attached to them.

(42) 'In die lig van die ou en tydegenootlike skrywers bevind ek my met leedwese verplig om die bede toe te staan' per Steyn J at 1016(G).

(43) Act No 33 of 1960.

2.3.5. Adoption

When a child is formally adopted according to the requirements set out in Section 74 of the Children's Act,(44) the status of legitimacy is conferred upon the child. The law deems the child to be the legitimate child of the adoptive parent or parents.(45)

The position of the AID child in regard to adoption is thus as follows: if the spouses formally adopt an AID child which is born to the wife the child becomes for all legal purposes their legitimate child.(46)

In Strnad v Strnad(47) the parties sought custody of an AID chiid born with the consent of the husband. The court stated inter alia, that the child should be considered as potentially or semi-adopted by the husband and that he was consequently entitled to the rights of a foster parent who had formally adopted and acquired the rights of a natural parent. This reasoning is faulty and has been criticised(48). It is submitted that it is not possible to apply this analogy in South African law for the same reason, viz, that adoption is a statutory procedure which must be complied with according to the provisions of the statute.(49) The fact that the husband has consented to AID and has thus agreed to accept the child into the family, which is the basis of adoption proceedings, is not however sufficient to comply with the provisions of section 71 of the Children's Act.

Furthermore, the publicity involved in formal adoption proceedings is the very antithesis of the secrecy which has been carefully nurtured by the spouses

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(44) Act No 33 of 1960.

(45) See section 74 of Act 33 of 1960; Boberg The Law of Persons & the Family (1977) 363; Spiro The Law of Parent & Child 3rd (1971) at 62.

(46) Masters (1953) 10 SALJ 377 at 379. Carmen Nathan 'A Father and his Illegitimate Child : Towards a Permanent Relationship' (1980) 43 THRHR 292 at 297.

(47) 190 Misc 786 78 NYS 2d 390 (Sup Ct 1948).

(48) D A Sergeant 'Legal Status of AI : A need for policy' (1970) 19 Drake Law Review at 426.

(49) Section 71(2)(d) Act No 33 of 1960.

who embark upon AID and would advertise the fact of the husband's sterility to the community in which the couple live, a fact about which he is probably sensitive, and wishes to conceal. Formal adoption would also constitute an admission of prior illegitimacy of the AID child which might inhibit the social acceptance of the practice.(50)

2.3.6. The presumption of legitimacy

There is a presumption which exists in our law that a child born to or conceived by a married woman is presumed to be legitimate ie the law presumes that the woman's husband is the father of the child.(51) The maxim expressing this presumption is expressed as follows, pater est quem nuptiae demonstrant.(52) The operation of the maxim thus presupposes a valid marriage(53) and may be rebutted on a balance of probabilities,(54) by the corroborated evidence of the plaintiff, blood tests,(55) or by the HLA system of tissue typing.(56)

According to these principles if a husband fails to rebut the presumption, an AID child born to his wife will be presumed to be legitimate and he will be presumed to be its natural and legal father.(57) This rule is founded upon decency, morality, public policy, sacredness and the desire to preserve the harmony of the family relationship.(58) This presumption is well entrenched in our law, and serves the purpose of protecting an innocent child from the stigma associated with bastardy.(59)

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(50) Dienes (1968) 54 Iowa LR at 282.

(51) Grotius 1.12.3; Voet 1.6.6; Atkin v Estate Bowmer 1913 CPD 505 at 509.

(52) viz the father is he to whom the marriage points.

(53) Spiro Law of Parent and Child 3rd (1971) at 15. Children born of putative marriages will be dealt with infra.

(54) Van Lutterveld v Engels supra at 703.

(55) Ranjith v Sheela & Another NO 1965 (3) SA 103 (D).

(56) Van der Harst v Viljoen 1977 (1) SA 795 (C).

(57) Park v De Necker 1978 (1) SA 1060 (N) at 1061-2. The court held that the presumption pater est quem nuptiae demonstrant was not negated by the fact that a maintenance court had found that the husband of the child's mother was not the natural father of her child; in other words, the child retained its status of legitimacy until the presumption was specifically rebutted.

(58) E Spiro 'Legitimate and Illegitimate Children' (1964) Acta Juridica 53 at 56.

(59) ibid; see also Sergeant (1970) 19 Drake LR at 424.

2.3.6.1. To whom is the presumption applicable

The presumption relates to the husband because the wife carries the child and there is thus no doubt as to her identity. Consequently the scope of this presumption does not extend to children born during the existence of the husband's marriage if these children were conceived with a woman other than his wife.(60)

The presumption is naturally not applicable if the marriage is void, for, it is submitted, such a 'marriage' is not capable of 'pointing to a father'.(61)

The presumption is however applicable if the circumstances are indicative of conception before the marriage.(62)

The presumption is also applicable on the termination of the marriage if the wife was pregnant at the time.(63)

2.3.6.2. The presumption is rebuttable

The pater est quem nuptiae demonstrant presumption may not always have been rebuttable(64) but there is adequate authority to prove that in modern law(65) it is rebuttable. The AD has held(66) that in civil cases the presumption can be rebutted on a balance of probabilities. The effect of a rebuttable presumption

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(60) Spiro (1964) Acta Juridica 53 at 56.

(61) Ibid.

(62) J D van der Vyver & D J Joubert Persone - en Familiereg (1980) at 181.

(63) D 36.2.18; 50.16.141; 50.17.187; Voet 36.1.15.

(64) Schorer Ad Grotium note 47(1).

(65) According to Article 197 of the Dutch Civil Code a child born in wedlock has the husband of the mother as his father. A child born before the 307th day after the dissolution of a marriage is presumed to be the child of the former husband. The presumption contained in Act 197 is rebuttable if the husband or former husband institutes a disclaimer petition. Art 198 allows the mother and child to petition but only under narrowly restricted circumstances.

(66) Van Lutterveld v Engels 1959 (2) SA 699 (A) at 702.

is that the presumed state of affairs is regarded as existing nisi contrarium evidenter constiterit ie the presumed facts are accepted as being proved unless and until there is a rebuttal.(67)

2.3.6.3. Who may rebut the presumption?

In the case of Van Lutterveld v Engels(68) the Appellate Division laid down the rule that the pater est quem nuptiae demonstrant presumption could be rebutted by the wife and her husband on the balance of probabilities in the particular circumstances of the case.

In an AID situation in addition to the mother and her husband, the doctor and, in certain circumstances, the donor, is an additional party who can testify to rebut the presumption.

The presumption of legitimacy can only be rebutted by clear evidence that the husband could not have been the father. In order to effect this rebuttal the wife or her husband or both of them may, since 1935,(69) in either civil or criminal proceedings, give evidence that they had not had sexual intercourse with one another during the period when the child was conceived. In addition to such evidence the husband and/or wife would have to lead evidence to prove that the child had been born as a result of AID.

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(67) Spiro (1964) Acta Juridica at 57.

(68) 1959 (2) SA 699 (AD) at 703.

(69) Section 344(1) Act 51 of 1977 and Section 3 of the Civil Proceedings Evidence Act 25 of 1965. In Surmon v Surmon 1926 AD 47 at 54 Kotze JA followed with great reluctance the rule of English law expressed in Russell v Russell [1924] AC 687 viz that 'neither a husband nor a wife is permitted to give evidence of non-access to bastardize a child born in wedlock.' However in 1935 our legislature provided that the husband and wife could furnish proof of the fact that they did not have intercourse at the time of the child's conception cf section 101(3) of the General Law Amendment Act No 46 of 1935.

This section was repealed by section 344(1) of Act 51 of 1977 and Section 3 of the Civil Proceedings Evidence Act 25 of 1965 now reads as follows:

> 'For the purposes of rebutting the presumption that a child to which a married woman has given birth is the offspring of her husband, she, or her husband, or both ot them, may give evidence that they had no sexual intercourse with each other during the period when the child was conceived.'

(continued on the next page)

Evidence of the husband's sterility would under normal circumstances be sufficient to rebut the presumption, but medical evidence might be tabled to proved that the sterility was not absolute or certain (eg where he merely has a low sperm count).(70)

The onus of rebuttal can be further complicated in AID situations if the physician who performed the AID mixes the husband's semen with that of the donor, in order to give the couple at least some slight hope that the child is really the husband's. Another factor complicating rebuttal will occur if the physician chooses a donor whose blood group is the same as that of the husband. This will prevent the child being bastardised by a blood test.(71) The fact that no public records of AID procedures are maintained, mainly to protect the donor, will further complicate the rebuttal of the presumption. Recent advances in the field of haematology now enable scientists to prove with a very high degree of accuracy whether a child is the child of a particular person. In the case of Van der Harst v Viljoen(72) a paternity suit was resolved by utilising the HLA system of tissue typing. Medical evidence was led which proved that the chances of another individual taken at random from the white South African male population having a similar HLA Haplotype A29/B7 which the defendant and the child had in common was 7 in 10 000. The putative father (defendant) in this case was thus 210 times more likely to be the true father than someone else taken at random. Applying the Essen-Möller formula the degree of probability was 99,85 per cent.

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(69) (continued from the previous page)
See also Mayer v Williams 1981 (3) SA 348 (A) in which it was held that corroboration of the plaintiff's evidence (ie the woman alleging that intercourse had taken place) is no longer necessary.

(70) Glanville Williams The Sanctity of Life (1958) at 116.

(71) Glanville Williams The Sanctity of Life (1958) at 116; Mary Hayes 'The Use of Blood Tests in the Pursuit of Truth' (1971) 87 Law Quarterly Review 86.

(72) 1977 (1) SA 795 (C) at 796(E-G). The HLA system is a sophisticated system based on matching the A type and B type antigens which exist in haplotypic combination in the white blood cells. HLA or antigen typing has become so accurate that one expert has claimed, 'no matter whether the egg is fertilised outside the womb or implanted in another woman, not matter whose sperm is used, we can determine exactly who the genetic parents are' Dr Terasaki quoted in Parker (1982) 12 Family Law 103 at 106; Carr (1973) 26 Alabama LR 142-145.

2.3.6.4. Duration and Effect of the presumption

(a) Duration

In South African law the duration of the pater est quem nuptiae demonstrant presumption is in no way restricted by a time limit.(73) In other words the presumption operates for as long or until it is rebutted with the result that if the child was not in fact legitimate, it was deemed to be legitimate until such time as it was proved otherwise.(74)

Unless they have been properly counselled on the legal aspects of AID, it is quite possible that some AID children will be declared illegitimate because the majority of parents would probably never realise that their child might be declared illegitimate until litigation was engendered, whether by marital strife, contestation of the deceased husband's will, or competition for an intestate share of the husband's estate.(75)

(b) Effect

Where the legitimacy of an AID child is contested and the presumption is rebutted, the result is that the child is illegitimate,(76) because there is no biological link between the child and the mother's husband. Consequently the husband has no rights in respect of the child(77) unless the court is prepared to make new law by saying that there has been a quasi-adoption or semi-adop-

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(73) Such a time limit has however been recently introduced in the Louisiana Civil Code art 209, as amended by 1980 La Acts No 549 para 1; K S Spaht 'Rehabilitative Alimony' (1981) 41 Louisiana Law Review 372 at 385:

'5. A civil proceedings to establish filiation must be brought within 6 months after the death of the alleged parent, or within nineteen years of the illegitimate child's birth, whichever occurs first. If an illegitimate child is born posthumously a civil proceeding to establish filiation must be instituted within six months of its birth ....'.

(74) Spiro (1964) Acta Juridica at 58; V d Vyver & Joubert Persone & Familiereg (1980) at 182; Mayer v Williams supra at 351 (H).

(75) Carr (1973) 26 Alabama LR at 145.

(76) V v R 1979 (3) SA 1006 (T).

(77) In an AID case such as V v R supra the parties are validly married but only the wife is a biological parent.

tion,[78] or unless legitimacy is conferred on the AID child by legislation.[79] In the case of Strnad v Strnad[80] the issue was the husband's visitation rights to his AID child. The New York Supreme Court in fact held that the husband's consent and acceptance of the child had resulted in the child being potentially or semi-adopted by the husband. This would in turn entitle him to the rights of a foster parent who formally adopts and acquires the rights of a natural parent. This decision can only be described as judicial legislation since adoption in common law countries is regulated by statute.[81]

It is submitted that a possible basis for the decision, had it been made by a South African court, would have been for the court to invoke its power as upper guardian of minors[82] and then, by acting according to the well-established norm of the child's best interests,[83] have granted access to a person who was not its biological father if this was justifiable in terms of the above norm.

Bearing in mind the large number of current AID births, the number of court cases, worldwide, challenging the legitimacy of such children is low. It is submitted that this is probably due to the fact that an AID child is usually registered in the normal way at birth as a legitimate child although such an action is fraudulent in most jurisdictions.[84] The fact of the child's AID origin is not usually divulged and consequently no one is any the wiser about the child's true biological origins. In addition, the common law presumption that the child

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(78) Glanville Williams The Sanctity of Life (1958) at 116.

(79) This is the position in twenty American states, listed in note 68 in Turner (1981) 58 J of Urban Law at 468 and this is the proposed solution for the problem in South African law see section 39 of the Draft Child Care Bill (28 Oct 1981) 7864 Government Gazette.

(80) 190 Misc 786, 78 NYS 2d 390 (Sup Ct 1948).

(81) Glanville Williams op cit 116.

(82) Grotius 1.7.10; Voet 26.5.5; Calitz v Caltiz 1939 AD 50 at 63; Wehmeyer v Nel 1976 (4) SA 966 (W).

(83) Fletcher v Fletcher 1948 (1) SA 130 (AD); Van Oudenhove v Gruber 1981 (4) SA 857 (AD).

(84) See section 46 of the Births, Marriages & Deaths Registration Act No 81 of 1963.

of a married woman born during the marriage, is legitimate unless it is established that the husband was impotent or that it was impossible for the couple to have coitus at the material time operates to prevent any question of the child's legitimacy from arising where husband and wife are co-habiting and continuing to engage in coitus.(85)

It is further submitted that our law should work towards ridding itself of the concept of illegitimacy as a violation of the status and dignity of a child so that if AID is an acceptable solution for some sterile couples the child's status as a lawful child of the family would be accepted, recognised and secured in law.(86)

Finally, it is worth noting the opinion of Lord Kilbrandon, a judge of the House of Lords, on consensual AID. He states that

> 'the child is legitimate in that it was borne by the wife, in fulfilment of the wishes of the husband, and in that sense, to call it illegitimate is a misuse of language.'(87)

3. Arguments against legitimating AID children

3.1. Presumption does not alter the fact of illegitimacy

Protagonists of AID have stated that official recognition of the legitimacy of the AID child would merely amount to 'regularising' what is currently happening in practice anyway because the parents of AID children, sheltering behind the pater est quem nuptiae demonstrant maxim, register the child as being legitimate in the knowledge that it is most unlikely that the presumption of legitimacy will ever be challenged.(88)

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(85) P Creighton Artificial Insemination by Donor (1977) 48; R Snowden & D Mitchell 'Anonymous AID for the Childless Couple' (13 March 1980) New Scientist at 828.

(86) Creighton op cit 48; The Law Commission Working Paper No 74, Family Law : Illegitimacy (1979); J M Eekelaar 'Reforming the English Law Concerning Illegitimate Persons (1980-81) 14 Family Law Quarterly 41 at 48-50.

(87) (1973) 17 CIBA Symposium at 92.

(88) G P R Tallin 'Artificial Insemination' (1956) 34 Canadian Bar Review 166 at 167-169.

However, regardless of the presumption operating in its favour, the child's legal status in fact, remains the same (ie illegitimate) whether or not it was ever officially established.(89) If on other grounds it would be wrong for him to have the status of a legitimate child, the fact that in practice it is difficult to prevent him enjoying the advantages of apparent legitimacy is not a sufficient reason for converting appearance into reality.(90)

3.2. Protection afforded to child by legitimacy exaggerated

It is conceded that even in this day and age there is still a serious social stigma attached to the condition of illegitimacy,(91) which handicap the AID child would be relieved of if he were declared to be legitimate. This would not however alter the fact that he was not the son of his supposed father and that conception was due to the insemination of his mother with the seed of another man. It has been submitted that this could be a danger to the child's security, a fact against which his so-called legitimacy will not protect him since it would still be possible for him to find out that he was not biologically the child of his supposed father.(92)

3.3. New class of legitimate children

Declaring an AID child to be legitimate would involve the South African Courts in a novel venture which would result in the creation of a unique class of legitimate children not related in blood to the mother's husband and whose legitimacy had not come about as a result of one of the accepted legal means.(93) It has also been submitted that a community which is prepared to tolerate AID has a duty to protect the interests of the resultant children.(94)

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(89) Bartha Maria Knoppers 'The Legitimization of Artificial Insemination : Promise or Problem' (1978) 1 Family Law Review 108 at 110.

(90) Tallin (1956) 34 Canadian Bar Review at 171.

(91) E Spiro 'Children of Unmarried or Cohabiting Parents of Successive Marriages' (1979) 42 THRHR 403 at 405.

(92) Lucinda Ann Smith 'Artificial Insemination : Disclosure Issues' (1980) 11 Columbia Human Rights Review 87 at 92.

(93) For example by the subsequent marriage of the parents or adoption. For more detail see pages 221-226 supra.

(94) Jeffrey M Shaman 'Legal Aspects of Artificial Insemination' (1979/80) 18 Journal of Family Law 331 at 350-351.

However this argument is refuted on the ground that the community tolerates AID to the extent that it does not outlaw the act by which such a child is conceived; but that its tolerance does not extend to the logical conclusion, viz, the removal of all distinctions between legitimate and illegitimate children.(95)

3.4. Official encouragement of AID

It was also submitted that legitimacy status for the AID child would constitute a degree of official encouragement of AID which, in the light of the dangers to which AID children would be exposed after birth, should not be allowed.(96)

3.5. AID could constitute an encroachment on the rights of other members of the husband's family if the AID child is pronounced legitimate.(97) If the child enjoys the status of legitimacy it will rank as an intestate heir thereby reducing or excluding the claims of other family members.(98) In the field of testate succession it was also submitted that it would be inequitable for an AID child to succeed to property under a disposition made before his birth.(99)

On the other hand it must be pointed out that a husband can encroach on the inheritance rights of his natural children by adopting(100) a child or he can exercise his freedom of testation to disinherit them entirely by not naming them as beneficiaries in his will.(101)

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(95) Feversham Report at 51.

(96) Ibid at 50-51.

(97) Shaman (1979/80) 18 J of Family Law 331 at 339.

(98) Turner (1981) 58 J of Urban Law 459 at 468.

(99) Feversham Report 50. For a detailed discussion see chapter 10.

(100) See section 72(2) & (3) of the Children's Act 33 of 1960; C P Joubert 'Enige Wanopvattinge insake Adopsie en Erfopvolgingwet No 13 van 1934' (1957) 74 SALJ 331, 431; E Spiro 'Effect of Adoption in South Africa' (1961) 71 SALJ 318.

(101) Corbett, Hahlo, Hofmeyr & Kahn The Law of Succession in South Africa (1980) 33-34.

4. Public Policy and AID

South African law retains the distinction between legitimate and illegitimate children but the fact of illegitimacy can be obscured by the pater est quem nuptiae demonstrant maxim as well as by fraudulent registration of the birth.(102)

One of the most important consequences of the status of illegitimacy appertains to property rights, viz, an illegitimate child has no rights to succeed intestate to his father,(103) which in turn relates back to the concept of 'family ownership' in Roman law.(104) It is submitted that this fact, viz, property rights, has been one of the major factors sustaining the retention of illegitimacy in S A law.(105) In a country like England which has hereditary succession to titles and dignities through blood descent this is an important element of family life and requires true unblemished descent in blood from the grantee. In England the peerage titles of honour and Monarchy itself depends on descent through blood.(106)

The extent to which public policy in the USA had swung around to support consensual AID was reflected in the decisions of Sorenson(107) and In re Adoption of Anonymous(108) which commented favourably on AID. These cases

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(102) S A Strauss Doctor, Patient and the Law (1980) at 151. See also chapter 8.

(103) M M Corbett, H R Hahlo, G Hofmeyr and E Kahn The Law of Succession in South Africa (1980) at 586; E L Biskind 'Legitimacy of Children Born by Artificial Insemination' (1965) 5 Journal of Family Law 39 at 50.

(104) Inst 3.1.1-10; R Sohm, The Institutes at 50 remarks:

> 'In the oldest times the family is the sole owner; individual ownership is unknown and common ownership is the only recognised form of ownership .... The after effects which the original conception of family ownership produced on private ownership are clearly visible in the rights assigned to the family in the law of inheritance. The death of the individual does not remove the true owner of the property, because the family continues to exist. The individual holder of the property dies, but his family and, through it, his property survive him.'

(105) E Spiro 'Legitimate & Illegitimate Children' (1964) Acta Juridica 53 at 67.

(106) Feversham Report 49.

(107) 68 Cal 2d 280, 437 P 2d 495, 66 Cal Rptr 7 (1968). See also R E Lee, North Carolina Family Law 3rd ed (1976) at 141.

(108) 74 Misc 2d 99, 345 NYS 2d 430 (Surr Ct 1973). See also W Birk 'Artificial Insemination - Upon Whom Shall the Duty to Support Rest?' (1963) De Paul Law Review 575 at 579.

articulated the fact that the law favours legitimation to protect the integrity of the family unit, and that no useful purpose was served by stigmatizing an innocent AID child as illegitimate.

In the South African case of V v R[109] the court took cognisance of the fact that public policy had accepted the fact that the offspring of bigamous, incestuous and adulterous relationships can be legitimated. There is far less reason, in the light of the non-adulterous circumstances surrounding the child's conception and birth, to categorize the AID child as illegitimate. The court in an obiter dictum[110] expressed itself in the following terms:

> 'Waar 'n kind gebore is tydens 'n wettige huwelik uit 'n gewaande vader waar die moeder geen owerspelige handeling begaan het nie meen ek dat die korrekte maatskaplike en wetlike beoordeling behoort te wees dat so 'n kind nie as buite-egtelik gebore aangesien behoort te word nie en dat so 'n kind vir doeleindes van die toepassing van art 71(2)(d)(i) van die Kinderwet 33 van 1960 nie buite-egtelik behoort te wees nie.'

It was thus not public opinion or conscience which persuaded Steyn J to find that the consensual AID child was illegitimate but rather his helplessness in the face of well-established Roman-Dutch principles regarding legitimacy and illegitimacy and the total lack of precedent in South African law as this was the first South African court which was called upon to face certain of the consequences of AID.

It is submitted with respect that, on the basis of the law as it then stood, Steyn's decision in V v R was correct. However, on the basis of equity and sound policy it is submitted that no valid purpose is served by a law which compels a man, whose clear intent in sanctioning the AID procedure was to give birth to a 'legitimate' child, for whom he would undertake the paternal rôle of administering love, support and guidance to go still further and to expend time and money adopting the child he considers to be his own.[111] AI is a scientific

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(109) 1979 (3) SA 1006 at 1015 (T); J D v d Vyver V v R 1979 (3) SA 1006 (T)' (1980) 43 THRHR 89 at 95.

(110) V v R supra at 1015.

(111) C D Davies (1974) 23 Buffalo LR 548 at 557.

process to aid mankind and should be viewed as such rather than in terms of the emotional arguments of its detractors who see it as a technique which is amoral and bent on undermining the stability of the traditional Christian family.(112)

It is submitted that if one examines the procedure of AID in a cold objective light, it is as impersonal as a transfusion from a blood bank while the relationship between the recipient and the donor is on the same level of detachment.(113)

If one accepts the fact that Man's noblest achievement and strongest driving force is to propagate his species, it would be contrary to logic and the attainment of the above goals to deny him access to the beneficial scientific aids which will enable him to do so.(114) If upon serious consideration AI meets the ethical and moral standards of the sterile couple, it is difficult to grasp why society should object, because the technique of AID cannot reasonably be thought of as a threat to monogomy or as an inducement to promiscuity. It serves the same purpose as adoption which is universally approved.(115)

5. The Status of the AID child in certain foreign jurisdictions

5.1. United States

Volumes can, and have been written, on the status of the AID child in the United States but I will confine my comments to the two most recent cases on the status of AID children and also examine the general trend in the US Supreme Court on the legitimacy issue.

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(112) J C Foster 'Artificial Insemination : Confusion Compounded' (1956) 3 Wayne Law Review at 43; Dienes (1968) 54 Iowa LR at 283.

(113) Dienes (1968) 54 Iowa LR at 283.

(114) Carr (1973) 26 Alabama Law Review 120 at 140.

(115) M Mayo (1976) 50 Australian LJ 562 at 567; C M v C C 377 A 2d 821 at 824; V d Vyver (1980) 43 THRHR 89.

5.1.1. People v Sorensen

In this case, a husband who had been married for fifteen years during which he had failed to father a child and was subsequently medically certified as being sterile, consented in writing to the insemination of his wife with the semen of a third party donor. A male child was conceived and born. For four years there was a normal family relationship with the husband treating the child as his own son. The couple then separated and were later divorced. Mrs Sorensen retained custody and agreed to support the child.

Two years after the divorce Mrs Sorensen became ill and disabled and was forced to apply for public assistance under the Aid to Needy Children Program to support the child. Following the prescribed procedure the local district attorney demanded that Mr Sorensen pay for the child's support. When he failed to respond he was prosecuted and convicted in the municipal court for nonsupport in terms of section 270 of the California Penal Code.(116) Mr Sorensen successfully appealed against his conviction to the First District Court of Appeal,(117) but this decision was in turn reversed and his conviction upheld by the California Supreme Court.(118)

In handing down the judgment of the Supreme Court, Justice McComb extended the interpretation of 'father' in section 270 so as to characterize Mr Sorensen as the 'lawful father' of the AID child. This would in turn bring him within the ambit of section 270 and render him guilty of non-support.

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(116) The pertinent portion of section 270 provides:

> 'A father of either a legitimate or illegitimate minor child who wilfully omits without lawful excuse to furnish necessary clothing, food, shelter or medical attendance or other remedial care for his child is guilty of a misdemeanor ....'.

(117) 254 Adv Cal App 869 62 Cal Rptr (1967) 462.

(118) 66 Cal Rptr 7 437 P 2d 495 (1968).

In justifying his decision Justice McComb said that the scope of section 270 was not limited to the biological father, but that the 'lawful father' was the determinative factor. The court declared that a child conceived by AID does not have a 'natural father' according to the normal meaning of that term, since the anonymous donor of the sperm cannot be considered to be the natural father as he was no more responsible for the use made of his sperm than was the donor of blood or a kidney.(119) The court then opined that due to the lack of a natural father, the search could only be for a lawful father.

Justice McComb conceded that the statute was not enacted with AID in mind, but he concluded the intent of the legislature was to hold every lawful parent liable for the support of every child, legitimate or illegitimate. He argued:

> '... one who consents to the production of a child cannot create a temporary relation to be assumed and disclaimed at will, but the arrangement must be of such character as to impose an obligation of supporting those for whose existence he is directly responsible ... it is safe to assume that without defendant's active participation and consent the child would not have been procreated'.(120)

Acknowledging that paternity was an essential element of the crime under section 270 the court construed the word 'father' as follows:

> '... to include a husband who, unable to accomplish his objective of creating a child by using his own semen, purchases semen from a donor and uses it to inseminate his wife to achieve his purpose ....'(121)

He then concluded that Mr Sorensen's paternity had been established beyond reasonable doubt.

Paternity having been settled to his satisfaction Justice McComb ventured certain statements, albeit obiter, on the legitimacy of the AID child:

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(119) Sorensen supra at 498.

(120) Sorensen supra at 499.

(121) Sorensen supra at 499-500.

'... [the] public policy of this state favours legitimation, and no valid public purpose is served by stigmatizing an artificially conceived child as illegitimate',(122)

and also stated that the court was not

'... persuaded that the concept of legitimacy demands that the child be the actual offspring of the husband of the mother and if semen of some other male is utilised the resulting child is illegitimate'.(123)

In essence the court's finding that a consensual AID child was legitimate was based on the fact that legitimacy was a legal status which might exist despite the fact that the husband was not the natural father of the child.

In response to the Sorensen decision the California legislature amended its Penal Code in 1970 by adding the following:

'The husband of a woman who bears a child as a result of artificial insemination shall be considered the father of the child for the purposes of this section, if he consented in writing to the artificial insemination.'(124)

Its effects were also felt on the Civil Code to which the following was added in 1974:

'A child born to a woman as a result of conception through artificial insemination to which her husband has consented in writing is legitimate if the birth occurs during the marriage or within 300 days after the marriage has been dissolved.'(125)

5.1.2. In re Adoption of Anonymous(126)

The above case is the most recent and far reaching case involving AID litigation in the USA. It is also the first American case squarely to confront the issue of the legitimacy of the consensual AID child. Previously cited decisions only dealt with the issue to the extent that it was necessary in order to decide maintenance or visitation rights.(127)

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(122) Sorensen supra at 501.

(123) Sorensen supra at 501.

(124) California Penal Code para 270, West 1970.

(125) California Civil Code para 216, West Supp 1974.

(126) 74 Misc 2d 99 345 NYS 2d 430 (Sur 67 1973).

(127) Davies (1974) 23 Buffalo LR 548.

The facts of the case, which are exactly in point with the recent V v R case decided in the Transvaal Provincial Division, were that in the course of A & B's marriage an AID child was conceived and born to the wife with the full knowledge and consent of her husband (B), who was also listed on the birth certificate as being the child's father. A & B subsequently separated and were divorced. In both the separation agreement and the divorce decree the child was listed as the daughter of A & B. The husband complied with all provisions of the divorce decree and retained visitation rights. His former wife later re-married and she and her new husband (C) sought to adopt the 14 year old child of his wife's marriage.

According to the New York Domestic Relations Law,(128) if a child is designated as being born 'in wedlock', both 'parents' must consent to the adoption. B (the former husband) refused to give his consent to the adoption(129)

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(128) Paragraph 111 of which reads as follows:

'Subject to the limitations hereinafter set forth consent to adoption shall be required as follows:

...

2. Of the parents or surviving parent, whether adult or infant, of a child born in wedlock.

3. Of the mother, whether adult or infant, of a child born out of wedlock ....'

(129) It is interesting to note that the rights of the father of an illegitimate child were significantly enhanced by the decision in the case of Caban v Mohammed 99 S Ct 1760 (1979) in which the United States Supreme Court upheld the the right of the father of an illegitimate child to block the adoption of his illegitimate child by withholding his consent.

In terms of section 111 of the New York Domestic Relations Law, the mother of an illegitimate child, but not the father, may block the adoption of their child simply by withholding consent. Similarly, the father of a legitimate child may block the adoption of his children. The Appellant asserted that this situation violated the equal protection clause of the fourteenth amendment in that it denied equal protection to the father of illegitimates.

The Court held that section 111 treated parents differently according to their sex and that although as a class unwed mothers might be closer to their children than unwed fathers, an unwed father could have just as close a relationship with his illegitimate children as the mother did. The Court found that this was in fact the position in the present case. The Court thus rejected any claim that the broad gender-based distinctions of the applicable state statute were justified by any innate difference between the relationship of a mother to her child and that of a father to his child 'at every phase of a child's development'.

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upon which C (the current husband) instituted adoption proceedings in the Surrogate's Court of Kings County alleging that B's consent was unnecessary because he was not the 'parent' of the child within the meaning of the statute.

The court dismissed the petition for adoption holding that a child born of consensual AID during a valid marriage was legitimate and consequently entitled to all the rights and privileges of a naturally conceived child of the same marriage.(130) The court held further, relying heavily on Sorensen, that the father of such child was therefore the 'parent' whose consent was a prerequisite to the adoption of such child by another.(131)

The Surrogate's Court of Kings County also examined and totally rejected(132) the much criticised(133) Gursky v Gursky(134) decision which held that consensual AID children are illegitimate.(135) The Court held as follows:

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(129) (continued from previous page)

In cases such as Caban, where the father has admitted paternity, where there is no difficulty in identifying him, and where the father has developed a relationship with the child, the Court held that there was no justification for differentiating under section 111 between unwed fathers and unwed mothers. The Court thus concluded that section 111 was overbroad in its gender-based classification and struck it down on the ground that it infringed the equal protection clause.

The position regarding consent to adoption in South African law is likewise regulated by statute. In terms of section 71(2)(d) of the Children's Act 33 of 1960 only the mother of an illegitimate child need consent to its adoption (Basetti v Louw 1980 (2) SA 225 (W)).

(130) Anonymous supra at 433.

(131) Anonymous supra at 433.

(132) 'At the outset, it is observed that Gursky is not persuasive': Anonymous supra at 434.

(133) R E Wangard 'Artificial Insemination and the Law' (1968) University of Illinois LF 203 at 208; L G Kamlet (1975) 24 Cleveland State LR at 346 states: 'The Gursky court's basic failure lies in its inability to modify common law concepts so as to render them compatible with a situation engendered by modern technology'.

(134) 39 Misc 2d 1083, 242 NYS 2d 406 (Sup Ct 1963).

(135) 'The concept which historically is deeply imbedded in the law is that a child who is begotten through a father who is not the mother's husband is deemed to be illegitimate'; Gursky supra at 408.

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'... a child born of consensual AID during a valid marriage is a legitimate child entitled to the rights and privileges of a naturally conceived child of the same marriage.'(136)

5.1.3. Trends in US Supreme Court decisions on legitimacy

Between 1968 and 1978 the US Supreme Court handed down fourteen decisions(137) on the constitutionality of statutes which allegedly discriminated against illegitimate children. In ten of these cases(138) the statutes were found to be unconstitutional and the position of the illegitimate child was ameliorated by virtue of the state legislation being struck down on the ground that it violated the fourteenth amendment Equal Protection Clause viz that,

'No state shall ... deny to any person within its jurisdiction the equal protection of the laws.'

The net result of the decisions handed down between 1968 and 1973 were that a state could not constitutionally refuse an illegitimate child statutorily created rights to support from his father, to welfare benefits, to workmen's compensation benefits for the death of his father, or to wrongful death benefits for the loss of his mother.(139) The state could, however, refuse to allow the illegitimate to share in the intestate estate of his deceased father.(140) During the

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(135) (continued from previous page)
The reasons advanced by the court for declining to follow Gursky are that the definition of an illegitimate child which that case relied on were developed long before the advent of artificial insemination and that public policy favoured legitimacy (para 24 NY Domestic Relations Law).

(136) Anonymous supra at 435.

(137) New Jersey Welfare Rights Organization v Cahil 411 US 619 (1973); Griffin v Richardson 346 F Supp 1226 (Md) summarily Aff d 409 US 1069 (1972); Davis v Richardson 342 F Supp 588 (Conn 1972 aff d 409 US 1069 (1972); Gomex v Perez 409 US 535 (1973); Weber v Aetna Casualty & Surety Co 406 US 164 (1972); Labine v Vincent 401 US 532 (1971); Glona v American Guarantee and Liability Insurance Company 391 US 73 (1968); Levy v Louisana 391 US 68 (1968); Norton v Matthews 427 US 524 (1976) Faillo v Bell 97 S Ct 1473 (1977)). Mathews v Lucas 427 US 495 (1976); Beaty v Weinberger 478 F 2d 300 (Ct App 5 1973) summarily aff d 418 US 901 (1974); Jiminez v Weinberger 417 US 628 (1974); Trimble v Gordon 97 S Ct 459 (1977).

(138) In all cases except Faillo, Norton, Lucas and Labine.

(139) R L Stenger 'The Supreme Court and Illegitimacy 1968-1977' (1978) Family Law Quarterly 365 at 378.

(140) Labine supra.

next four years the Court heard six cases in which the issue was an illegitimate child's entitlement to social security benefits.(141)

The fourteen above mentioned decisions concerning various rights affecting illegitimates delivered in the space of ten years, has perforce focused legal concern upon a group which had previously received little attention. The collective results in these cases and the methodology employed by the Court in resolving them has brought about a vastly enhanced status for the illegitimate child under the US Constitution.(142)

Before 1968 each state, free of constitutional restrictions, enacted its own legislation and could deny illegitimates rights to support, inheritance, and other statutorily created benefits. Since the illegitimate had few vocal proponents of his rights, remedial legislation was not likely to be enacted.(143) There was some social interest in having the child supported by his biological father rather than the community, and such interest resulted in narrow support statutes.(144)

In 1968, however, in Levy and Glona the Court held that illegitimates had constitutional rights.(145) But the Labine decision in 1971, by upholding Louisiana's denial of inheritance rights from the biological father, raised questions about the scope of the rights announced in Levy and Glona. Weber and subsequent cases recognised the unfairness of penalizing innocent children for their parent's misdeeds, but the ambiguity of Labine remained. It was only with Trimble in 1977 that the Court recognised directly the aberrant character of Labine and attempted to bring consistency into its decisions.(146)

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(141) Jiminez, Mathews, Trimble, and Faillo supra.

(142) Stenger (1978) 11 Family LQ 365.

(143) Stenger (1978) 11 Family LQ 365 at 400.

(144) Harry D Krause 'The Uniform Parentage Act' (1974) 8 Family Law Quarterly 1 at 17.

(145) 'Centuries of legal development have brought slow progress for the illegitimately born .... The bastard has no lobby. Suddenly, however, it was discovered that he has constitutional rights ....': Stenger (1978) 11 Family LQ 365 at 400.

(146) Krause (1974) 8 Family LQ 1 at 8.

Illegitimates cannot now be totally and automatically excluded from 'children' who are eligible under support, welfare, workmen's compensation, wrongful death and descent and distribution statutes if such statutes provide benefits to children generally. So also, benefits under federal legislation cannot be made available to some children to the exclusion of all illegitimate children.(147)

It is submitted that a fair conclusion to be drawn from this long line of decisions is that state and federal law may not discriminate between legitimate and illegitimate children in any significant substantive area other than inheritance.(148) However, to date, state legislatures have made little effort to grasp this point and enact new laws in keeping with the constitutional mandate of equality. The old law of illegitimacy is all but a dead letter, but the new law has not yet been implemented, leaving a confused situation for lawyers.(149)

The Uniform Parentage Act(150) is intended to fill this vacuum. Its guiding principle is full equality for all children (including AID children) legitimate and illegitimate, in their legal relationship with both parents. Moreover, the Act emphasizes that the right in question is the right of the child,(151) not the right of its mother as is presently the position in most state laws.

5.2. United Kingdom

Legitimacy at common law is defined as follows:

'A child is legitimate ... if his parents were married at the time of his conception or at the time of his birth.'(152)

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(147) Krause (1974) 8 Family LQ 1 at 8.

(148) E S Harris 'A look at Trimble v Gordon and Faillo v Bell' (1977-78) 16 Journal of Family Law 57 at 58.

(149) M W Dobbins 'Mathews v Lucas : A setback in the Illegitimate's Quest for Equality under the Law' 16 Journal of Family Law 37 at 54. Carmen Nathen in 'A Father and his Illegitimate Child : Towards a Permanent Relationship' (1980) 43 THRHR 291 at 298 made an appeal for an investigation to be launched into the position of the illegitimate child and its father with a view to improving our law so that a healthy and permanent relationship can be established between them.

(150) Krause (1974) 8 Family LQ 1 at 8.

(151) See section 6(a) Uniform Parentage Act.

(152) P M Bromley Family Law 5th (1976) 281.

According to this definition a child born as a result of AID is illegitimate,(153) and the fact that the husband has consented is immaterial. The presumption, pater est quem nuptia demonstrant which operates in favour of a child born to a married couple is rebuttable but according to the normal standards of proof in civil matters ie on a balance of probability.(154) The old common law rule requiring evidence beyond reasonable doubt was struck down by section 26 of the Family Reform Act of 1969.

Discrimination against a person born out of wedlock has been for centuries a fundamental tenet of the Common Law. The illegitimate child was looked upon as filius nullius, a stranger to both his father and mother: consequently he enjoyed none of the legal rights deriving from the status of parent and child.(155)

In England as in other European countries the trend has been to steadily erode the discrimination inherent in the status of illegitimacy and to move to a position where the status of illegitimacy is abolished.(156) Recent legislation aimed at improving the status of the illegitimate includes the Legitimacy Act of 1959, the Family Reform Act of 1969, the Domicle and Matrimonial Causes Act of 1973, the Affiliation Proceedings (Amendment) Act 1972, Guardianship of Minors Act 1971, Children's Act 1975, and the Legitimacy Act 1976.(157)

The percentage of the children born illegitimate has steadily increased over the years eg 1956 - 4,8%; 1967 - 8,4%; 1973 - 8,6%; 1977 - 9,7%. While the total number of births declined by 31,86% between 1967 and 1977, the number

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(153) Report of the Departmental Committee on Human Artificial Insemination (1960) Cmnd 1105 para 80, hereinafter referred to as the Feversham Report; Olive M Stone 'English Law in relation to AID and embryo transfer' in (1973) Law and Ethics of AID & Embryo Transfer Ciba Symposium at 71.

(154) Bromley Family Law 5th ed (1976) 283.

(155) A G Chloros The Reform of Family Law in Europe (1978) at 70.

(156) Eekelaar (1980) 14 Family LQ 41 at 48.

(157) Chloros The Reform of Family Law in Europe (1978) 79; Eekelaar (1980) 14 Family LQ 41 at 48-52.

of illegitimate births declined by only 21,3%.(158) The problem of the status of illegitimate children is not inconsiderable if one considers that 55,379 illegitimate children were born in 1977 and some ½ million recorded illegitimate births have taken place in England and Wales since the 2nd World War.(159)

5.2.1. Feversham Report

Responding to proposals made to it in 1960, the Feversham Committee declined to recommend(160) that and AID child born to consenting spouses should be declared legitimate. Their decision was in line with the views of Parliament which had, after a short debate, the previous year(161) declined to add a clause to the Legitimacy Bill of 1959 whereby 'any child born to a married woman, and accepted as one of the family by her husband' would have been deemed a child of the marriage.

5.2.2. English Law Commission

The most recent display of official concern at the status of the illegitimate child is contained in a Working Paper published by the English Law Commission in June 1979.(162) This study reviews current English law as it affects illegitimate children and sets out possible approaches for its reform. It suggests that the

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(158) Eekelaar (1980) Family LQ 41 at 42.

(159) The Law Commission, Working Paper No 74, Family Law: Illegitimacy (1979) (hereafter abbreviated to WP 74).

(160) According to the Feversham Report para 169:

> 'To make AID children legitimate would be an entirely new departure. They would be the only class of legitimate children not related in blood to the mother's husband .... The simple question of principle is whether a child may become the legitimate issue of those who are not his natural parents. That seems to be a contradiction in terms and the invasion of standards accepted from time immemorial. It would be the introduction of a new concept which alters the meaning of parentage .... The change proposed is one which would alter not only the status of the AID child but also that of all children now described as legitimate, since marriage of their father and mother would no longer be necessary for the status they now enjoy.'

(161) House of Commons Official Report 8 May 1959 col 760.

(162) WP 74.

distinction between the statuses of legitimate and illegitimate children be eliminated. It also considers the issue of the status of AID children and suggests four approaches to the problem:

(a) To do nothing. This according to WP 74 leaves the parents of the AID child in the invidious position of having to break the law by making a false declaration as to the parentage of the child in the Births Register if they wish to achieve legitimate status for their child. This state of affairs they correctly interpret as being unacceptable.

(b) Introduce a special form of adoption for AID children. This solution they conclude would be cumbersome and unrealistic as the publicity of an adoption is one of the very factors which the parents seek to avoid by resorting to AID. This solution is also unsatisfactory in cases of AIM (husband's semen mixed with that of donor) because a slight possibility exists that the child might be the husband's.

(c) Introduce a system of annotating the register. In terms of this system the husband would formally have to notify the registrar of his consent to the AID. The register would then be annotated to the effect that the child was conceived by AID and that the husband should be deemed to be the father.

The problem with this system according to WP 74 is that it would retain the difficulties mentioned above in low fertility cases, and it is most likely that this system would not be used as prospective AID parents would prefer (as now) not to reveal the origin of the child's birth.

(d) Introduce a provision which deems the wife's husband to have consented to the birth of the AID child and to be the father of the child. Furthermore to presume his consent unless evidence can be led to the contrary.

This is the approach favoured by the Commission, although it says that it is open to the objection that it,

'involves a deliberate falsification of the birth register'.(163)

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(163) The European countries which have specifically provided for this situation

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A similar approach has been adopted in the United States.(164)

Until the Act containing the above provision is passed the AID child will continue to be classified as illegitimate in Britain.

5.3. New Zealand

The Status of Children Act 1969 was a startling departure from traditional legal ideas. Its object was to remove the legal disabilities of children born out of wedlock. It achieved this by abolishing illegitimacy as a legal status whilst retaining various jurisdictional, procedural and evidentiary distinctions that are founded on practical realities.

The heart of the new act is section 3(1) which roots out the status of illegitimacy in uncompromising fashion.(165)

5.4. France

There is no reference to AID in the French Civil Code despite the fact that it is estimated that 1000 couples resort to it annually.(166) This benevolent neglect is however preferable to the attitude of the Swiss legislature which has forbidden AID as being incompatible with the institution of marriage.(167) Thus in the absence of legislative guidance French jurists rely on legal principles to determine the effect of AID on affiliation and legitimacy.(168)

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(163) (continued from previous page)
viz the Netherlands and Switzerland, adopt an approach similar to this by barring an action for disavowal of paternity if the husband has consented to the act leading to the wife's conception.

(164) M Mayo 'Legitimacy of the AID Child' (1967) 6 Journal of Family Law 19.

(165) Section 3(1) 'For all the purposes of the law of New Zealand the relationship between every person and his father and mother shall be determined irrespective of whether the father and mother are or have been married to each other, and all other relationships shall be determined accordingly'.

(166) M Revillard 'Legal Aspects of Artificial Insemination and Embryo Transfer in French Law' (1974) Int & Comp Law Quarterly 383 at 386.

(167) J M Grossen (1960) 62 'Law Protection de la Personnalité en Droit Privé' Report presented to the Swiss Society of Jurists 51a-52a.

(168) Revillard (1974) 22 Int & Comp LQ at 387.

French legal doctrine has attempted to reconcile AID with a theory of denied paternity balancing the interests of the child by way of the rules of medical secrecy and the pater est quem nuptiae demonstrant presumption.(169) The legitimacy of a child is normally determined by the established principle that the parents should have been married at its birth or conception.(170)

Following the Decree of 3 January 1972 any evidence is admissible to rebut the presumption of paternity(171) provided that it has been lodged within six months after the birth.(172) According to Revillard(173) the above mentioned conditions constitute a sufficient guarantee to the people concerned in artificial insemination, and no legislation is needed.(174)

5.5. Holland

Legitimacy is not specifically defined in Dutch law, but according to Asser(175) it can be deduced as follows:

> 'Een kind is een wettig kind van een man en een vrouw, indien het met semen van de man bij de vrouw is verwekt en het geboren wordt staande het huwelijk van die beiden, dan wel op een zodanig tijdstip, dat het staande het huwelijk kan zijn verwekt; met verwekking met semen van de man wordt gelijk gestelt een door de man aanvaarde verwekking met semen van een andere man.'

According to artičle 197 of the Dutch Civil Code a presumption exists that a child born in wedlock has the husband of the mother as his father, and is thus

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(169) This presumption is not applicable to a child born more than 300 days after the husband's death or disappearance cf Art 340 Code Civil.

(170) M Daste (1948) Annales de Medicine Légale 225-261.

(171) Art 312, para 2 Civil Code.

(172) Revillard (1974) 23 Int & Comp LQ 391.

(173) Ibid.

(174) 'The laws of affiliation ensure for the ensuing child a status similar to that of a legitimate child. The particular conditions of a child's conception should be no concern of the law, and this is why the confidentiality of such an intervention should be maintained in all cases.' cf Revillard (1974) 23 Int & Comp LQ at 39.

(175) C Asser Personen-en Familierecht Deel 1 10th ed (1974) at 63.

legitimate.(176) Furthermore a child born before the 307th day after the dissolution of a marriage has the former husband as his father unless the mother has remarried.(177) In the event of her remarriage the general rule again applies that the husband is the father.(178) The presumption is rebuttable by the husband or former husband subject to certain restrictions(179) safeguarding the interests of the child. The basis of the petition was that the husband was not the natural father of the child.(180)

There are ceratin exceptions set out in Article 201, according to which, despite the fact that the husband has proved that he is not the natural father of the child, his petition to disclaim paternity must fail. One of these refers to the position where the husband has consented to his wife being inseminated with the semen of a donor. In this situation the husband is deemed to have accepted the paternity of the child.(181)

5.6. Australia

5.6.1. Common Law

There are no laws in Australia which expressly sanction, or forbid, artificial insemination as such.(182) Accordingly the status of the AID child in Australia is unclear,(183) and this in turn is restricting the work of Australian doctors(184) who are naturally uneasy about promoting this therapy for male sterility.(185)

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(176) Asser Personen-en Familierecht Deel I 10th ed (1974) at 63.

(177) Chloros The Reform of Family Law in Europe (1978) at 33.

(178) Ibid.

(179) Ibid.

(180) Article 199 Dutch Civil Code.

(181) Article 199 Dutch Civil Code. See also Chloros op cit 33.

(182) D F J J de Stoop 'Human Artificial Insemination and the Law in Australia' (1976) 50 Australian Law Journal 298 at 299.

(183) M Mayo 'The Legal Status of the AID Child in Australia' (1976) 50 Australian Law Journal 562.

(184) Mason (1982) 56 Australian LJ 347 at 352.

(185) Estimates place the number of barren marriages due to male sterility at 80 000 and the number of donor inseminations peformed in Australia at 40-50 per week. Cf J Leeton and J Backwell (1976) 16 Australia & NZ J of Obstet & Gynaec at 45.

If the common law rules determining legitimacy are applied to the AID child then it must be classified as being illegitimate[186] because its mother was not married to its natural father (viz the donor) either at its conception or at any subsequent date.[187] The pater est quem nuptiae demonstrant presumption is recognised and the following category of children are accordingly presumed to be legitimate:

> '... [those] born during a marriage, whether conceived before or after the marriage took place, and to children conceived during the marriage, whether born before or after the marriage is dissolved by the husband's death or otherwise.'[188]

The presumption which operates in favour of an AID child is rebuttable[189] in which event the child will be held to be illegitimate.

There have been a dearth of cases on AID in Australia, and the Victoria case of Roberts v Roberts,[190] although touching on the issue of the legitimacy of an AID child, essentially decided a point of disputed access. The court stated that there was no blood relationship between the AID child and her mother's husband. It also declared, obiter, that it was 'not persuaded that the child should be regarded as legitimate' despite the fact that the husband had consented to its conception.[191]

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(186) Because artificial insemination and AID children were not contemplated when the common law rules relating to illegitimacy were evolved, it is difficult at this stage to fit such a radical departure from conventional procreation techniques into existing legal principles based on the norm and not the exception.

(187) Mayo (1976) 50 Australian LJ 562.

(188) Per Dixon J in Cocks v Juncken (1947) 74 CLR 277 at 294.

(189) Actions of this nature normally only arise where matrimonial proceedings are taken by one of the parties.

(190) [1971] VR 160 at 166.

(191) Mayo (1976) 50 Australian LJ 562 at 566; Mason (1982) 56 Australian LJ 347 at 352.

5.6.2. Effect of state legislation on the status of AID children

The disabilities of children born out of wedlock[192] (illegitimates) were substantially diminished by recent legislation passed in the states of Tasmania, Victoria and South Australia. The acts referred to are The Status of Children Act, 1974, in Tasmania and Victoria and The Family Relationships Act, 1975, in South Australia. Neither act specifically mentions the AID child although they do remove the distinction between legitimacy and illegitimacy.[193]

Certain sections[194] of the above Acts can be interpreted in a way which is favourable to the AID child. On the other hand, according to new legislation the child is deemed to have a 'parent and child' relationship with only his mother and biological father viz the donor.[195] No recognition or status is accorded to his 'putative', social or accepting father.

The legislature again chose to ignore the AID child in the Family Law Amendment Act 1976 (Cth), which substitutes a new section 5 for that in the Family Law Act 1975 (Cth). In terms of section 5(1)(c) of the 1975 Act the AID child is categorised as being an ex-nuptial child of the wife and as such would be entitled to the advantages of custody, access and maintenance from its mother, if its mother and social father were separated or divorced. According to section 5 of the 1976 Act the definition of 'child of the marriage' will no longer include an AID child unless it has been adopted by the spouses.[196]

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(192) Illogical as it is, the AID child must be deemed to fall into this category.

(193) Mayo (1976) 50 Australian LJ at 564.

(194) They clarify the AID child's right to succeed to his social father's estate, while entry of a certain person in the Register of Births as the father of the child is deemed to be prima facie evidence of his paternity, section 8 (1) Family Relationships Act 1975 (SA).

(195) Mayo op cit 567.

(196) Mayo op cit 565. H H Finlay '1976 in Family Law' (1976) Annual Survey of Law 163 at 171.

5.7. Federal Republic of Germany

The trend towards the elimination of discrimination between legitimate and illegitimate children is also evident in the law of West Germany.(197) The reform of the BGB in this respect has been in force since 1 July 1970 and was initiated by the fact that Article 6(5) of the Basic Law(198) required that illegitimate children should be entitled to the same conditions of physical and spiritual development as legitimate children.

However the reform, which was actually implemented in regard to 'nichteliche kinder' or non-marital children, did not bring about complete equality between them and legitimate children. The position today is that the non-marital child is entirely equal to a legitimate child only in relation to its mother, but not in relation to the father. Except that, in terms of para 1589(2) of the BGB, father and child are now regarded as related in the law.(199)

The position of the AID child is thus that it will be presumed to be legitimate unless or until one of the spouses rebuts the presumption of legitimacy.(200)

6. The South African Law and the Status of the AID child

6.1. The decision in V v R

The parties in this pioneer AID case in South Africa were married to each other in 1965 and divorced in 1974. The husband, the respondent, was sterile and

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(197) M T Bohndorf 'The New Illegitimacy Law in Germany' (1970) 19 International and Comparative Law Quarterly 299 at 300.

(198) Art 6(5) reads as follows:

> 'Extra marital children are to receive by legislation the same conditions for their physical and mental development and their position in society as legitimate children.'

(199) J Gerhnhuber Lehrbuch des Familienrechts 3 Aufl (1980) section 45 x.

(200) D Giesen Zeitschrift Für das gesamte Familienrecht (1965) at 248.

consented to his wife, the applicant, now remarried, being artificially inseminated with the semen of a donor. As a result of this insemination his former wife fell pregnant and a son was born to the spouses in 1971. In terms of the divorce settlement the applicant was granted custody of the child while the respondent was allowed reasonable access and undertook to pay maintenance of R30 per month for the child.

The applicant and her second husband wished to adopt the son born to her by AID conception. However in terms of section 7(2)(d) of the Children's Act No 33 of 1960, before a court will grant an adoption order it must be satisfied that consent to the adoption has been given,

> 'by both parents of the child, or, if the child is illegitimate by the mother of the child ....'

Applicant's first husband refused to give his consent to the adoption. She therefore applied to the TPD for an order declaring that her first husband was neither the natural nor the legal father of her AID son. A decision in her favour would in effect illegitimate her son and circumvent the statutory requirement of her erstwhile husband's consent to the proposed adoption.

In order to decide the narrow issue raised in the application Steyn J had perforce to look more widely at the status of the AID child concerned. According to our old authorities the key to legitimacy is determined as follows:

> 'Children who are both conceived and born during the subsistence of the marriage of their parents are clearly legitimate'.(201)

The position in the present case is that the spouses (applicant and respondent) both gave an informed consent to applicant's insemination with the semen of a donor. Subsequent to this insemination and during the subsistence of their marriage applicant conceived and gave birth to a son. Two of the three requirements of legitimacy emphasised above were thus complied with.

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(201) Grotius Inleiding tot de Hollandsche Rechtsgeleertheyt 1.12.2 (my emphasis); Van Leeuwen Censura Forensis 1.1.3.5; Van Leeuwen Het Roomsch Hollandsch Recth 1.7.2; Schorer Ad Grotius note 47(1). Steyn J op cit 1012(h) referred to Kotze's translation of Van Leeuwen's Commentaries on the issue of legitimacy:

> 'These persons are legitimate who are procreated by their parents in lawful wedlock.'

The old authorities reflected the law of their time which did not contemplate conception other than by intercourse and thus their definition of legitimacy could not be extended to encompass the AID child.(202) Furthermore the SA academic writers on the topic of AID available at that time were also of a similar mind.(203) Steyn J was thus not inclined to take a bold and innovative approach as the American Courts did in Sorensen and Anonymous and break new ground in our law on AID, but settled instead for the safer conservative approach in line with our common law's definition of legitimacy.(204)

6.2. V v R - possible alternatives

The basis of my analysis of the legal status of the AID child has been that negative legal policies can retard the rapidity of social change. Thus the decision in V v R, viz that and AID child was illegitimate, would, it is submitted, probably discourage(205) potential parents from utilising this technique to provide them with a much wanted child. Although our law has made progress in removing the worst disabilities(206) for illegitimates, the status of illegitimacy still carries several legal inequalities.(207)

It is submitted that there were alternative approaches, within the ambit of our law which Steyn J could have used to avoid declaring the child illegitimate.

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(202) Pieter Pauw V v R (1980) Tydskrif vir Suid-Afrikaanse Reg 192 at 194.

(203) Masters (1953) SALJ 377; Spiro (1972) Acta Juridica 214; Strauss (28 Oct 1978) South African Medical Post; Gordon, Turner & Price Medical Jurisprudence (1953) 67-68; Hahlo (1957) SALJ 174.

(204) Van der Vyver (1980) 43 THRHR 94.

(205) Strauss Doctor, Patient and the Law (1980) 154.

(206) Green v Fitzgerald & Others 1914 AD 88 at 99; Ex parte J 1951 (1) SA 665 (O); section 11(1) & (2) Births, Marriages & Deaths Registration Act 81 of 1963.

(207) Van der Vyver & Joubert Persone en Familiereg (1980) 189-192.

6.2.1. A 'Lawful Father'

The definition of legitimacy which is generally accepted in our law is:

'Legitimate children are those born from parents united in wedlock'(208)

In V v R's case the mother and her husband were lawfully married at the moment of the child's conception and birth. This means that we must concentrate on the second requirement in the definition, viz, the term 'parents'. The Shorter Oxford Dictionary defines 'parent' as follows:

> 'father or mother, progenitor, kinsfolk. By extention: a person who holds the position of parent'.

Identifying the mother of the AID child presents no problem legally or biologically. This narrows down the definition to consideration of the 'father' of the AID child, and in particular whether our courts would be prepared to follow the precedents in Sorensen(209) and In re Adoption of Anonymous.(210) In these cases the respective courts found an AID child of consenting parents to be legitimate by extending the meaning of the word 'parent' to include the husband (non-biological parent) who had consented to his wife's insemination by a donor. They classified this non-biological father as the'lawful father'.(211)

Although our law places a heavy emphasis on biological fatherhood (except where it specifies otherwise in legislation), it is submitted that the concept of non-biological parents are not unknown in our law.(212)

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(208) Grotius Inleiding 1.12.2 (my emphasis).

(209) Supra.

(210) Supra.

(211) Van der Vyver (1979) 66 SALJ however submits that SA courts are unlikely to follow the reasoning in the above mentioned cases because in our law a man who is not a natural father of a child can only acquire the status of a parent by adoption.

(212) Hahlo (1968) 85 SALJ at 319 says:

> '... the father who is not really the father at all, is not a recent phenomenon.'

We find examples of this in the earliest periods of Roman law in the concepts of adoption and of the paterfamilias, while the man who marries a wife with children from a previous marriage and accepts them as his own becomes their father. Steyn J[213] took a few tentative steps in the direction of creating a new category of 'father' in our law, or extending the present definition of the term, by referring to the 'putative father' in V v R. The Oxford Dictionary also includes in its definition of parent, 'a person who holds the position of a "parent".' This would naturally cover the consenting husband whose wife produces an AID child.

6.2.1.1. Waiver of rights by AID parents

It is submitted that the concept of a 'lawful father' of an AID child can be introduced into our law on the following basis viz when a husband and wife decide to have a child by AID, their conscious decision to start a family differs in no way from that of parents who decide to start a family in the 'normal' way (they can even start a family 'accidentally' without conscious forethought). The conscious decision by the spouses to start a family by AID should be interpreted as being a waiver by both the husband and the wife of all rights which might be vested in them to have their AID child subsequently declared illegitimate.[214] By so doing, the presumption of pater est quem nuptiae demonstrant becomes irrebuttable.[215] Although Olivier states that it is possible to rebut the presumption of paternity at any time and that this right is not extinguished by prescription, it is submitted that this does not mean that it is not possible to waive the power to rebut this presumption.[216] It must however be proved that the spouses waived their power in the light of a full knowledge of their rights. The fact that the

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(213) 'Daar is na my oordeel egter geen gesag in ons reg wat verhinder dat die instemmende eggenoot van 'n vrou wat 'n kind in the wêreld bring deur middel van kunsmatige inseminasie van 'n skenker, geplaas word in 'n spesiale verhouding tot die aldus gebore kind nie': V v R at 1016 (E).

(214) Pauw (1980) TSAR at 196.

(215) Ibid.

(216) Ibid.

spouses made a conscious decision to resort to AID should satisfy this requirement.(217)

6.2.1.2. Extension of the exceptio doli

It is submitted that by an extension of the exceptio doli on the grounds of equity it would be possible to defeat the action of an AID parent who at a subsequent stage, ie after his/her consent and agreement(218) to the conception and birth of the AID child, institutes an action to dispute the legitimacy of the child.(219) It is submitted that an act of this nature would be uberrimae fides and a thoroughly unconscionable act on the part of the parent who resorts to such litigation.(220)

Our Supreme Court is the upper guardian of all minors and when adjudicating on matters affecting minors it is at all times guided in its decisions by what it considers to be the best interests(221) of the minor concerned. Where the facts of the case indicate that it would be in the best interests of the AID child to declare its mother's husband to be its 'father' it is hoped that our courts will give serious consideration to taking this bold step, which it is submitted can be justified on the grounds set out above.

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(217) Strauss Doctor, Patient and the Law (1980) 151.

(218) In terms of section 201 of the Nederlandse Burgerlijk Wetboek a man cannot deny his paternity if he has agreed to the act which resulted in the conception of the child. The non-biological father in an AID situation would thus not be entitled to dispute his paternity where he had consented to AID.

(219) Pauw (1980) TSAR at 196.

(220) Zuurbekom Ltd v Union Corporation Ltd 1947 (1) SA 514 (A) at 537;

> 'It was this breadth of scope that fitted the exceptio doli for becoming, above all things, the instrument which was used, both in the theory and practice of Roman Law, for effecting such modifications of the material law as equity seemed to require'

and at 543,

> '... the device was resorted to of supposing that it was fraud on the plaintiff's part to claim that which it would be "unfair" to require the defendant to perform.'

(221) Fletcher v Fletcher 1948 (1) SA 130 (AD).

7. In Vitro Fertilization

7.1. Introduction and outline of problems

Although there are no reported cases of in vitro fertilization in South Africa[222] the practice has already taken enormous strides[223] since the birth of Lousie Brown on 25 July 1978.[224] Edwards and Steptoe have established the Bourn Hall Clinic at Cambridge in England, where their patients pay a fee of R2 750 for an attempt to conceive by this method. In the first 9 months of this year they treated 120 patients, despite the fact that one in four fertilizations failed within the first three months after the fertilised embryo had been implanted in the womb.[225]

The technique of in vitro fertilisation and embryo transfer separates the genetic and biological aspects of parentage from the social aspects of parentage. This in turn creates legal problems because it upsets the stability and certainty normally associated with family relationships eg in relation to the status of the IVF child. It is possible in such a conception for two women to claim motherhood of the child. Who is therefore to be considered as being the actual mother, the ovum mother or the womb mother?

If one approaches the problem from the usual genetic viewpoint then the donor of the egg and the husband who provides the sperm are the parents of the child to whom parental rights and obligations attach. But, it is submitted, that

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(222) The first baby born in South Africa which was conceived by IVF was Dominique Darvas. She was born in Pretoria on 26 January 1982. Although she was born in South Africa the conception and implantation was performed at Bourn Hall Clinic cf The Citizen 8 February 1982 page 1. At this date there were 16 recorded IVF conceived children who had been born world-wide.

(223) Dr Saroj Bhattacharaya disclosed that a 3,35kg girl was born to a Hindu housewife from Calcutta on 3 October 1978: cf Natal Witness 7 October 1978. A number of in vitro births have been announced by a team of gynaecologists from Monash University Medical School, Melbourne: cf Daily News 6 June 1980.

(224) Mrs Lesley Brown gave birth to a second IVF daughter, Natalie Jane, in June 1982 Natal Mercury 16 June 1982.

(225) Sunday Tribune 4 October 1981; Mercury 15 July 1980.

such a result would not advance any of the social interests at stake.

The courts and various legislatures have tackled some of the problems arising from AID eg that the social or 'legal father', despite the fact that he is not the biological father, has rights concerning the adoption, custody and visitation of the AID child where he has consented to it. It is further submitted that it is hoped that the legislature and the courts will adopt a similar positive policy towards IVF and ET in order to extend the maximum degree of individual autonomy in regard to the procreative policy, and at the same time bring about the minimum disruptive effect on the marital relationship.

I will thus deal with the issue of the status of the IVF and ET child as follows, first, I will discuss the legal position in regard to the various possible permutations of embryo and sperm in the light of the existing principles of our common law. I will then make submissions relating to possible alternative means of determining parenthood which is, after all, the hub of the status or legitimacy problem facing a child conceived in this manner.

7.2. The legal status of IVF children according to current South African Law

7.2.1. Wife's ovum, husband's sperm, Wife carries the child

It is submitted that in terms of section 7 of the Anatomical Donations and Post Mortem Examinations Act, 24 of 1970 the removal of the wife's embryo, its fertilization with her husband's sperm and its subsequent reimplantation are legal within the context of the Act and may be performed without the permission of the Minister of Health.

This procedure, it is submitted, furthermore creates no legal problem regarding the legitimacy of the child as its parents are married to each other at the time of its conception and birth and, furthermore, they are both the biological and genetic parents of the child.(226)

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(226) Douglas J Cusine 'Some Legal Implications of Embryo Transfer' (28 June 1979) New Law Journal 627 at 628.

7.2.2. Wife's ovum, donor's sperm, wife carries the child

Relying on current SA law the position regarding the child's status in this set of circumstances is analogous to the position of the AID child, viz, it is illegitimate.(227) The reason being that its biological father is a sperm donor and is not married to its mother either at birth or conception.(228) However, if consent is accepted as the controlling criterion, as is the case with AID in many jurisdictions, the child would be legitimate or would be considered as being the natural child of its mother's husband.(229)

7.2.3. Husband's sperm, ovum donated, wife carries the child

This situation creates a far more complex problem because to date the law has never been in doubt as to the identity of the mother of a child when it was born. Birth in itself has been conclusive proof of motherhood.(230)

When however the ovum comes from a donor, is fertilized and transferred into the wife's uterus, the question becomes whether contributing the germ cell or carrying and giving birth to the child entitles a woman to claim motherhood.(231)

If one applies existing legal principles to this situation, then the husband is clearly the father of the child. His wife who gives birth to the child could on the face of it be regarded as the mother of the child (mater semper certa est) or one could argue, by virtue of the fact that the oocyte, though emanating from a donor, becomes W's by the legal process of accessio.(232) If this submission were accepted the child would be legitimate.

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(227) V v R supra at 1016(D).

(228) Boberg The Law of Persons and the Family (1977) 318; section 1(xxix) Children's Act 33 of 1960.

(229) David S Rosettenstein 'Defining a Parent : The New Biology and the Rebirth of the Filius Nullius' (22 October 1981) New Law Journal 1095.

(230) Robertson Encyclopedia of Bioethics (1978) 1468; Grad (1968) 15 UCLA Law Review 480 at 503.

(231) Turner (1981) 58 J of Urban Law 459 at 474.

(232) Glanville Williams The Sanctity of Life (1958) at 114.

However, if one characterises the parent child link on the basis of purely genetic considerations, then the child would be the genetic product of a man and a woman to whom he was not married.(233) The child would then be illegitimate.(234)

We must however remember that illegitimacy in SA law is a status which establishes jurisprudential links between the child and the woman who gives birth to the child.(235) This consequence rests on the assumption that the woman is the genetic parent of the child - a thesis which until recently constituted an unchallengeable proposition. Because this great sine qua non has been disproved it is submitted that we must redefine the term 'parent' or 'mother' and 'father' in the light of the new biology.(236)

7.2.4. Donated ovum, donated sperm, wife carries the child

If the above set of facts was judged according to our established law relating to legitimacy which relies on genetic links, then the resulting child would be the illegitimate child of the sperm and ovum donors.

7.2.5. Wife's ovum (Mrs A), husband's sperm (Mr A), hostess mother (Mrs X) carries the child

The question to decide in the next three situations is whether the law will determine the child's status on the basis of its genetic origin or whether it will only consider the circumstances surrounding the child's birth.

In the above example the fertilised embryo is genetically that of Mr and Mrs A and if the law relies on genetic ties to determine parentage the resultant

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(233) Oakley (1974) 8 Family LQ 385 at 391.

(234) Grotius 1.12.2; V v R supra 1012 (F-H).

(235) 'Een moeder maakt geen bastaard'. See also Dhanabakium v Subramanian 1943 AD 160.

(236) Rosettenstein (22 October 1981) New Law J 1095. See also page 219 supra.

child would be their legitimate child, notwithstanding the fact that Mrs X actually brought the child to term and gave birth to it. However if the act of birth (viz the mater semper certa est) approach is adopted the child will be the illegitimate child of Mr A and Mrs X.

7.2.6. Wife's ovum (Mrs A) donor's sperm, hostess mother (Mrs X) carries the child

In this situation Mrs A's ovum is removed, fertilised in vitro with a donor's sperm and then implanted into a hostess mother, viz Mrs X. There is no relationship between the sperm donor and the hostess mother.

The status of the child will once again be determined by the policy choice made by the law. If our law continues, as it does at present, to regard the persons supplying the genetic raw materials as the child's parents, the child will be the illegitimate child of Mrs A and the sperm donor. If the law chooses to establish legal links through the act of birth, then Mrs X, who brought the child to term and actually gave birth to it will be its mother. The child will then be the illegitimate child of Mrs X.(237)

7.2.7. Wife's ovum (Mrs A), donor's sperm (Mr X), hostess mother (Mrs X) carries the child

The status of the child once again hinges on the vital decision as to whether the law chooses to recognise the child's status as being determined by its genetic origins, in which case it will be the illegitimate child of Mr & Mrs X. If however the law chooses to place a higher emphasis on the fact that the hostess mother has nurtured the child and given birth to it then that fact will outweigh the fact that she is not its biological mother and the child's status will change for the better viz it will be the legitimate child of Mr & Mrs X.(238) Presumably it will then have to be adopted by H & W (Mr & Mrs A).

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(237) Cusine (28 June 1979) New Law J 627 at 628.

(238) Cusine (28 June 1979) New Law J 627 at 628.

7.3. Alternative methods of determining the status of the IVF & ET child

We have seen from the various permutations of embryo and sperm discussed above that the law's traditional formula for determining legitimacy which is based on genetic ties between the mother and father of a child who are in addition married to each other at the time of its conception or birth or at any time between these dates is totally inadequate to cope with the problems created by the new biology.(239) It is thus submitted that the traditional legal approach to the problem of legitimacy will have to be challenged on the basis of social reality.(240)

A similar but less complex problem arose with the development of AID for which a number of American State legislatures devised a simple solution viz that if the child's mother was married to a man who consented to insemination using donated semen, the child may be deemed legitimate or the father may be deemed the natural father of the child.(241)

The most significant feature of the above solution lies in the element of consent. It triggers the recognition of a parent-child relationship, but divorces that relationship from the traditional dependency on the factual genetic link between father and child. In other words the genetic link is replaced by the consent (effectively of both parties) to the insemination procedure. It is submitted that this element of consent would, if applied in the IVF and ET situation prove equally effective in solving the many problems this technique creates.(242)

7.3.1. Establishment of legal links via the act of birth

In a situation involving a donated oocyte the traditional genetic link between the gestational mother and the child does not exist.(243) According to current SA law the child is thus not the legitimate child of its gestational mother. In

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(239) Grad (1968) 15 UCLA Law Review 480 at 503.
(240) Reilly Genetics and the Law (1975) at 372.
(241) See footnote 68 Turner (1981) 58 J of Urban Law at 468.
(242) Rosettenstein (22 Oct 1981) New Law J 1095.
(243) Oakley (1974) 8 Family LQ 385 at 391.

order to overcome this unusual problem one could substitute the act of birth as being the factor which creates the legal links between the child and its parents.(244)

By applying this criterion a child could be classified as being legitimate if the woman giving birth to it was married to the child's genetic father at the time of birth. If however the status of illegitimacy is abolished as was recommended by the English Law Commission,(245) the woman giving birth could be considered to be the child's mother.(246)

The adoption of the act of birth as the criterion for determining legitimacy would , it is submitted, result in the child born in the permutations discussed in 7.2.1, 7.2.2, 7.2.3, and 7.2.4 supra being a legitimate child.

The unspoken premise on which a jurisprudential tie is established between mother and child in such cases is the fact that the woman has consented to act as mother to the child.(247)

7.3.2. Establishment of legal links via the place of fertilisation

If the place of fertilisation was used as a criterion to establish status the child would be the offspring of the woman in whose womb fertilisation occurred and of the semen donor; if these two people were married, the child would be legitimate.(248)

This procedure could be used to identify the mother where the oocyte was fertilised in the uterus of the donor by AI and the resulting embryo was transferred to the hostess mother within a few days. This process will be referred to in abbreviated form as IVFD.(249) If we apply this criterion to the relevant permutations referred to above it proves to be of very little assistance as this

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(244) Rosettenstein (22 Oct 1981) New Law J 1095 at 1096.

(245) See Law Com No 74 : Illegitimacy and Eekelaar (1980) 14 Family LQ 41 at 58.

(246) Rosettenstein (22 Oct 1981) New Law J at 1096.

(247) Ibid.

(248) Rosettenstein (22 Oct 1981) New Law J 1096.

(249) Ibid.

procedure is only practically useful in one set of circumstances viz 7.2.5 where the wife's ovum was fertilised in her uterus with her husband's sperm and the resulting blastocyst was then implanted into a hostess mother who gave birth to the child. In all the other relevant permutations this criterion will result in the child being illegitimate.(250) It is obvious that relying on the place of fertilisation to identify the mother in instances of IVF (ie fertilisation in glass outside the human body) is clearly meaningless.

7.3.3. Establishment of legal links via consent

It is submitted that the most practical and universally applicable norm to determine the parents and hence the status of IVF and ET children is by adopting a consent based approach.(251) If consent is used to supply a foundation for determining legitimacy, or maternity in instances of oocyte donation, then the law would be brought into line with section 39 of the proposed Draft Child Care Bill(252) which proposes that a child conceived by artificial insemination using donated semen should be deemed to be the legitimate offspring of the married couple who have procured the procedure. Such an approach produces de facto and de iure parents for the child.

In general the consent based approach will identify the child's parents as the husband and wife who want the child and have indicated their intention to raise the child. All the rights and duties of parenthood will then vest in this couple from the moment of the child's conception. The norm of consent, it is submitted, is the only one which is sufficiently functional and flexible to apply equitably to all the permutations of egg and sperm which are possible with the new biology.(253)

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(250) Cusine (28 June 1979) New Law J 627 at 628.
(251) Rosettenstein (22 Oct 1981) New Law J at 1096.
(252) (28 Oct 1981) 7864 Government Gazette.
(253) Rosettenstein (22 Oct 1981) New Law J at 1096.

CHAPTER 8

REGISTRATION AND DOCUMENTATION OF THE BIRTH OF AN AID OR IN VITRO CHILD

1. Secrecy of the AID and in vitro practice

As compared with other medical practices, artificial insemination by donor and in vitro fertilization are highly secretive.(1) There are a number of vital reasons for this, first, as the law stands at present(2) an AID child is illegitimate regardless of whether the husband had consented to AID or not.(3) For this reason AID babies are usually registered as being legitimate with the consenting husband entering his name as that of the father. However, in so registering a child, a husband is committing an offence in terms of section 46 of the Act.(4)

The secrecy which characterises AID has two components. First, the knowledge of the nature of his or her own conception is kept from the AID child. This is achieved by keeping the AID secret from all relatives and friends (unless of course they are already aware of the husband's sterility) and allowing them to assume that the conception was 'natural'. Secondly, there are the barriers to information which are put up between the accepting couple and the semen donor which ensure that the anonymity of the donor is preserved and that the donor remains unaware of the outcome of his involvement.

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(1) M Curie-Cohen, M S Luttrell & S Shapiro 'Current Practice of A.I. by Donor in the USA' (1979) 300 The New England Journal of Medicine No 11, 585 at 589.

(2) In terms of s 39 of the Draft Child Care Bill (28 October 1981) 7864 Government Gazette, any child conceived within wedlock by AID shall for all purposes in law be deemed to be the legitimate child of the mother's husband if both spouses consented to the AID.

(3) V v R 1979 (3) SA 1006 (T) at 1016 (D).

(4) Births, Marriages & Deaths Registration Act No 81 of 1963.

A third factor to consider is the social implication of AID, because it affects what many consider to be the basis of social organization within our society viz the family. The AID family is a special type of family because it is artificially created through the use of fertile semen donated by an anonymous third party. This act however, introduces an element of uncertainty into family relationships which traditionally rely on retaining pure bloodlines. If the status of illegitimacy were to be abolished or if family relationships were to be established on the basis of consent then the fact that a child was born as a result of AID would have no bearing on its status.

AID produces a family where blood ties on the husband's side are absent but where there is usually a pretence that they are present. This pretence keeps other kin in ignorance and the basis of the family relationship is artificially maintained by the continuance of this pretence over a long period of time, indeed, often for life. It seems reasonable to suppose that for some AID couples keeping such a long-term secret from one's kin may well lead to stress, which has to be dealt with in some way.(5)

2. Extent of Documentation of AID

The most accurate and comprehensive survey conducted to date on the practice of AID is that done by Curie-Cohen in the USA.(6) Their survey revealed

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(5) R Snowden, D Mitchell, 'Anonymous AID for the childless couple' (13 March 1980) New Scientist 828, 829.

(6) M Curie-Cohen, L Luttrell & S Shapiro 'Current Practice of Artificial Insemination by Donor in the USA' (15 March 1979) 300 New England Journal of Medicine 585.

In December 1977 the authors sent a questionnaire to each physician named in a listing of the American Fertility Society of physicians performing AID. They also sent questionnaires (9% of mailing) to authors of recent articles on the subject and to all medical-school departments of obstetrics and gynaecology. 94% of those surveyed were obstetricians and gynaecologists.

Each questionnaire contained 32 questions divided into seven sections , viz frequency of artificial insemination, success rate, donor selection, recipient, diagnostic testing, insemination procedure, population served and additional information.

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that 93% of physicians kept permanent records on the children born after AID, while only 30% kept any permanent records on donors. Furthermore 83% opposed any legislation that would mandate the keeping of records because it would make protection of the donor's anonymity more difficult.(7)

The fear of record keeping seems to be based primarily on the idea common in legal literature, that if identifiable(8) the donor might be sued for parental obligations (eg maintenance or succession) by one of his 'biological children', sired by AID, and that this suit might be successful.(9) The converse of this rationale is naturally that without the assurance of anonymity there would be no donors.

2.1. The need to keep records

2.1.1. In order to monitor the effectiveness of the sperm

It is important to maintain careful records of the product of a particular batch of sperm. In other words if a donor is used more than once, the birth of a defective child should be grounds for immediately discontinuing the use of the sperm for the protection of potential future children.(10) Since the survey revealed that most physicians have no policy on how many times they use an individual donor, while 6% had used one for more than 15 and one had used a donor

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(6) (continued from the previous page)
The researchers received 346 out of 711 questionnaires from the first mailing and 125 out of 354 from the second mailing, yielding a total return rate of 471 out of 1065 mailings or 44%. Their respondents were located in 46 states and the District of Columbia.

(7) Curie-Cohen, Luttrell & Shapiro op cit at 585.

(8) The doctor-patient relationship is not privileged in our law. A doctor can thus be forced to reveal the identity of a semen donor, cf Parkes v Parkes 1916 CPD 702.

(9) G J Annas 'Fathers Anonymous : Beyond the Best Interests of the Sperm Donor' (1980) 14 Family Law Quarterly 1 at 10.

(10) Kamlet (1975) 24 Cleveland State LR 341 at 354; Jewett (1968) 19 Syracuse LJ 1009 at 1026.

for no less than 50 pregnancies - this issue is far more likely to affect the life of a real child than the highly speculative lawsuit is to affect a donor.(11)

2.1.2. No meaningful study of the characteristics of donors can ever be made if there are no records kept concerning them.(12)

2.1.3. In those cases where family history is important (and surely it is sufficiently important to accurately record that of every donor) the AID child will never be able to accurately search his genealogical background.(13)

2.1.4. Most significant of all is the fact that unless records are kept, the child will never, under any circumstances be able to determine its genetic father. Since we do not know what the consequences of this will be, it cannot be said that destroying this information is in the best interests of the child. The most that can be said for such a policy is that it is in the best interests of the donor. However this is not a satisfactory situation vis-á-vis the child. Its effect is that the donor has a choice in the matter, but that the child has none. Furthermore, it is possible for the donor and physician to take steps to guard their own best interests, the child however, is not in a position to do the same.(14)

3. Should parents keep the AID and In Vitro origins of children secret?

A difficult question facing the husband and wife in an AID or embryo transfer (embryo donated) situation is whether the resulting child should be told of the circumstances of his conception, and whether, if he is not told, he is likely to find out.(15)

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(11) Annas (1980) 14 Family LQ 10; Sergeant (1970) 19 Drake LR 409 at 435.

(12) Annas (1980) 14 Family LQ 1 at 10; Charles C Thomas Artificial Insemination 2ed (1976) 77.

(13) Thomas ibid.

(14) Snowden & Mitchell (13 March 1980) New Scientist 828 at 829.

(15) Feversham Report 44.

There are various possibilities which exist in the above situation; eg if the couple are sufficiently well adjusted they will gradually forget about their recourse to donated genetic material and end up by genuinely believing the child to be fully their own. Alternatively if this does happen it is possible that it is due not to forgetfulness but to a deliberate suppression of the truth, which may be harmful to family relationships. It is further submitted that if the couple know that the husband's chances of fatherhood are remote they will not be able to permanently 'live a lie'. Circumstances requiring not merely avoidance of disclosure but misstatement of the truth must almost inevitably arise as the child approaches maturity.(16)

It is feasible that some people will be able to keep such a secret successfully from the child, while others may not be able to avoid revealing it either explicitly by their replies to the child's questions or implicitly by their conduct. The infertility of a couple who had a child by one of these methods might well become fairly widely known beforehand by reason of their need to go for treatment, and the child's arrival would then be an occasion for gossip and suspicion. While some couples could successfully keep the secret, there would always be the possibility of the child finding out about its genetic origins through circumstances beyond his parents' control.(17)

3.1. Should the Child be told of his Genetic origin?

In the fifties and sixties when AID was still a pioneer venture and embryo transfer and in vitro fertilization had not yet been attempted in humans, doctors advised parents not to tell the child of its origin. The reason for this advice was that public opinion was strongly anti AID and the stigma would have had serious repercussions for the child.(18) However, as a result of considerable

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(16) Feversham Report 44.

(17) Biskind (1965) 5 J of Family Law 39 at 49.

(18) Feversham Report 45.

publicity in the last ten to fifteen years, public opinion has become much more enlightened towards AID. The birth of the first child conceived in vitro viz Lesley Brown, was hailed in banner headlines world wide. She became an instant celebrity and certainly suffered no adverse publicity. Consequently doctors today are, by and large, encouraging parents to tell their children of their origins.(19)

It is further accepted that every child has a right to know who his real father and mother are, but there are occasionally circumstances unconnected with AID which may render the truth very harmful to a child and where on that account his right to know should be discounted.(20)

If the decision is taken to tell the child, the most appropriate persons to do so are obviously the mother or her husband. The next problem hinges on judging the most suitable age at which to inform the child; this decision is in practice not an easy one. The reason being that AID and embryo transfer are highly technical procedures which a child cannot be expected to understand at an early age; in fact he will not be in a position fully to comprehend these procedures until he knows, in some detail, what happens in sexual intercourse.(21)

Adoption is much easier to grasp and adoptive parents are advised to begin telling the child from a very early age that he was adopted, but it is submitted that it would be very difficult to explain AID or ET even in the most general terms to a child of tender years. Conversely if an explanation had to be deferred until a later age, it would extend the period during which a deception was practised on the child, and would make it more difficult for him to eventually accept the nature of his origin. Furthermore, the longer the parents delay telling the child the greater becomes the risk of its getting to know by accident.

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(19) Feversham Report 45.

(20) Snowden & Mitchell (13 March 1980) New Scientist 828 at 829.

(21) Mayo (1976) 50 Australian LJ 502 at 566.

The next stage in the child's life is adolescence, which, because it is considered to be a particularly vulnerable period and thus not suitable, would mean deferring the explanation to near adulthood.(22)

Ultimately the individual circumstances of each case will determine the moment of revelation, the effect of which on the child is unpredictable. However if the relationship between him, his mother and her husband was a happy one, and the explanation of his origin had been managed with tact and understanding, the emotional impact of the news would be considerably softened. But, whatever the circumstances of their revelation, the facts could scarcely be other than disturbing.(23)

4. Conflicting Interests of the Various Parties Involved

The interests of the parties involved in the artificial insemination or embryo transfer procedure are the major factors to be considered in deciding whether to disclose information concerning the biological father/mother. The parties directly involved viz the child, mother, acting father, acting mother, biological father, biological mother and physician - and their respective interests - are fairly similar to those involved in the adoption process. Consequently the disclosure provisions contained in adoption laws will be examined in order to determine whether they provide a possible basis for similar provisions which could be implemented with respect to AID and in vitro fertilization.

4.1. General - why are biological origins sought?

Several answers to this question can be advanced by drawing on proven information in the adoption context. This is necessary since to date there are no

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(22) P Creighton Artificial Insemination by Donor (1977) at 39.

(23) Feversham Report 46.

cases pertinent to the issue of disclosure in the AID or in vitro situation.(24) In South African law provision exists for a 'secret adoption'(25) in which, at the request of the adoptive parents(26) and with the consent of the natural parents,(27) the identity of the former is not disclosed to the latter. The court must be satisfied that such non-disclosure will be in the best interests of the child, and the Minister must approve thereof. Consent to a 'secret adoption' contains no reference to the identity or particulars of the proposed adoptive parents.(28) South African adoption legislation does not make express provision for revealing the name of the natural parents to an adopted child who has been adopted in accordance with the provisions of a 'secret adoption'.(29) However should the adopted child require urgent information regarding the medical condition of a natural parent he/she can make application to the Agency through which he/she was placed and they will attempt to obtain this information without revealing the identity of its natural parents.(30)

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(24) L A Smith 'Artificial Insemination Disclosure Issues' (1980) 11 Columbia Human Rights Law Review 87 at 90.

(25) In terms of the Regulations promulgated under section 92 of The Children's Act No 33 of 1960 in GN R 2433 (10 December 1976) 5357 Government Gazette (Reg Gaz 2402) regulation no 13(1) provides for '... a consent which does not set out the names and other particulars of the adoptive parents shall be made in the form of Form No 21 .... and may be accompanied by a statement in the form of Form No 22 signed by the parents, parent or guardian of the child to be adopted consenting to the non-disclosure to them or him of the identity of the applicants ....'

(26) GG 5357 Regulation 13(8), Form No 21.

(27) GG 5357 Regulation 13(8), Form No 22.

(28) Spiro Law of Parent and Child 3rd ed (1971) at 577; Boberg The Law of Persons & the Family (1977) at 357.

(29) The Act makes provision for rescission of the adoption under certain strictly defined circumstances, see section 76(2)(a)(b) & (c) none of which are apposite to revealing the biological parents' identity. See also Spiro op cit at 60, 61.

(30) Boberg op cit at 357; A Guide to Adoption Practice in South Africa (1972) 57.

In a country like the United States where AID is practised on a large scale the confidentiality of AID records particularly those of the donor's identity, are likely to be the subject of a great deal of litigation in the near future. This submission is made because of recent litigation in which adopted children have sought to learn the identity of their biological parents.(31)

The two most important reasons why adoptees seek disclosure of a parent's identity or other information concerning an unknown parent are, firstly, that ignorance as to the identity of one's biological parents can be psychologically disturbing to an adoptee. This problem has been described as 'genealogical bewilderment' which in turn results in insecurity and an underdeveloped sense of identity.(32) The second reason hinges on the concern an adoptee might have about the heredity characteristics of its unknown parent(s) and the possible impact of these genetic factors on the adoptee himself or his own children.(33)

The reasons expressed above apply equally in the AID context. However, should an AID child or a child born of a transferred embryo have the right to learn the identity of his natural father or mother?

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(31) J M Shaman 'Legal Aspects of Artificial Insemination' (1979/80) 18 Journal of Family Law 330 at 337. See In re Adoption of Female Infant 1979 5 Fam L Rep (BNA) 2311, in which an adoptee requested that her adoption records be revealed to her. She based her claim on the following grounds:

(a) her need to resolve the question of her identity,
(b) her desire to love and help the members of her biological family,
(c) her need to obtain medical information to guard her children against any possible hereditary diseases
(d) her children's right to know their blood relatives.

The court decided that these grounds were 'good cause' for disclosure of the information she sought.

(32) M Hanley 'A Reasonable Approach to the Adoptee's Sealed Records Dilemma' (1975) 2 Ohio Northern Law Review 542 at 546. In the case of In Re Ann Carol S 172 NYLJ 31 13 Aug 1974 at 12, a New York Surrogate Court granted an adoptee access to her birth records to foster her emotional/psychological well-being. While the court observed that 'mere curiosity' about one's forebears does not amount to 'good cause: for disclosure, disclosure is justified where a person's social adjustment is hampered by a lack of information about his/her natural parents. See also In re Anonymous 92 Misc 2d 244, 399 NY 5 2d 857 (Sup Ct 1977); In re Adoption of Spinks 32 NC App 422, 232 SE 2d 479 (1977).

(33) In re Anonymous supra; In re Adoption of Spinks supra; see also Klayman (1970) 39 Cincinnati LR 291 at 319.

4.2. The Interests of the Child in knowing its origins

4.2.1. Psychological need

The AID or ET child may have a strong psychological need to know the identity of his/her biological father/mother. However, the AID/ET child's psychological or 'genealogical bewilderment' needs are not as great as those of the adoptee since the former at least have knowledge about the identity and medical background of one parent.(34)

Notwithstanding the knowledge they have of one parent, AID/ET children are still likely to be hindered in the process of identity formation if they are denied information of their other parent. The development of a personal identity is a life-long process, and a healthy psyche may be impaired by lack of such vital information of one's origin.(35)

4.2.2. Medical Information

The need to obtain medical information about their AID/ET father/mother, which may be vital to them or their own children might be the reason that children, with this type of origin seek their true identities. This information can be readily supplied without revealing the donor's identity in New York where a statute requires physicians who perform AID to keep a medical history of donors.(36) This approach was adopted in Chattman v Bennett(37) where an adopted child sought access to her records of adoption to obtain medical information about her biological parents. The court allowed access to the medical information, but not to the identity of her natural parents. This approach would

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(34) E Klibanoff 'Genealogical Information in Adoption: The Adoptee's Quest and the Law' (1977) 11 Family Law Quarterly 195, 196.

(35) Shaman (1979/80) 18 J of Family Law 330 at 338.

(36) New York City Health Code (1959) para 21.07(a).

(37) 57 App Div 2d 618, 393 NYS 2d 768 (1977).

however be inadequate where the medical information on record about the donor is incomplete or not up to date. Should such an eventuality arise, the child may need to learn the donor's identity in order to obtain the necessary medical information directly from him.

4.2.3. To prevent incestuous marriages

Disclosure might be necessary to prevent an incestuous marriage between two AID children who have the same donor-father or two ET children who have the same donor-mother.(38)

If a physician practising AID/ET adopts a responsible attitude to the use of donors(39) eg by not using a donor for more than six pregnancies then it is highly improbable that such marriages are likely to occur. However, there was a case in Tel Aviv(40) and another in the United States in which a family doctor is reported as having discouraged two persons from marrying because he knew that the same AID donor was their biological father.

4.2.4. Inheritance

An AID/ET child may also seek to learn the identity of his/her natural father/mother so as to seek support from him/her or to claim a share in his/her estate upon death.(41) In order to protect the anonymity of the donors and not to discourage their willingness to act as donors eight jurisdictions in the United States have provided by way of statute that an AID donor has no obligation to support the child and furthermore that the child has no interest in the estate of the donor.(42)

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(38) Shaman (1979/80) 18 J of Family Law 330 at 339; N L Ros 'Artificial Insemination, Incest' The Washington Post 10 November 1974.

(39) Conversely Curie-Cohen et al (1979) 300 New England J of Med 585 589 reported that many doctors do not limit the number of times they use a particular donor.

(40) J Hoffer 'The Legal Limbo of AID' (1 Nov 1979) Modern Medicine 27; Curie-Cohen et al (1979) 300 New England J of Med 585 at 589; W J Finegold Artificial Insemination (1964) at 32.

(41) Curie-Cohen et al op cit 589; Shaman (1979/80) J of Family Law 330 at 339.

(42) Cf California Civil Code para 7005 (West 1979); Colorado Revised Statutes

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In the states which do not offer the donor statutory protection, his anonymity was guaranteed by physicians who inseminated patients with multiple donors in a single cycle, thus making the identity of the genetic father uncertain.(43) This practice has been further justified in the light of recent court orders in the USA to open the records of adoption agencies.(44)

It is however submitted that one should maintain a sense of balance and proportion in regard to undisclosed AID paternity by remembering that there is a higher percentage of unknown paternities in the general population arising from natural conceptions. Furthermore a high percentage of the putative fathers of these children could be excluded as the genetic fathers on the basis of blood and/or tissue typing.(45)

Despite the problems outlined above, it is submitted that accurate records of genetic paternity are important to provide AID/ET children with information which will satisfy their psychological needs and which may also be critical in the process of genetic counselling(46) which is becoming an increasingly useful

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(42) (continued from the previous page)
para 19-6-106 (1977); Conneticut General Statutes para 45-69 (1) (1975); Montana Revised Ann para 61-306 (2) (1975); Oregan Revised Statutes para 109-239 (1977); Texas Family Code Ann tit 2 para 12.03(b) (Vernon 1977); Washington Annotated Revised Code para 26.26.050 (2) (1978); Wyoming Statutes para 14-2-103(b) (1978).

(43) A R Holder Legal Issues in Pediatrics and Adolescent Medicine (1977) 25.

(44) In Spillman v Packer 332 SO 2d 573 (La Ct of App 1976), it was held that an adoptee's desire to determine whether he had inherited property from his biological parents constituted a valid reason for a court order releasing his adoption records to him.

(45) According to (April 1981) Stats at 54-57 the breakdown of illegitimate births amongst some of our population groups in 1980 was as follows:

	Total Number of Births	Illegitimate Births	Percentage of Illegitimates
Whites	72932	3285	4,5
Coloureds	67871	33402	49,2
Asians	19227	2324	12,1

(46) H Krever 'Some Legal Implications of Advances in Human Genetics' (1975) 17 Canadian Journal of Genetics and Cytology 283, 296; J Greenfeld

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tool in preventative medicine. However it is further submitted that in supplying this information to the child the donor's identity should not be revealed without his consent. For the doctor's performing AID and E/T paternity records are needed to evaluate semen and embryo fertility and the eugenic value of a donor through 'progeny testing'.(47)

4.2.5. Potential hazards which the AID/ET child faces

To sum up, we have seen that a married couple who have a child by AID or ET are faced with a dilemma in deciding whether to disclose the facts of the child's origin or whether they should say nothing and run the risk of his/her suspicions being aroused either by their demeanour or by what he/she may hear from others. It is submitted that this dilemma emphasises the fact that the AID/ET child enters the world under a potential handicap because of his/her unconventional origins.(48)

If the practitioner has chosen well and the mother and her husband are entirely suitable as parents, the child should not suffer in any way, in fact, he/she may be better off than many children conceived in the normal way but who have unsatisfactory parents. The parents and the physician must thus use the greatest care and circumspection in conceiving this type of child in order to minimize the possible harm to which the child is exposed, as with AID/ET it is impossible to be certain in any particular case that the child will be immune from harm.(49)

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(46) (continued from the previous page)
'Advances in Genetics that can Change Your Life' (1975) 51 Today's Health 20; E Glowienka 'A Brighter Side of the New Genetics' 25 (1975) 2 Bio Science 94; B D Davis 'Prospects for Genetic Intervention in Man' (1970) 170 (3) Science 1279; M A Grant 'Genetic Control and the Law' (1978) Medical Trial Technique Quarterly 307, 309.

(47) Grant (1978) Medical Trial Tech Q 307 at 310.

(48) Feversham Report 46.

(49) Smith (1980) 11 Columbia Human Rights Review 87 at 92.

The following are some of the hazards to which the child is exposed:

(a) Disclosure of his/her AID/ET origins.

(b) Harmful reaction to such disclosure.

(c) Uncertainty of his/her parentage.

(d) Unwise exercise of discretion by the doctor in his choice of donor on moral, physical or mental qualities

(e) Change of attitude on the part of the husband.

(f) Change of attitude on the part of the wife.(50)

It is submitted that in these matters the advocates of AID/ET tend to assume the optimum conditions, but that bearing the very definite potential hazards in mind it is not possible to be too careful in deciding to conceive a child in this way.(51)

4.3. The Interests of the Donor

The sperm/embryo donor has a greater interest in remaining anonymous than do the biological parents in an adoption setting. In the adoption context, the biological parents' interests are usually a reliance based upon a guarantee of anonymity and an interest in protecting themselves from any embarrassment or disruption caused by the reappearance of the adopted child.(52) Although these concerns apply equally to the AID/ET case the donors have an additional interest eg:-

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(50) Feversham Report 46; Shapiro & Spece Bioethics & Law 563-565.

(51) Thomas Artificial Insemination 2nd ed (1976) at 77; Kamlet (1975) 34 Cleveland State LR 341 at 352. Conversely the American writer Lillian Atallah recently revealed that when she was told at the age of 20 of her AID origins, her reaction had been that it was a good experience which gave her a new perspective. She said that, 'knowing about my AID birth did nothing to deplete my feelings for my family. I felt grateful, especially to my father for all the trouble they had taken to give me life,' she did add however that '... the news of a donor-father might well be traumatic to a young child' see New York Times 3 June 1976.

(52) Klibanoff (1977) 9 Family Law Q at 195; Shapiro & Spece Bioethics & Law (1981) 565-569.

(a) they do not even know if a child has been conceived with their sperm/embryo, whereas in the adoption situation the party (or parties) placing the child for adoption knows that a child was not only conceived but that the child was in fact born. Thus the 'reappearance' of a child in the AID/ET situation could be even more disruptive to the biological parent than it would in the adoption context.(53)

(b) It is unfair to the donor to reveal his identity or to impose the emotional or financial obligations of parenthood on him ex post facto when those were not his reasonable expectations.

The strange case of C M v C C(54) proved to be the exception to the rule as here was a situation in which the sperm donor in fact sought to enforce his parental rights vis-á-vis the child. The facts were that an unmarried girl became pregnant as a result of inseminating herself with sperm supplied by her boyfriend. After the third month of her pregnancy the relationship was terminated and after the birth of the child C C refused to allow C M the donor/father visitation rights. C M sued for, and was granted, these rights on the ground that as the child's natural father he should be allowed to exercise the responsibilities of parenthood. The court observed that there was no other person to act as the child's father and that it was in the child's best interest to have two parents whenever possible.

4.4. The Physician

The physician and/or sperm/embryo bank who maintain the records about a donor also have an interest in the disclosure issue. Drawing again upon the

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(53) Snowden & Mitchell (13 March 1980) New Scientist 828 at 829. Conversely one can argue that the biological father/mother will feel no disruption whatsoever upon the reappearance of the child since he never had the slightest attachment to the child. One cannot however, discount the possibility that the appearance of a stranger who claims genetic relationship might be disruptive, particularly if the child bears a marked resemblance to the donor.

(54) 152 N J Super 160, 377 A 2d 821 (Cumberland County Ct 1977).

adoption analogy, the comparison lies most closely with the adoption agencies' desire to protect the biological parents.(55)

The doctor who receives the sperm/embryo has an interest in preserving the physician-patient confidentiality and thereby encouraging future donations. Furthermore assurances of confidentiality enable the patient to discuss more freely possible medical, psychological or hereditary concerns.(56) Disclosure of this background information may be beneficial in two ways:

(a) if the additional information encouraged by the guarantee of confidentiality is included in the medical record, this information may be helpful to the child at a later time.

(b) a second benefit reaped from the confidential relationship of physician-patient is if the donor discusses his medical history more freely, the physician may become aware of reasons not to use the donor's sperm/embryo.(57)

4.5. The State

The state has an interest in maintaining the integrity of the AID/ET process because it can contribute to the stability of a marital situation by allowing a couple, one of whom is infertile, to have a child.(58) Moreover, public knowledge that there are or might be disclosures of donors' identities, or information about donors, might discourage future donors from contributing.(59)

By protecting the AID/ET family from the public stigmatization that might result from disclosure, while also shielding the donor's privacy the state is at the same time advancing its own interests by maintaining a stream of donors and thus promoting the stability of family life within a section of the population which is infertile.(60)

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(55) Application of Anonymous 82 Misc 2d 132, 390 NYS 2d 779, 781 (Surrogate's Ct 1976).

(56) L Hinkle 'Living with the Demands of Confidentiality' (1977) 9 Journal of Legal Medicine 230.

(57) Smith (1980) 11 Columbia Human Rights Review 87 at 94.

(58) Klayman (1970) 39 Cincinnati LR 291 at 296.

(59) Klayman ibid.

(60) Smith (1980) 11 Columbia Human Rights Review 87 at 94.

4.6. Society

Society has an interest in maintaining and strengthening the foundation on which it rests viz the estate of marriage, and of actively resisting any threats or influences which tend to weaken it or to threaten the security of children who are the product of a marriage.(61) It has been submitted that these interests are infringed by AID/ET in that it results in the procreation of a class of children who, whatever their legal status may be, are not permitted to know who their biological fathers/mothers are.(62) This fact is also withheld from society because it is only ascertainable by referring to the practitioner's confidential papers.(63) The possibility that AID is a threat to all children has also been advanced, in that if other children know that AID/ET is practised doubts about their parentage may well be raised in their minds, and because of the secrecy in which the practise is shrouded, they would find it well nigh impossible to establish whether they too were conceived in this way.(64) Thus the knowledge that there is uncertainty about the fatherhood of some is a potential threat to the security of all.(65)

However the question must be asked whether society in fact has a right to be able to identify a particular child as being the offspring of a particular biological father? It is submitted that it is doubtful whether society at large has such a right, since in most of one's dealings with one's fellow citizens it is of no consequence to know who the other person's biological father was.(66) On the other hand within

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(61) Feversham Report 44.

(62) Snowden & Mitchell (13 March 1980) New Scientist 828 at 829.

(63) Annas (1980) 14 Family LQ 10 & 11.

(64) Feversham Report 66.

(65) Feversham Report 66.

(66) Smith (1980) 11 Columbia Human Rights Review 87 at 94. Society could well have an interest in knowing who the 'legal' father was eg for purposes of maintenance, custody and guardianship Chapter 9 for detail.

a fairly wide circle of friends and relatives the reasonable assumption is usually made that the mother's husband is the father of the child or that the child was conceived from an embryo released by the mother's ovum.(67) It is a fact though, that with AID/ET it is usual for only the mother and her husband to be aware of the true facts, consequently the practice does result in the permanent (yet necessary?) deception of a considerable number of people.

A further consequence of AID/ET which deviates from the current accepted norms of society is that it dissociates the responsibility for physical procreation from the responsibility for the upbringing of the child thus created.(68) It is the custom of our society for a woman to choose a man who she knows and loves to beget children for her and to assist in their upbringing. Yet AID does not permit a woman to choose who shall be, in the physical sense, the father of her child. It substitutes an anonymous and mechanical procedure for an intimate personal relationship. It is submitted that this is not an ideal situation, but then neither is sterility. Any fertile couple would prefer to conceive a child which is genetically their own, but if faced with the choice of having a child by AID or ET or not having a child at all, most spouses would resort to the radical option of AID or ET rather than fatalistically accepting the burden of sterility. These processes do have the merit that they are able to transform an unsatisfactory, childless marriage into a happy, stable family unit.(69)

5. Circumstances under which disclosure may be contemplated

There are fewer so-called 'good cause' reasons justifying the disclosure of parental identity in the AID/ET situation than there are in the adoption situation.(70)

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(67) Feversham Report 67.

(68) Creighton Artificial Insemination by Donor (1977) 41.

(69) Arthur A Levisohn 'Dilemma in Parenthood : Socio-Legal Aspects of Human Artificial Insemination' (1959) 36 Chicago Kent Law Review 1 at 29; Klayman (1970) 39 Cincinnati LR 291 at 305-306.

(70) Eg whereas 'genealogical bewilderment' is a major factor justifying disclosure in the adoption situation its impact is lessened in the AID/ET context because the identity and familial history of one of the parents is readily available to the child.

In fact it is submitted that in the AID/ET context the identity of the sperm/oocyte donor should not be disclosed because he/she has a significant interest in maintaining the confidential nature of their identity.(71)

Furthermore the sperm donor is one step further removed from the conception of the child than are the biological parents in the adoption situation, in fact, the sperm donor's situation is analogous to that of the blood donor viz that it is clinical, impersonal and often undertaken for monetary reward.(72)

Situations can and do arise in which an AID child is justified in seeking information about his biological father. It is possible to furnish him/her with this information without revealing the donor's identity. In order to provide this information the practitioner should take a full physical and medical history of the biological father/mother at the time of receiving the donation.(73) By obtaining a complete medical history of the donor initially it obviates having to track down the donor at a later date and interfere with his privacy.

The following are suggested as ways in which the necessary information can be obtained from the donor's medical record without disclosing his/her identity. The AID/ET child having applied to court for the specified information, the judge would then order the practitioner in possession of the medical record to produce it. The judge or his appointee would then examine the record in camera in order to protect the donor's interests and privacy. The court or court appointee could then divulge the required information to the applicant without revealing any details which might result in identifying the donor.(74)

If in the court's opinion the information available from the record is insufficient for the child's purpose, it could instruct its appointee to trace the donor, obtain the additional information and then provide the applicant with it.

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(71) Smith (1980) 11 Columbia Human Rights Review 87 at 97.

(72) The going rate in the USA varies between $ 10 and $ 75 per specimen.

(73) Smith (1980) 11 Columbia Human Rights Review 87 at 98.

(74) Chattman v Bennett supra note 36.

If this method is employed the applicant should bear the costs of the search for his/her parent.(75)

In the event of the donor refusing to provide the information requested he should submit to the court his reasons for so refusing.(76) The court is then in a position to balance the interests of the two parties viz the donor's interest in nondisclosure and the child's interest in obtaining knowledge about his biological parent. Conceivably, should the court decide that the child's interest outweighs the biological father/mother's and should the latter continue to resist disclosure of information, the court could either use its power of contempt(77) or subpoena medical records from the donor's personal physician.(78)

It is submitted that regulation 13(8)(79) dealing with non-disclosure in adoption cases be amended so as to incorporate AID/ET.

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(75) In re Adoption of Female Infant supra note 31.

(76) In order for the donor's identity to remain secret, someone will have to represent his interests cf Application of Anonymous 89 Misc 2d 132, 390 NYS 2d 779 (Surr Ct 1976).

(77) Smith (1980) 11 Columbia Human Rights Review 87 at 100.

(78) Ibid.

(79) In GN R 2433 GG 5357 of 10 December 1976 (Reg Gaz 2402) see also Spiro Parent & Child 3rd ed (1971) 577. See page 294 for a discussion of the donor's position concerning disclosure and his liability for maintenance.

6. Registration of the AID/ET/IVF Child

6.1. The AID child

Technically the development of AID presented few conceptual challenges to the law. Conventionally the child's link to the preceding generation was based on genetic ties. The child was illegitimate if the father was not married to the child's mother at the time of conception or birth.(80) This is also the position in England(81) and in the majority of jurisdictions in the United States.(82)

According to the pater est quem nuptiae demonstrant presumption applicable in South Africa law the parents of the AID child could connive to register the child in terms of the Births, Marriages and Deaths Registration Act(83) as their own child. Such an act on their part constitutes an offence in terms of section 46 of the Act, but as long as there are no complications in regard to their marriage the secrecy attached to AID is likely to protect them from any prosecution and guarantee the 'legitimacy' afforded their AID child by virtue of being registered as a child of the marriage.(84)

In the Draft Child Care Bill published on 28 October 1981, the draftsman has adopted a very progressive approach to the legitimacy (and therefore registration) of the AID child. In section 39 of the Bill such a child is deemed to be legitimate '... for all purposes whatsoever in law ...' which would include registration as such, if the spouses consented to the AID. This is in line with existing

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(80) V v R supra at 1016 (D).

(81) J M Ekelaar (1980) 14 Family Law Q 43, 46; Feversham Report 27, 28.

(82) People v Sorensen supra 499.

(83) Act No 81 of 1963. In order to safeguard their AID secret, parents have also resorted to the subterfuge of entrusting the confinement and delivery of their child to a doctor other than the one who performed the artificial insemination. This devise will ensure that the wife's husband's name and not that of the donor is entered on the birth certificate cf S E Vecchi 'Artificial Insemination and Legitimacy in Pennsylvania' (1961) 66 Dickinson Law Review 1 at 9; Slagle (1969) 23 Arkansas LR 81 at 90.

(84) S A Strauss Doctor Patient and the Law (1980) 149; Biskind (1965) 5 J of Family Law 39 at 49.

legislation in a number of states in the USA[85] and is the approach recommended by the English Law Commission.[86]

The feature of this alternative means of legitimating the AID child is vested in the element of consent. It creates the recognition of a parent-child relationship, but divorces that relationship from the traditional dependency on the factual genetic link between father and child. In essence the concern for a genetic link is displaced by the informed consent of both parties to the AID.[87]

It is submitted that, with the proliferation of infertile couples resorting to AID as a means of achieving parenthood, the consent forms signed by them, as well as the donor, will assume an ever increasing significance, and these items could be filed in a central computerised registry. This would enable a proper monitoring of these records to be instituted which would make it easier to control the number of donations by a single donor thereby reducing the risk of subsequent incestuous relationships. A central data bank of this nature would also facilitate the use and retrieval of other essential information pertaining to AID.[88] On the other hand such a bank could lead to state control which should be avoided at all costs.

It is further submitted, and strongly emphasised, that it is vital to protect the privacy and identity of donors and recipients and to this end it is submitted that the names of donors and recipients which are filed into the data bank, should be coded and their names should only be released after application to court by the child and upon proof of the most compelling reasons for requiring this information.

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(85) Annas (1980) 24 Family LQ 1, 2.

(86) Law Commission Working Paper 74, 1979 para 10(9).

(87) D S Rosettenstein 'Defining a Parent : The New Biology and the Rebirth of the Filius Nullius' (22 October 1981) New Law Journal 1095.

(88) De Stoop (1976) 50 Australian LJ 298 at 307.

6.2. The in vitro child

6.2.1. Husband's semen

An analogy can clearly be established between an IVF child and one born as a result of AI with the husband's semen. Naturally a child born in this way is legitimate and no problem in regard to its registration in terms of the Act will arise.(89)

6.2.2. Donated semen

If the semen is provided by a person other than the husband, but with the latter's consent, the analysis in 6.1. supra is applicable, viz if genetic considerations are accepted as being the key consideration, the child will be illegitimate. However, if consent is taken to be the criterion, the child would be legitimate or would be considered as being the natural child of the woman's husband, and would be registered as such in terms of the Act.(90)

6.2.3. Oocyte donated

When the oocyte is donated by a third party, fertilised with the husband's semen and implanted in his wife's uterus, and one characterises the parent-child link on the basis of genetic considerations the child would be the genetic product of a man and a woman to whom he was not married. The child, it is submitted, would be illegitimate and would be registered as such.(91) However, according to South African law, illegitimacy is a status which established jurisprudential links between the child and the woman who gave birth to the child.(92) This result in turn rested on the assumption that the woman was the genetic mother of the child - which until recently was an unchallengable proposition.(93)

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(89) Mayo (1976) 50 Australian LJ 562 at 565; Glanville Williams The Sanctity of Life (1958) 124.

(90) Cf section 5 Act No 81 of 1963.

(91) Section 5 Act 81 of 1963; see also Rosettenstein (22 October 1981) New Law Journal 1095.

(92) Spiro Parent & Child 3rd ed (1971) 14; Van der Vyver & Joubert Persone-en Familiereg (1980) 515.

(93) Reilly Genetics & the Law (1975) 359 at 370.

Would it serve any useful purpose to challenge the legitimacy of a child born to a married couple where the wife received an oocyte donated by a third party? It is submitted that such a move would achieve very little because it would result in the fact that the law would be establishing links to someone (viz the oocyte donor who would insist on secrecy as a condition of donation) with whom the child would not normally be expected to come into contact. The end result would be that the child, in part de facto in part de iure, would become a latter day filius nullius.(94) If this analogy were to be applied in terms of the position as our law now stands, the child would be illegitimate and consequently it would have legal links with a mother (oocyte donor) who was in fact unknown, and in principle no legal links with a father who was known.(95) The child would in terms of our current law thus have to be registered as illegitimate in terms of section 5 of the Act.(96) Even if illegitimacy as a status were to be abolished, the definition of a parent on the basis of genetics would, in fact, only provide the child with a father.

7. Problems involving registration, official entries and misrepresentation

Additional problems flowing from registration and the child's consequent status arise in official documents eg proposals for an insurance policy or application for a passport which require the biological father or child to be identified.(97) This has obvious implications for AID/ET because a correct entry (which in view of the donor's anonymity would be impossible in most cases) would constitute a gross invasion of privacy. A false entry on the other hand, might constitute an offence or deprive the person concerned of some insurance policy or other benefit.(98)

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(94) Rosettenstein (22 October 1981) New Law Journal 1095.

(95) Spiro Parent & Child 3rd ed (1971) 14; Van der Vyver & Joubert Persone-en Familiereg (1980) 515.

(96) Births, Marriages & Deaths Registration Act No 81 of 1963.

(97) De Stoop (1976) 50 Australian LJ 298 at 307; Jewett (1968) 19 Syracuse LJ 1009 at 1026.

(98) Jewett ibid; W D Thies 'Property Rights and the Posthumously Conceived Child' (Nov 1971) Trusts and Estates 922; Sergeant (1970) 19 Drake LR 409 at 435.

A further problem arises if at any time during the AID/ET child's life, either his mother or her husband claims any property, allowance or tax concessions by representing the child as the child of the husband, he/she in so doing commits the offence of fraud or of making a false declaration.(99)

It is again submitted that the solution to these problems requires the draft Child Care Bill to be amended to include ET children together with AID children as qualifying to be registered as legitimate.

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(99) De Stoop (1976) 50 Australian LJ 298 at 307; Hager (1961) 39 North Carolina LR 217 at 232.

CHAPTER 9

LIABILITIES OF THE PARENTS OF AID/ET CHILDREN WITH REGARD TO CUSTODY, MAINTENANCE AND ACCESS

1. The Duty of Support or Maintenance of the AID child

The duty to support a child arises from the fact of parenthood[1] and not merely from the marriage.[2] When it thus comes to determining a father's duty of support[3] the law does not draw a distinction between legitimate and illegitimate children.[4] The obligation to support an illegitimate child is divided between its mother and father[5] in proportion to their respective resources.[6]

The maxim pater est quem nuptiae demonstrant will normally protect a child's right to claim maintenance from his mother's husband. Conversely,

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(1) Ford v Allen 1925 TPD 5 at 7; '... the obligation to render this support was regarded as arising from a sense of natural justice and filial and parental dutifulness and from the affection of blood ....'

(2) Boberg The Law of Persons and the Family (1977) at 338; Van Lutterveld v Engels 1959 (2) SA 699 (A); Holloway v Stander 1969 (3) SA 291 (A) The basis of the father's duty of support is paternity, not delict or quasi-delict see S v Swart 1965 (3) SA 454 (A) It is naturally a sine qua non that his paternity of the child is proved cf Van der Harst v Viljoen 1977 (1) SA 795 (C).

(3) In re Estate Visser 1948 (3) SA 1129 (C) at 1135; 'Die juiste posisie m.i. is dat 'n eis vir onderhoud as 'n skuldvordering sui generis beskou moet word wat nie met gewone krediteure kan kompeteer nie, maar wat, in 'n gewone saak 'n voorkeur bo erfgename en legate geniet.'

(4) Van der Vyver & Joubert Persone-en Familiereg (1980) 539; Tate v Jurado 1976 (4) SA 238 (W) 241; Sursathi v Elliott 1963 (3) SA 233 (D) 235.

(5) A v M 1930 WLD 292 at 293-294; '... the burden of maintaining a child is common both to the father and the mother unless one of them is indigent, and that burden applies whether the children are born in lawful wedlock or not .... The burden falls on the father and mother according to their means.'

(6) A v M supra 293-5; Lamb v Sack 1974 (2) SA 670 (T) 671-2.

however, and in order to protect the husband from having the duty and expense of maintaining a child he has not fathered, foisted on him, this presumption is rebuttable.(7)

The effectiveness of the pater est quem nuptiae demonstrant maxim was weakened by the General Law Amendment Act 46 of 1935. Prior to this Act our law had adhered to the rule that the spouses themselves could not give evidence 'to bastardise their own issue'.(8) It is submitted that in terms of this rule the AID and ET child would have enjoyed absolute security regarding its legitimacy as the parents are the only persons likely to initiate litigation to challenge the cloak of legitimacy which this maxim extends to the AID or ET child.

In terms of section 101(3) of the above Act both spouses are now competent to give evidence of such a nature that it would bastardise the child.(9)

By applying the well-established principles of our law enumerated above to the position of the AID child it follows that its natural parents viz its mother and the semen donor are liable to maintain their child. However the claim against the donor would be futile since he is protected from such liability by the secrecy surrounding AID.(10) The only chink in his armour however, is the fact that disclosures between doctor and patient are not privileged in South African law. A doctor could thus be forced, by a court, to reveal the identity of a semen or oocyte donor.(11)

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(7) As in Van Lutterveld v Engels supra where the court accepted evidence by a husband and wife that although they had shared a room, no sexual intercourse had taken place between them, and that the father of the wife's child was a nineteen year old youth whom she had taken as a lover.

(8) Williams v Williams 1925 TPD 538; Surmon v Surmon 1926 AD 47.

(9) Van Lutterveld v Engels supra; V v R 1979 (3) SA 1006 (T).

(10) Spiro (1972) Acta Juridica 213 at 215; see however the case of CM v CC 152 NJ Super 160 377 A 2d 821 (1977) (Cumberland County Ct) in which the donor sought and was granted rights of access to his child.

(11) Parkes v Parkes 1916 CPD 702.

Faced by the constraints of the secrecy in which the donor-father's identity was shrouded and by the practical demands of the situation, the court in V v R[12] held that where the husband had consented to his wife conceiving a child by AID, he, as the 'putative father', was liable to maintain the child,[13]

> 'Ek bevind ... dat geen ander man as die gewaande vader onderhoudspligtig is jeens so 'n kind nie ....'

The court's finding that the husband was liable for maintaining the AID child to which he had consented was certainly fair and equitable, but ran contrary to the currently established South African legal principles in this regard. Furthermore Steyn J's view, expressed in an obiter dictum,[14] that the husband who had consented to the birth of an AID child had a duty to maintain that child, founded on the analogy of a putative marriage, is unconvincing. I submit that he was driven to embracing the refuge of this rather forced analogy by the demands of justice and equity rather than current legal principle.[15]

1.1. Maintenance of the AID Child - alternative suggestions

The decision in V v R, was that the husband should be liable for maintaining the AID child. This decision, it is submitted, is neither consistent in terms of current SA law,[16] nor is it bold and inventive.[17] I therefore propose to examine alternative foundations for maintenance in our law by comparing SA law with the position in the USA and the UK.

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(12) V v R supra at 1015.

(13) V v R supra at 1015(B).

(14) V v R supra at 1012; J D van der Vyver 'V v R' (1980) 43 THRHR 1980 89 at 91.

(15) A putative marriage is invalid, but because of the bona fides of one or both of the spouses, any child born of such a 'marriage' is deemed to be legitimate. By analogy Steyn J argued, a husband who had consented to his wife's AID ought to be regarded as the 'putative' father of the child and consequently liable for its maintenance. It is submitted with respect, that Steyn's analogy cannot be supported by present SA law, because legitimacy depends on the relationship of the biological parents to each other at the time of the conception or birth or at any time between these dates, not on the acceptance of the child by a person other than its biological father.

(16) Sinclair (1979) Annual Survey of SA Law at 65; Nathan (1981) 10 Businessman's Law 121.

(17) P Pauw (1980) TSAR 192 at 195; Van der Vyver (1980) 43 THRHR 89 at 92.

1.1.1. South African Law

1.1.1.1. Liability of the husband based on boni mores

Support for the proposal that a husband should be held liable to maintain a child born to his wife, but not fathered by him, is found in the decision of the Maintenance Court in the case of F v F.[18] The husband in this case discovered that he was sterile, and, in order to fulfil his wife's craving for a child, he encouraged her to conceive by resorting to an adulterous union. This stratagem was successful and she was in due course delivered of a child which at least initially her husband treated as his own. He subsequently underwent a change of heart and deserted his wife. This act in turn led his wife to seek and be granted an order against him in the Maintenance Court of Ceres in terms of which he was ordered to make regular contributions towards the upkeep of the child born to his wife.

The Magistrate was hard pressed to motivate his judgment in terms of legal precedent, but submitted that a duty to support a child could perhaps be founded on boni mores,[19] in other words that a person (the husband) who had once accepted a responsibility towards another (the adulterine child) should be under a legal obligation to execute that responsibility even though the relationship between the persons concerned did not amount to a contractual liability. It is submitted that the Magistrate was indeed clutching at straws and that there is no such rule in South African law.[20] However, the principle that is abundantly clear is that a man cannot escape the obligation which rests on him to maintain his close

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(18) Case No 14/3/2 - 11/77 decided in the Maintenance Court of Ceres on 20 April 1977; see also F R Smit 'Die Saak van die Ingevoerde Bul'(1977) 12 Landros 134; see also Van der Vyver (1979) 96 SALJ 436.

(19) Smit (1977) 12 Landros 134.

(20) J D van der Vyver 'Legal Status of the Homo Novus' at 13. Paper delivered at a symposium on Genetics and Society held at the University of Durban-Westville on 13 & 14 July 1979.

relatives.(21) This obligation arises from a 'family duty'(22) which in turn stems from the fact of consanguinity.(23) This explains why the duty of support does not exist between a step-parent and a stepchild(24) or why it does not extend to relatives by marriage.(25) It therefore follows in terms of current SA law that in an AID situation a husband should not be compelled to maintain a child born to his wife if he was not the author of its being,(26) whether or not he consented to the AID procedure.(27)

1.1.1.2. Liability of the husband based on consent to AID

A further submission as to the legal basis for a husband's liability for his wife's AID child is contained in S A Strauss's article in the S A Medical Post.(28) His submission is based on the fact that the husband's consent renders him causally responsible for the child's birth and hence its maintenance:

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(21) Ford v Allen supra; A v M supra; Lamb v Sack supra.

(22) Voet 25.3.4; A v M supra; Ford v Allen supra.

(23) D 25.3.5.2; Ford v Allen supra.

(24) Joffe v Lubner 1972 (4) SA 521 (C) 523-4; Wilkie-Page v Wilkie-Page 1979 (2) SA 258 (R) 259.

(25) Ford v Allen supra.

(26) Van der Vyver (1979) 96 SALJ 436. Yet in V v R supra at 1015(B) Steyn J, in attempting to arrive at an equitable decision extended the definition of father to include the husband who consents to AID under the aegis of a putative father. This in turn would render him liable for maintenance of the AID child he had consented to, without however, granting him any of the normal rights of a father such as guardianship.

(27) In terms of the provisions of section 39 of the Draft Child Care Bill the spouses' consent will in fact form the basis for the AID child's legitimacy and hence the husband's duty of maintenance.

(28) S A Strauss 'Do we need to legislate?' (28 Oct 1978) South African Medical Post 7.

> 'It is questionable, however, whether a consenting husband could evade liability for maintenance of the child by subsequently proving that the child was conceived in AID. In my opinion no court would allow a husband in these circumstances to renounce his responsibility to maintain a child where, through his voluntary collaboration with the AID he was also "causally" responsible - at least in a juridical sense - for the birth of the child.'

Strauss sought authority for the above submission in a dictum of Briggs J in R v Chenjere[29] in which he held that where a third person takes a mother and her young child from the protection of the natural guardian, husband or father with the apparent intention of forming a new 'family' relationship of a permanent nature, the third person assumes a protective relationship towards the mother and child. Extrapolating the above concept to the AID maintenance situation was, according to Strauss:[30]

> '... a small step ... for a court to rule that the voluntary acceptance of an AID child in a marriage relationship amounts to an assumption of a protective relationship involving the duty of maintenance.'

It is worth noting that Strauss's submission is contradicted by a dictum of Rosenow J, in S v Macdonald:[31]

> 'The authorities appear to be unanimous on the point that a step-father is not obliged to support a stepchild, so much so that in certain instances he could even require a refund of money spent in maintenance ....'

Steyn J's concern for the welfare of the AID child in V v R, hampered as it was by the well entrenched principles of our law in regard to maintenance, which was in turn tied to legitimacy or a biological link, led him to come to an inconsistent decision in this regard. On the one hand he held that the 'putative' father who had consented to his wife being inseminated by AID was liable for maintaining the child, yet on the other hand he was not prepared to grant him the other rights which accompany parenthood.[32]

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(29) 1960 (1) SA 473 (FC) 482.

(30) Strauss (28 Oct 1978) SA Medical Post 7.

(31) 1962 (2) SA 431 (C) at 432.

(32) V v R supra at 1015 (B-C); see also Pauw (1980) TSAR 192 at 194-195 and Sinclair (1979) Annual Survey of SA Law at 66.

It is submitted that part and parcel of a husband's consent to AID is the fact that his consent amounts to a waiver of the right to rebut the presumption of fatherhood in all its aspects and cannot be selectively applied to the aspect of maintenance alone.(33) A husband, when he decides to father a child, assumes all the duties and responsibilities which attach to the role of a father. He cannot contract out of any of the responsibilities which the law attaches to parenthood.(34)

Alternatively our law does not expect a man to maintain an illegitimate child of which he is not the father. The father of an illegitimate child is obligated to maintain that child by virtue of his biological link with the child.(35) The husband in an AID situation does not have that link but it is submitted that the link by blood can be substituted by a link established by consent.(36) But then the link of fatherhood must be one which establishes a complete parental relationship.

1.1.1.3. The provisions of the Child Care Bill

It would appear that Strauss's rhetorical question in his article in the S A Medical Post as to whether legislation to regulate AID was necessary has been answered in the affirmative by the legislature's publication of the Child Care Bill section 39 of which reads as follows:

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(33) Pauw (1980) TSAR 192 at 197.

(34) Shields v Shields 1946 CPD 242- 243:

> '... I am not prepared to make it an order of Court in that form, because it does not seem to me that a parent, the mother in this case, on behalf of the child to be born should be allowed to agree that the husband shall not be responsible for the maintenance of that child. It seems to me it is contrary to public policy ... and I do not approve of it.'

(35) Ford v Allen supra.

(36) Anonymous v Anonymous 41 Misc 2d 886, 246 NYS 2d 835 (Sup Ct 1964).

'(1) Any child conceived within wedlock by means of artificial insemination shall for all purposes whatsoever in law be deemed to be the legitimate child of his mother's husband if both mother and her husband requested or consented to the said artificial insemination.'

'(2) For the purpose of subsection (1) artificial insemination shall include the artificial insemination of any woman with the semen of a donor who is not her husband.'

The logical conclusion to be drawn from the provision that the AID child will be the legitimate child of its mother's husband for 'all purposes whatsoever in law' is that this will include the obligation of maintenance. The AID child's position will then be analogous to that of the adopted child viz AID would have imitated nature to the greatest possible degree.

2. Maintenance of the AID child in the USA

Generally speaking, according to most state legislation in the USA, a husband is not liable to support a child born to his wife but not procreated by him. If an AID child is considered to be illegitimate then the donor, not the husband, is responsible for support; but it is unlikely that he will ever be called upon to actually pay maintenance as he will be protected by the secrecy surrounding AID.(37) However, despite this accepted principle, the courts resorted to a number of strategems in order to provide the AID child with the maintenance he required but which his novel form of conception denied him.(38)

2.1. Gursky v Gursky(39)

In this case an annulment was granted by the trial court because the husband was unable to consummate the marriage. When the couple had discovered

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(37) J M Rockett 'Legal Consequences of Artificial Insemination : The California Answer' (1968) 3 Univ of San Francisco Law Review 178 at 184; Sergeant (1970) 19 Drake LR 409 at 430.

(38) Drumheller (1968) Un of Illinois LF 203 at 221; Kamlet (1975) 24 Cleveland State LR 341 at 346.

(39) 242 NYS 2d 406, Misc 2d 1083 (Sup Ct 1963).

the husband's infirmity, they decided that the wife should be artificially inseminated with the semen of a donor. Both husband and wife signed the proper consent for the procedure. The husband agreed to pay all expenses and signed a contract for waiver of liability as well as for medical treatment. A child was born to them and the husband was listed as its father on the birth certificate.

The court ruled that though the child was illegitimate, the husband's declarations and conduct implied a promise on his part to furnish support for the child and that he should be required to pay support upon granting the wife annulment. The court pointed out that the document signed by the husband in giving his consent constituted more than mere acquiescence and was in fact a request to the physician to perform AID for the express purpose of providing a child for the mutual happiness of the parties. Thus, it was reasonable to presume that the wife was induced to act or change her position to her detriment in reliance upon the husband's express wishes. Liability was based not only on the above implied contract, but also on the alternative ground of equitable estoppel.(40)

It is submitted that the decision in Gursky's case is open to criticism in that it appeared unable to modify common law concepts so as to render them compatible with a situation created by modern technology. This decision is similar to our own V v R in that the husband who consented to his wife's insemination with the semen of a donor ended up having to maintain the child. The unkindest cut was the fact that despite his attempt to compensate for his inadequacy by consenting to the AID his marriage was annulled.(41)

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(40) Sagall (1973) 9 Trial 59 at 61; Sergeant (1970) 19 Drake LR 409 at 431; Rockett (1968) 3 Un of San Franscisco LR 178 at 184.

(41) Kamlet (1975) 24 Cleveland State LR 341 at 346.

2.2. Anonymous v Anonymous[42]

This was a divorce action which followed the ratio of the earlier decision in Gursky with regard to the implied promise theory of support, and ordered the husband to pay temporary support to sustain his wife and the two children conceived by AID with his consent.[43]

The reasoning in the two cases supra reflects the doctrine of promissory estoppel and implied contract as set out in the Restatement of Contracts.[44]

> 'A promise which the promisor should reasonably expect to induce action or forebearance on the part of the promissee or a third person and which does induce such action or forebearance is binding if injustice can be avoided only by enforcement of the promise.'

The courts could thus reasonably hold that the consent of the husband to AID constituted an implied promise that the child would become a part of his family and be supported by him, and, in addition, because the wife relied and acted on this promise given by her husband, he would be estopped from refusing to support the child.[45]

2.3. People v Sorensen[46]

The trend towards liberalisation of AID by the courts began with the above case which also saw the culmination of the various statutory and non-statutory considerations on AID with the husband's consent. This was also the first AID case which was decided at State Supreme court level.[47]

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(42) 41 Misc 2d 886, 246 NYS 2d 835 (Sup Ct 1964).

(43) Supra at 887, supra at 836.

(44) Restatement (Second) of Contracts para 90 (1965).

(45) Sergeant (1970) 19 Drake LR 431 at 432; Jacobs & Luedtke (1965) Wisconsin LR 859 at 880.

(46) 68 Cal 2d 280 437 P 2d 495, 66 Cal Rptr 7 (1968).

(47) Kamlet (1975) 24 Cleveland State LR 341 at 346.

The Supreme court, in finding that Sorensen was liable to support the AID child born to his wife, rejected the implied contract approach of the New York court in Gursky. Instead the California court employed a rationale which resembled estoppel but went further than a normal application of estoppel would by stating affirmatively that the husband of the recipient was the legal father of the child, because the AID child did not have a natural father(48) as the term is generally understood. The decisive factor was whether the legal relationship of father and child in fact existed.(49)

The court added that a reasonable man who, because of his sterile condition, consents to AID should know that his behaviour carries with it legal responsibilities for support:

> '... a reasonable man who, because of his inability to procreate, actively participates and consents to his wife's artificial insemination in the hope that a child will be produced whom they will treat as their own, knows that such behaviour carries with it the legal responsibility for non-support.'(50)

The court logically pointed out that the child would not have been born without the husband's active participation and consent.(51) Upholding the husband's conviction of the crime of failing to support his child, the court concluded that the husband cannot create a temporary relationship which can be assumed at will, but that the arrangement must be of such a nature as to impose on him the obligation of supporting those for whose existence he is directly responsible.(52) The main policy ground for the court's decision to impose criminal liability was the state's interest in protecting the public from the burden of supporting the neglected child.(53)

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(48) In terms of the Cal Penal Code para 270 (West 1970) the court held that the meaning of the word 'father' was not limited to the natural or biological father but extended to the legal father, a relationship determined by the court.

(49) Rockett (1968) 3 Univ of San Francisco LR 178 at 184.

(50) Sorensen supra 291, 66 Cal Rptr 11.

(51) Sergeant (1970) 19 Drake LR 431 at 432.

(52) Rockett (1968) 3 Univ of San Francisco LR 178 at 184; Sagall (1973) 9 Trial 59 at 61.

(53) Sorensen supra at 287, 66 Cal Rptr at 12.

The question which we must now ask ourselves is whether the decisions in Gursky and Sorensen provide any examples of legal principles which the South African courts can draw upon to assist them in developing our law regarding the AID child. Sorensen's case, it is submitted, provides a good example of a bold innovative judicial decision which surmounted the problems which can occur when technology advances beyond the existing principles of the law. The solution was provided by the simple devise of extending the meaning of the word 'father'. In South African law a man who is not the natural father of a child can currently only acquire the status of a parent by means of adoption, or by marrying a pregnant woman and then relying on the pater est quem nuptiae demonstrant presumption to provide him with the status and position of a parent.(54)

It is submitted that Steyn J in V v R(55) could have extended the meaning of 'father' in our law to create a new category of parent viz the 'lawful father' ie the husband who consents to his wife being inseminated with the semen of a donor.(56) He chose instead to only go half-way towards an acceptable and equitable solution by resorting to the analogy of the 'putative father'.(57)

It is further submitted that a husband who consents to his wife being inseminated with the semen of a donor should be estopped from denying responsibility for maintaining a child which is subsequently born.(58) The husband could hardly argue that he had only consented to the birth and not the ensuing maintenance. Maintenance is an automatic consequence of parenthood.(59) Alternatively it is submitted that the husband's consent to the AID could amount to an

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(54) Park v De Necker 1978 (1) SA 1060 (N) at 1061-1062.

(55) 1979 (3) SA 1006 (T).

(56) Pauw (1980) TSAR 192 at 194.

(57) Supra at 1015(A); see also Sinclair (1979) Annual Survey of SA Law at 65.

(58) Van der Vyver 'Legal Status of the Homo Novus' 16. Paper delivered at a Conference held at University of Durban-Westville 13 July 1979.

(59) Holloway v Stander 1969 (3) SA 291 (A); Sager v Bezuidenhout 1980 (3) SA 1005 (O) at 1009(A).

implied contractual undertaking to assume the responsibility of maintenance.(60)

It is submitted that should the Child Care Bill become law that the provisions of section 39 are such as to place the responsibility for maintenance firmly on the shoulders of the husband who consents to AID.(61)

3. Maintenance of the AID Child in the United Kingdom

It would appear that the maintenance problem concerning the AI child has been resolved by the Matrimonial Proceedings (Magistrate's Court) Act 1960 in terms of which the courts' powers in regard to custody, access and maintenance of a 'child of the family' are set out. 'A child of the family' is defined as including:(62)

> 'Any ... child of either party who has been accepted as one of the family by the other party.'

Furthermore by virtue of section 2(5) of the Act the court may include in a matrimonial order provision for the payment of maintenance by one of the parties in respect of a child of whom that party is not a natural parent:

> 'In considering whether any, and if so what [maintenance] provision should be included in a matrimonial order for payments by one of the parties in respect of a child who is not a child of that party, the court shall have regard to the extent, if any, to which that party had, on or after the acceptance of the child as one of the family assumed responsibility for the child's maintenance, and to the liability of any person other than a party to the marriage to maintain the child.'

A number of provisos must be met before section 2(5) can be implemented, eg it must be proved:

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(60) Van der Vyver 'Legal Status of the Homo Novus' 16.

(61) (28 Oct 1981) Government Gazette No 7864.

(62) See section 16(1).

(a) that the acceptance is into a family. Simply allowing a child to live in the matrimonial home does not constitute acceptance.(63)

(b) that the acceptor had full knowledge of all the relevant facts at the time of acceptance.(64)

(c) that the relevant time for determining whether there has been acceptance has been established.(65) This is normally the date of the marriage.

(d) that the children of one spouse were accepted by the other spouse as children of the family.(66)

In a concurring judgment in Bowlas(67) Salmon J added that the mere fact that a man marries a woman with children does not necessarily imply that he accepts those children as members of the family.

It is submitted that the terms of section 39 of the proposed Child Care Bill regulating the position of the AID child are much tighter and less open to ambiguity(68) than the British Matrimonial Proceedings Act with its reference to 'a child of the family'.

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(63) B v B [1969] P 37; Bowlas v Bowlas [1965] P 450; [1965] 3 All ER 40.

(64) R v R [1968] P 414; Kirkwood v Kirkwood [1970] 11 WLR 1042.

(65) Snow v Snow [1972] Fam 74.

(66) Dixon v Dixon [1968] 1 WLR 167.

(67) Bowlas v Bowlas supra.

(68) Problems could for example arise where the mother of an AID child and her husband live apart and proceedings are taken by one of the parties to the marriage for maintenance or custody of the child. In such issues the paternity of the child might become an issue (as it did in V v R). Should the presumption of legitimacy be rebutted and the child declared illegitimate, the respective rights of the parents and the child could be affected as a result of the child's status - especially where the child is found not to be a 'child of the family' or 'of the marriage'.

4. Maintenance Rights of the IVF & ET Child

In the absence of legislation or judicial precedent regulating this aspect of the IVF and ET child's position I propose to formulate the position as best I can by applying the established principles relating to maintenance to the various permutations involving IVF and ET.

Regardless of its legal status ie whether it is legitimate or illegitimate the duty to support a child rests upon its natural parents.(69) I will also work on the assumption that the term parent refers to the genetic parent.(70)

4.1. Wife's ovum, husband's sperm, wife carries the child

This particular combination presents no problem at all. The husband and wife are the natural parents of their child and as such are liable to maintain it. The only difference between it and a normal child is that instead of being conceived in its mother's womb it is conceived in vitro and reimplanted into its mother's womb in the form of a blastocyst.

4.2. Wife's ovum, donor's sperm, wife carries the child

In this set of circumstances the wife's ovum is fertilised in vitro and the blastocyst is reimplanted into her uterus. Consequently the wife and the sperm donor will be the child's natural parents and as such liable to maintain the child. However practically speaking the secrecy surrounding the sperm donor will protect him from ever being pinned down to this obligation. The husband would under normal circumstances have consented to his wife's conception in this way and for as long as the marriage survives and is happy there can be little doubt that the husband will maintain his IVF child.(71) It is only in the event of a divorce

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(69) Voet 23.3.5; Lamb v Sack 1974 (2) SA 670 (T).

(70) Reilly Genetics and the Law (1975) 372.

(71) Furthermore if Steyn J's decision in V v R supra at 1015, viz that the child fathered by a donor's sperm but with his consent, is analogous to the ET situation, and I can see no reason why it should not be, then it appears that there is legal precedent for holding the husband liable for maintenance and not merely on pragmatic/equitable reasons.

that the possibility will arise that the husband will deny paternity in order to escape future maintenance liabilities. It is submitted, that should this happen, the husband would be in the same position as the husband who consents to AID. He will be bound to maintain the child by virtue of his consent.(72)

4.3. Husband's sperm, ovum donated, wife carries the child

The natural parents of a child conceived in this way are the husband and the oocyte donor, and under normal circumstances the law would lay the liability for the child's maintenance at their respective doorsteps. However practically speaking the oocyte donor would be protected by a veil of secrecy which would shield her from such liability. Once again the likelihood of a maintenance dispute arising would only occur if there was a divorce and the child's parenthood was disputed. In this type of situation it is totally impractical to link maintenance responsibilities to genetic parenthood exclusively, because the child's genetic mother is unknown. It is submitted, for the reasons advanced below, that the husband and his wife should be the 'parents' who are liable for the child's maintenance.(73)

In our example the ET child has two mothers - a genetic mother, who donates the oocyte, and a gestational or womb mother who actually nourishes, carries to term and gives birth to the child. It is submitted that this latter mother should be awarded the custody of the child and should have to bear a portion of the cost of its maintenance because in addition to her gestational link with the child she has given an informed consent to participate in its birth and to assume parental responsibilities for it.(74) The husband is the child's natural father and there is thus no way in which he can escape his liability to maintain the child he has fathered.

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(72) V v R supra at 1015(A); People v Sorensen supra at 437.

(73) Reilly Genetics and the Law (1975) 372.

(74) Oakley (1974) 8 Family Law Q 385 at 392; Rosettenstein (28 Oct 1981) New LJ 1095 at 1096.

In Shields v Shields,[75] for example, it was held to be contrary to public policy for a mother to consent to her husband contracting out of his duty to maintain his child after their divorce. The right to maintenance of a child against its natural parents is an inalienable right which the courts will jealously guard.

4.4. Wife's ovum, husband's sperm, hostess mother

In this set of circumstances the spouses are the genetic parents of the ET child and although the hostess mother carries it to term the child will be returned to the custody of its natural parents in accordance with the terms of their contract.[76] It is submitted that they are thus liable to maintain the child both during the course of their marriage and after a divorce in proportion to their respective means.[77]

4.5. Wife's ovum, donor's sperm, hostess mother

In this situation the wife and the sperm donor are the natural parents of the child and thus in terms of our law the duty of maintenance rests upon them. But again the practicalities of the situation dictate that the husband will provide the maintenance if he has consented to the child's birth.[78]

4.6. Wife's ovum (Mrs X), donor's sperm (Mr A), hostess mother (Mrs A)

In this permutation we have the rather bizarre situation that the sperm donor and the hostess mother are in fact married. Applying our established legal principles the child's natural parents are Mrs X and Mr A who should thus according to established legal principles, be liable for its maintenance,[79] but I submit that for practical reasons, Mr & Mrs X should be responsible for the maintenance of

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(75) 1946 CPD 242.

(76) Brophy (1981/2) 20 J of Family Law 263 at 268.

(77) Louw v Van Rensburg 1982 (3) SA 36 (SWA) at 39(D-E); Lamb v Sack 1974 (2) SA 670 (T).

(78) V v R supra 1015; see also note 71 supra.

(79) Lamb v Sack supra at 671(F-G).

the child.(80) The child is in their custody and was conceived as a result of their initiative and consent. Furthermore the child is genetically Mrs X's child, and because it is in their custody the child establishes social and psychological links with Mr & Mrs X.(81) They have a normal parental relationship with the child and it is thus submitted that as is the case with normal biological parents they should be responsible for the maintenance of the child.(82)

5. The Custody(83) of the AID child

During the course of the marriage the spouses will exercise their parental power and thus their custody of the AID child in the same way as normal married couples do in relation to their legitimate offspring. The problem as to who is to have custody of the AID child when its parents are divorced and whether the courts will apply the criteria of the best interests of the child as they do to deciding the custody of married couples with legitimate children is uncertain at present.

5.1. Rights of Mother to custody

In terms of current S A law an AID child is illegitimate.(84) Under normal circumstances the mother of an illegitimate child is its custodian from birth.(85) However the Supreme Court is in terms of our common law the upper guardian of all minors(86) and as such it is empowered to interfere with the parental power of a parent who exercises this power in a manner which

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(80) Rosettenstein (22 Oct 1981) New Law J 1095 at 1096.

(81) Oakley (1974) 8 Family LawQ 385 at 392.

(82) Reilly Genetics and the Law (1975) at 372.

(83) The term 'custody' in this section will be used in the sense that it includes all incidents of parental power concerning the person of the minor illegitimate child.

(84) V v R supra at 1015.

(85) Mathews v Haswari 1937 WLD 110; Mariam v Potchi 1916 37 NLR 363; Basetti v Louw 1980 (2) SA 225 (W).

(86) Grotius 1.7.10; Voet 26.5.5; Coetzee v Meintjies 1976 (1) SA 257 (T).

constitutes a danger to the life, health, morals or property of a minor.(87) One can safely assume that the Courts will exercise their discretion to interfere with parental authority in the case of one parent families as well(88) (ie where the child is illegitimate). It is submitted that the courts will apply the well established criterion of what is in the best interests of the minor child in order to determine whether its mother is in fact a suitable person to have custody or not, to AID cases as well. If she is found not to be suitable the court is empowered to award custody to a third party.(89)

5.2. Rights of the Sperm Donor to custody

The sperm donor or natural father of an AID child is usually protected by secrecy from being a party to any custody proceedings,(90) but in the case of CM v CC(91) a semen donor sought and was granted rights of access to his child. The mother of the child was however unmarried. If the child was born to a married couple and the donor sought custody of it(92) he would first have to rebut the presumption of pater est quem nuptiae demonstrant(93) and then prove that it would be in the child's best interests to be in his custody before he would succeed with his claim.(94) It is submitted that only in the event of the spouses

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(87) Calitz v Calitz 1939 AD 56; Botes v Daly 1976 (2) SA 215 (N).

(88) E Spiro 'Custody Orders in respect of Minors with one Parent' (1958) 21 THRHR 16 at 17; Rowan v Faifer 1953 (2) SA 705 (E) at 711; Ex parte Van Dam 1973 (2) SA 182 (W); C Nathan 'A Father and His Illegitimate Child : Towards a More Permanent Relationship' (1980) 43 THRHR 293.

(89) Rowan v Faifer supra; Ex parte Van Dam supra.

(90) In the English case of A v C 8 Family Law 1978 70 it was held that the donor has locus standi to bring an action for care and control of his AID child.

(91) 152 NJ Super 160 377 A 2d 821 (1977) (Cumberland County Ct).

(92) In Rowan v Faifer supra the court held that the father of an illegitimate child has locus standi to institute a claim for custody.

(93) Van Lutterveld v Engels 1959 (2) SA 699 (A).

(94) Van Oudenhove v Gruber 1981 (4) SA 857 (A).

getting a divorce and furthermore if it was proved that neither of them was a suitable person to have custody of the child would the donor's claim for custody have any hope of success.

It is submitted that when the Child Care Bill[95] becomes law provisions of section 39, which declare the consenting husband to be the AID child's father, will have the effect of severing what tenuous links there might be between the sperm donor and the AID child under current SA law.

5.3. Rights of the Husband to Custody

We have seen that as upper guardian of minors the Supreme Court may in its discretion award custody to a third party should the mother of an illegitimate child be deemed to be unsuitable for the role.[96] It is submitted that in an AID situation where the husband has consented to his wife giving birth to a child and where that husband has established a close, happy and loving parental relationship with the AID child, that he should qualify as a suitable 'third party' to whom the court could grant custody of the child.[97]

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(95) (28 Oct 1981) Government Gazette No 7864.

(96) Rowan v Faifer supra; Wehmeyer v Nel 1976 (4) SA 966 (W).

(97) Ex parte Van Dam supra 185:

'In the present case the mother and natural guardian of the illegitimate child wishes to renounce and surrender her guardianship on the ground that it would be in the interests of the child that the applicant should be the guardian. It is plainly not competent for a natural guardian to renounce guardianship in favour of a third person at will ....

However there are special circumstances in the present case and I am satisfied that it will be in the best interests of the child that the father and de facto guardian hitherto should continue to occupy a position of parental authority.'

See also the obiter of Steyn J in V v R supra at 1016 where he expresses the opinion that:

'Ek meen dat die term "gewaande vader" 'n paslike beskrywing van so 'n eggenoot is en dat 'n gewaande vader die verpligting tot onderhoud en regte van voogdy ten aansien van die kind het.'

In the case of Crane v Battle[98] an husband and wife had been separated for a period of seven years when a child was born to the wife. The husband could not possibly have fathered the child, yet he petitioned for paternity of his wife's child. He alleged that he was the putative father of his wife's child and that in terms of section 511 of the New York Family Court Act the court was empowered to declare him to be the child's father. The court, relying on section 511 declared him to be the father of the child.

Section 511 reads as follows:

'Jurisdiction: The family court has exclusive original jurisdiction in proceedings to establish paternity, and in such proceedings in which it makes a finding of paternity, to order support and determine custody as set forth in said article.'

5.4. Access rights of parents in regard to an AID child

The rights of parents of an AID child to access must be approached in the light of the fact that the child is illegitimate in terms of current law.[99] The natural father of a normal illegitimate child may apply for rights of access to the child.[100] In an AID situation the problem is more complex. The sole criterion on which a court will determine whether access should be granted or not, is whether it is in the interests of the minor illegitimate child that its natural father should have access or not.[101] This issue is only likely to arise in the event of the parents of the AID child seeking a divorce.

The natural father of the AID child is the sperm donor who desires above all else to remain anonymous and not to have any involvement with the offspring he has fathered. There are however rare exceptions of donors seeking access to their offspring.[102]

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(98) 307 NYS 2d 355.

(99) V v R supra at 1015.

(100) Rowan v Faifer supra; Mathews v Haswari 1937 WLD 110; Wilson v Eli 1914 WR 34; Spiro Law of Parent and Child 3rd ed (1971) at 426.

(101) Rowan v Faifer supra; Spiro ibid.

(102) CM v CC supra; A v C supra.

5.4.1. Donor's rights to access

The facts in the reported cases on this issue are rather bizarre and they come to opposite conclusions as to the donor-father's right to access.

5.4.1.1. C M v C C[103]

The facts in this case were that CM (an unmarried man) was seeking rights of custody and visitation to a child born to a friend CC (an unmarried woman) as a result of sperm donated by him. CC wanted a child but refused to have normal intercourse with CM before they were married. They approached a sperm bank for assistance but the doctor in charge declined to assist them. He did however explain to them the procedure used for achieving artificial insemination which involved the use of a glass syringe and a glass jar.

The couple thereupon decided to embark upon a 'do-it-yourself' AID child. CC made regular visits to CM's flat where he produced semen with which she artificially inseminated herself. Absolute privacy was observed and no intercourse took place between them. In due course CC conceived. CM had assumed that he would be allowed to develop a normal parental relationship with the child. Before the birth of the child they fought with each other and as a result CC was not prepared to allow CM to have any contact with the child. He thus applied to the Domestic Relations Court of New Jersey to be granted visitation rights.

The central issue to be resolved in order to determine whether CM was entitled to visitation rights was whether he was in fact the child's natural father. This fact was disputed on the ground that the sperm used to conceive the child was transferred to CC by unnatural means.[104]

The court held that public policy demanded that wherever possible it was in the best interests of a child to have two parents and that no distinction should

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(103) 152 N J Super 160 377 A 2d 821 (1977).

(104) Supra at 822.

be made between a child conceived naturally or artificially.(105) CM's petition was accordingly granted. Having recognised CM as the natural father the court in addition imposed on him the responsibility to maintain and support his child.(106)

5.4.1.2. A v C(107)

The facts in this case were that an unmarried 27 year old professional man was living with a divorced woman, the mother of two children, who was 5 years his senior. They were desirous of having a child of their own but his mistress was unable to have any more children. The man was not prepared to indulge in a casual affair with a third party in order to father the child he wanted. Through the offices of a prostitute they found a woman who was prepared to bear an artificially inseminated child for him for the sum of £3 000. The donor and the woman went to a clinic where the insemination was performed. When she had conceived a child from his semen he installed her in a flat. However after the birth of the child the woman underwent a change of heart, and despite further inducements refused to surrender the child.

The donor-father then instituted wardship proceedings in which he sought care and control of the child. In an interim order the mother was granted care and control while the father was granted access of one hour twice a week. At a subsequent hearing to grant a final order the mother and the Official Solicitor, as guardian ad litem, opposed the grant of access to the husband.

Comyn J found that there was no doubt as to the child's paternity and that it was illegitimate but that the donor-father was entitled to custody of two hours once a week. He based his decision on what he regarded to be the

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(105) It is submitted that had CM & CC married it would not have been possible for the court to rely on this line of reasoning to arrive at its decision.

(106) Supra at 825.

(107) 8 Family Division 1978 170.

best interests of the child. He held that prima facie, a parent should have access unless there was good reason to the contrary.

The judge throughout appeared to treat the father of the AID child in the same way as the father of any other illegitimate child. This meant that not only did the father have the right to apply for custody and access in wardship proceedings or under the Guardianship of Minors Act 1971, but also that access should be granted unless it was clearly not in the interests of the child.

On a subsequent appeal judges of the Court of Appeal unanimously ruled that the decision of the court a quo was wrong and that Mr A should not be entitled to access to see his son.

It is submitted that in SA law, despite the fact that the donor is the natural father and as such entitled to apply for access to his AID child, he would have great difficulty persuading the court that it was in the child's best interests for him to have access. It would be even more difficult if the spouses' marriage had survived for say 10 or 12 years and the putative father had developed a strong and loving relationship with the child. It is obviously in the child's interests to continue that relationship rather than start a new relationship with a stranger, albeit a person who is his genetic father.

5.4.2. Putative father's right to access

Except for the rare exception discussed above,(108) the donor (natural father) in AID cases is unknown. As a result the basic issue usually revolves around the rights of the putative father, eg whether he is entitled to access.

The American case of Strnad v Strnad(109) involved a proceeding between husband and wife for the custody and visitation rights of their AID child which was conceived with the husband's consent. The court authorised visitation rights for the husband holding that the child was potentially adopted or semi-adopted by the husband. Although he was not entitled to the same rights as a natural

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(108) CM v CC supra; A v C supra.

(109) 190 Misc 786, 78 NYS 2d 390 (Sup Ct) 1948.

parent would be under the same circumstances, he was entitled to the same rights as a foster parent who had formally adopted a child. If in addition it had not been proved that the husband was unfit to be a guardian and that it would furthermore be in the best interests of the child that the putative father should be permitted visitation, then the facts surrounding the child's conception should not be regarded as precluding the husband's right to visitation.(110)

In Abajian v Dennett(111) it was held that a former husband was entitled to visitation rights with his AID child, not only because it was equitable for the husband, but also because it was in the best interests of the child and preserved a sense of family unity to the extent possible after the mother and her husband had been divorced.

The position of the putative father in SA law, it is submitted, should be determined by the best interests rule, and he should not be excluded from consideration for access(112) on the basis that there is no blood relationship between him and the AID child. The court as upper guardian of minors is empowered to grant access to third parties(113) and if the putative father's credentials as a parent have been in keeping with those of a reasonable parent then his love, concern and interest in the AID child to whose birth he consented, should be rewarded with rights of access to enable the relationship to develop further to the mutual benefit of both the AID child and the putative father, in the event of the family being split by a divorce.

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(110) Shaman (1979/80) 18 J of Family Law 331 at 335; Klayman (1970) 39 Cincinnati LR 291 at 317; Sergeant (1970) 19 Drake LR 409 at 433.

(111) 15 Misc 2d 260, 184 NYS 2d 178 (Sup Ct 1958).

(112) V v R supra at 1016.

(113) Grotius 1.7.10; Voet 26.5.5; Calitz v Calitz supra at 63; Petersen v Kruger 1975 (4) SA 171 (C).

5.4.3. Future Developments

In terms of the Child Care Bill the AID child will be deemed to be the legitimate child of its mother and her husband for all purposes. This would of course mean, it is submitted, that when it came to determining the custody and access of such a child the same criteria which is applicable in determining the custody or access of any other legitimate child will apply viz the best interests of the child.

6. The Right to Custody and Access of the ET Child

In the absence of statutory guidelines or precedent in this regard I will attempt to fashion guidelines for the custody of a child born by the various possible permutations available in this field, by adapting the well established principles of our law relating to custody to the position of the ET child. Furthermore we must bear in mind that for the duration of the marriage the spouses will attempt to conduct as normal a family relationship as possible and that it is unlikely that any dispute as to who may exercise rights of custody will arise between them. It is only in the event of a divorce(114) that the truth of the child's birth may come to light and perhaps not even then if the parents maintain the conspiracy of silence.

If the spouses do not reveal the child's ET origins the award of rights to custody and access will be dealt with in the normal fashion as if it were in fact a legitimate child. There are also certain ET and IVF permutations which will create a legitimate child.

6.1. Wife's ovum, husband's sperm, wife carries the child

A child conceived in vitro and then reimplanted into the wife's uterus is undoubtedly a legitimate child. It is thus submitted that any dispute involving

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(114) See however the position in Crane v Battle supra, where the parties were separated but not divorced.

rights to its custody and access will be determined in the normal way viz by determining the best interests of the child[115] and then awarding custody to that particular parent with the right to reasonable access being granted to the non-custodian parent as is the custom in our law.[116]

6.2. Wife's ovum, donor's sperm, wife carries the child

A child conceived in this manner is illegitimate and thus according to our law its mother has a stronger right to its custody.[117] However it is submitted that should the mother's husband have established close links with the child in the course of the marriage and should the mother on analysis prove to be an unsuitable person to have custody of the child, the court is empowered to award custody to its 'father'.[118] Alternatively should custody not be awarded to the 'father' it is submitted that should he desire to have access to the child, he should be granted this right.

6.3. Husband's sperm, ovum donated, wife carries the child

A child conceived in this way will be the illegitimate child of the husband and the ovum donor, who is also the child's genetic mother. The ovum donor's identity is protected and she is usually not interested in having the custody or access of the child foisted on her. The custody of the child will thus be awarded to either its father or its womb mother. It is submitted that both should be treated equally and that the best interests of the child should determine to whom the custody should go.[119] It is submitted that the parent who is unsuccessful in the custody dispute should qualify for the right to reasonable access to the child should he/she desire it.

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(115) 1948 (1) SA 130 (AD); The Divorce Act No 70/1979 s 6(3); Fortune v Fortune 1955 (3) SA 348 (A) at 352-4; Petersen v Kruger 1975 (4) SA 171 (C).

(116) Botes v Daly 1976 (2) SA 215 (N) and Boberg Law of Persons and the Family (1977) at 462.

(117) Mathews v Haswari supra; Dhanabakium v Subramanian 1943 AD 160 at 166.

(118) V v R supra at 1016.

(119) Ex parte Van Dam supra at 185; see also note 97 supra.

6.4. Wife's ovum, husband's sperm, hostess mother

The child is the genetic offspring of the spouses and is thus their legitimate child. The hostess mother it is submitted fades out of the picture and has no further rights or obligations towards the child once she has given birth to it and handed it over to its genetic parents.(120) The custody of the child will thus be granted to one of its genetic parents according to the best interests doctrine.(121) It is submitted that the non-custodian parent will be entitled to rights of access in the normal course of the divorce action.(122)

6.5. Wife's ovum, donor's sperm, hostess mother

The child born in this way will be illegitimate. Neither the sperm donor nor the hostess mother are eligible nor likely to want the custody or access of the child to whose birth they contributed.

The right to custody of the child would thus vest firstly in its genetic mother and secondly in her husband, and failing an award of custody it is submitted that he should qualify for rights of access should he desire to have them.

6.6. Wife's ovum (Mrs A), donor's sperm (Mr X), hostess mother (Mrs X)

The child is the illegitimate child of Mrs A and Mr X. Once Mrs X has given birth to the child she will normally in terms of the agreement hand it over to Mr & Mrs A, and then have nothing more to do with it.(123) Should the custody of the child ever come into dispute Mrs A as the genetic mother will in terms of our law have the strongest claim to its custody subject always to the best interests(124) of the child. It is once again submitted that its putative father should be entitled to access should he desire to maintain his relationship with the child.

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(120) Reilly Genetics and the Law (1975) 359 at 372.
(121) V v R supra at 1015.
(122) Rowan v Faifer supra at 711.
(123) A v C supra at 170.
(124) V v R supra at 1015.

CHAPTER 10

DEVOLUTION OF PROPERTY

1. AID child's right of inheritance

The AID child's right to inherit is inextricably linked with the determination of its status viz whether it is deemed to be legitimate or illegitimate.(1) If a South African court is called upon to determine an AID child's right to inherit in terms of our current law,(2) it will have to apply existing legal principles in the absence of specific legislation on the rights of an AID child.(3)

2. Testate Succession

2.1. AID Child's Right to Succeed to its 'father'

The problems involved in the AID child's right to succeed are lessened if the husband leaves a will.(4) Although in terms of our current law the child is de iure illegitimate(5) it is afforded formidable protection by the pater est quem nuptiae demonstrant presumption and by the secrecy which surrounds the practice. Inevitably the parents would have relied on the above presumption to register the child as their legitimate child. If the mother and/or doctor who inseminated her do not challenge the will, no one else will have the knowledge to challenge the AID child's right to inherit from its mother's husband on the ground that it is

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(1) M M Corbett, H R Hahlo, G Hofmeyr The Law of Succession in South Africa (1980) 552; N J van der Merwe & C J Rowland Die Suid-Afrikaanse Erfreg (1974) 99.

(2) V v R 1979 (3) SA 1006 (T) 1016.

(3) The position will change dramatically if and when the draft Child Care Bill becomes law. Section 39 of the Bill legitimizes consensual AID children. Clothed in the status of legitimacy most of their problems regarding inheritance will naturally be resolved.

(4) D T Demars 'Artificial Insemination - Problem Child of the Law' (1964) 40 North Dakota Law Review 89 at 96.

(5) V v R supra at 1016.

illegitimate and thus disqualified from inheriting from him. Thus where the testator has worded his will in such a way that he bequeathes property to his 'children', 'descendents' or 'issue', the AID child will be included in the absence of evidence that he is an AID child; but if there is such evidence the AID child will be excluded since these terms do not in the absence of clear indications in the will include illegitimates.(6)

Where however there is ambiguity surrounding the use of terms such as 'children', 'issue' or 'descendants' used by a testator and it is common knowledge that his children were born as a result of AID then the intention of the testator may be determined by the circumstances surrounding the will.(7) For example, if the husband had consented to AID before or condoned the procedure after the child's conception or birth, the court could find that the husband had intended the AID child to be included in the provisions of the will. If it can furthermore be proved that the testator was sterile and incapable of conceiving his own children, this knowledge in conjunction with his consent to AID would mean that the only logical interpretation of the terms 'children', 'descendants' or 'issue' would mean that they refer to his AID offspring. The only possible exception would be if he had also adopted children not conceived by AID.(8)

Where the testator specifically names or identifies an AID child in his will the mere fact that he is an AID child and thus in terms of current S A Law illegitimate, will not disqualify him from inheriting in terms of the will unless he is indignus for some other reason.(9)

Although illegitimacy no longer carries the same stigma the presumption exists that if a testator has legitimate as well as AID (illegitimate) children and

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(6) Corbett et al The Law of Succession in South Africa (1980) 552; The ordinary meaning of child does not go beyond the testator's own child (his 'bloedkind'). In the absence of clear indications of a contrary intention, a stepchild is not included cf Boswell v Van Tonder 1975 (3) SA 29 (AD) at 35.

(7) C M Thompson 'The Legal Consequences of Artificial Insemination in South Dakota' (1968) 13 South Dakota Law Review 171 at 178.

(8) Sergeant (1970) 19 Drake LR 409 at 429; Glanville Williams The Sanctity of Life (1958) 118.

(9) Gafin NO v Kavin 1980 (3) SA 1104 (W); Ex parte Meier & Ano 1980 (3) SA 154 (T); Wessels NO v Lubbe 1954 (2) SA 225 (O).

in his will he leaves his estate to his 'children', he means his legitimate children only.(10)

2.2. AID child's right to succeed to its mother

The relationship between an AID child and its mother is determined according to the rule that 'n moeder maakt geen bastaard. In terms of this rule the AID child will qualify to inherit ab intestato from its mother, but the presumption against the inclusion of illegitimate issue under the term 'children' will disqualify AID children where the mother has other legitimate children and she has appointed her 'children' or 'issue' as her heirs;(11)

> 'It was therefore held, in In re Russo (supra), that, notwithstanding the rule that a mother makes no bastard, the presumption is that generally speaking, in the absence of clear indications in the will of a different intention, the term "issue" or "children" when used in relation to a mother refers only to her legitimate issue or children.'(12)

Where however the mother has clearly expressed the intention in her will that her AID children are to be her heirs or to share with her other children, their illegitimacy will not disqualify them from inheriting.(13)

2.3. AID child's right to inherit from his parents' relatives

The presumption against the inclusion of illegitimate issue under the term 'children' also extends to a situation where eg a grandparent leaves benefits to the children of his or her son or daughter,(14) for as Voet quite rightly says, as a general rule parents are not kindly disposed to the illegitimate children of their

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(10) Brey v Secretary for Inland Revenue 1978 (4) SA 439 (C); J Perello & B Salvador 'Legal Aspects of Artificial Insemination in the Phillippine Laws' (1958) 6 Far Eastern Law Review 47 at 52; Feversham Report 25.

(11) Voet 36.1.13; Corbett, et al The Law of Succession in SA (1980) 522.

(12) Brey v Secretary for Inland Revenue supra at 443(C-D).

(13) Corbett et al loc cit; Valeri (1968) 3 Portia LJ 235 at 241.

(14) Hoffman v Estate Mechau 1922 CPD 179; Hammond v Estate Hammond 1926 NPD 314; Dienes (1968) 54 Iowa LJ 253 at 284.

children.(15) In order to avoid any such disputes or misunderstandings regarding the inclusion of illegitimate children in a will it is advisable for a testator to use terms such as 'our legitimate children' or 'our lawful issue' or 'my son's legitimate children'. These terms are clear and unambiguous and leave no scope for doubt or dispute.(16)

2.4. AID child's right to inherit from the sperm donor

Because of the secrecy surrounding the donor's identity, it is most improbable that a situation would arise in which an AID child would be in line to inherit from its biological father viz the sperm donor.(17)

In the unlikely event of such a situation actually coming about, the determining factors will again be the testator's intention in the will, the status of the AID child vis-á-vis his biological father and the actual wording of the will.(18)

Unless the donor and the child's mother were married at either its conception or birth, the AID child is deemed to be the illegitimate child of the donor and its mother. Thus he/she will be entitled to inherit from his/her biological father only if he is able to identify the child or children born of his semen and unambiguously institute them as his heirs.(19) However, if he has legitimate children from his own marriage, and he institutes his 'children' or 'issue' as his descendants, then the AID (illegitimate children) children born of his donated semen will be excluded.(20) If the testator was unmarried then all his children including those he had fathered by AID would resort under the class of 'children' or 'issue'.

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(15) Voet 36.1.13; Creighton Artificial Insemination by Donor (1977) at 51.

(16) Executor Estate Jackson v Myers 1940 CPD 600.

(17) See however the case of CM v CC 152 NJ Super 160, 377 A 2d 821 (Cumberland County Ct 1977) in which a sperm donor did in fact seek to enforce his parental rights. This case was however an exception to the normal AID procedure which is highly secretive.

(18) Corbett et al The Law of Succession in SA (1980) 77; Green v Fitzgerald 1914 AD 88.

(19) Corbett et al op cit 14; Hennessy (1967) 10 Canadian Bar Journal 521.

(20) Hennessy op cit 552; Chandler (1968) 53 Cornell Law Review 497 at 508.

However should the donor and the mother marry, the AID child is legitimated and is entitled to inherit from either to the full extent of the law.(21)

2.5. Sperm donor's right to inherit from his AID child

Once again the secrecy surrounding the donor's identity is likely to preclude such an eventuality arising, but should the child be aware of his father's identity he can institute him as an heir in his will. If he institutes his 'father' as his heir, this term will be interpreted as being his biological father if it is known that he is an AID child.(22)

If, however, his parents never revealed his true origins to him and fraudulently registered him as their legitimate child, his reference to his 'father' in his will would perforce be interpreted as being a reference to his putative father.

3. Intestate Succession

The relationship of parent and child regarding their legal status vis-á-vis each other has a vital bearing in regard to intestate succession. The cardinal factor determining the AID child's right to inherit is his status. Particularly vital is his relationship vis-á-vis his father.(23) Intestate succession takes place when there is no valid will or when there is a failure of the testamentary heir or inasmuch as the testator has not disposed of his estate. There is a certain order of priority which determines whether a person qualified to succeed ab intestato, is in fact entitled thereto.(24)

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(21) Spiro Parent & Child 3rd ed (1971) 22.

(22) R L Drumheller 'Artificial Insemination and the Law', (1968) University of Illinois Law Forum 203 at 223; Klayman (1970) 29 Cincinnati LR 291 at 318.

(23) E Spiro 'Artificial Insemination and the Law' (1972) Acta Juridica 213 at 215; Jacobs & Luedtke (1965) Wisconsin LR 859 at 877.

(24) Spiro Law of Parent and Child 3rd ed (1971) 22; Carr (1973) 26 Alabama LR 120 at 158.

3.1. AID child's right to succeed to its father

In terms of current S A law the AID child is not related to his mother's husband, and unless they adopt their AID child he/she will be illegitimate. Consequently the AID child will have no rights to succeed intestate against his father and the latter's relatives and vice versa.(25)

3.2. AID child's right to succeed to its mother

According to the accepted maxim in our law that 'n moeder maakt geen bastaard, an illegitimate child is related to its mother and her relations. Consequently the AID child is entitled to succeed intestate to its mother and her relatives and vice versa.(26)

3.3. AID child's right to succeed to its siblings

Where an AID child has brothers or sisters conceived in like manner by the same mother they are entitled to succeed to each other ab intestato despite the fact that they are illegitimate.(27)

3.4. AID child's right to succeed to the donor and vice versa

It is hardly necessary to repeat the fact that because of the secrecy(28) surrounding the donor it is highly unlikely that a child born of AID will come into contention to inherit from its donor-father. But should the child be informed as to its donor-father's identity its relationship to the donor will be that of an illegitimate child and this will preclude the AID child from inheriting from its natural father. The same is true for the reverse viz the donor's right to inherit from the AID child.(29)

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(25) Spiro Parent & Child 3rd ed (1971) at 23; De Stoop (1976) 50 Australian LJ 304.

(26) Corbett et al The Law of Succession in SA (1980) 586; De Stoop op cit 304; Vecchi (1961) 66 Dickinson LR 1 at 11.

(27) Vecchi op cit 11.

(28) Sergeant (1970) 19 Drake LR 409 at 429; Verkauf (1966) 3 Houston LR 277 at 305.

(29) Corbett et al The Law of Succession in SA (1980) at 586; Green v Fitzgerald 1914 AD 88; Wellens (1968) 22 Miami LR 952 at 964; Verkauf (1966) 3 Houston LR 277 at 305.

4. Property rights and the Posthumously conceived child

4.1. The Nasciturus Rule

It became apparent to the Romans that if legal personality was only conferred upon a child at birth it could result in a child who had the misfortune of being born after his father's (or indeed after any other testator's) death, being denied a right to share in the estate.(30) For example, if a father bequeathed his estate to 'my children' and then died at a time when he had eg two children, but his wife was pregnant with a third, then the posthumous child would not share the inheritance with his siblings who were born before him.(31)

The reason for the posthumous child failing to qualify as an heir was that at the relevant date for determining who were the children in whom the right to inherit vested, viz the date of his father's death, the as then yet unborn child was not yet a legal person and therefore incapable of being the bearer of legal rights. Yet, on the other hand, when he was subsequently born and had acquired the necessary legal personality it was too late, because the inheritance had already vested in the children in existence at the moment of the testator's death.(32)

The Romans extricated themselves from this dilemma by extending the general rule that legal personality begins at birth, in terms of the following maxim:

nasciturus pro iam nato habetur quotiens de commodo eius agitur,(33)

the effect of this maxim was that an unborn child in its mother's womb (en ventre sa mère) was deemed to have been born, and therefore to have acquired legal personality, prior to the date of its actual birth, if this would be to its advantage. The rule was subject to the proviso that the child was in fact

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(30) Rudolf Sohm The Institutes 3rd ed (1907) 164, 165; Gaius Institutes 1.147.

(31) D 1.5.7; 1.5.26; Voet 1.5.5; Grotius Inleiding 1.3.4.

(32) Sohm op cit 165.

(33) D 1.5.7; 1.5.26; 50.16.231; Voet 1.5.5; 39.5.12; Spiro Parent & Child 3rd ed (1971) at 27-28.

subsequently born alive. If this proviso was met the posthumous child was entitled to share in its father's estate.(34) This rule has been accepted as being part of South African law, and has in fact been extended beyond the confines of property and succession to include claims for delictual damages which were inflicted on the foetus prior to its birth.(35)

4.2. Cryobanking - the source of the future posthumous child

It is submitted that the significant advances made towards perfecting the technique of freezing and preserving human semen has created the platform for a great leap forward in posthumous births in the next decade.(36) In cryobanking, semen is usually first perfused with a cryoprotective agent Dimethylsulfoxide (DMSO), temporarily frozen in dry ice and then permanently stored in liquid nitrogen at -196,5°C.(37) Although the fertilizing capacity of frozen sperm is approximately two thirds that of fresh sperm, it has the advantages of instant availability and of providing the prospective recipient with a wide choice of donors with varying characteristics.(38)

The popularity of human semen cryobanking in the early 1970's resulted in the first commercial cryobank being established, and by late 1973 there were three major commercial banks with a combined total of eight branch offices located in various cities throughout the USA.(39) A substantial down-turn followed shortly thereafter, however, as a result of both inaccurate market predictions and

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(34) Ex parte Administrator's Estate Asmall 1954 (1) PH 64 (N); Ex parte Boedel Steenkamp 1962 (3) SA 954 (O).

(35) Pinchin & Another v Santam Insurance Co Ltd 1963 (2) SA 254 at 260(A). However in Christian League of Southern Africa v Rall 1981 (2) 821 (O) at 830(A) the court held that there was no scope for the extention of the nasciturus fiction to protection against abortion.

(36) A survey conducted by J K Sherman in 1979 revealed ± 5000 births worldwide from frozen semen. These children also had fewer abnormalities and suffered fewer abortions than in the normal population.

(37) J A Panuska 'Cryonics' in Encyclopedia of Bioethics (1978) 216.

(38) M S Frankel 'Artificial Insemination and Semen Cryobanking Health and Safety concerns and the role of Professional Standards Law and Public Policy' (1979) 3 Legal Medical Quarterly 93.

(39) M S Frankel 'Human Semen Banking : Social & Public Policy Issues' (1967) 1 Man and Medicine 289.

scientific constraints.(40) But recent evidence points to a renewed upsurge in the use of frozen semen.(41)

4.3. Motivation for posthumous births

The most common motivating factor for a man to deposit a sample of his sperm with a cryobank is to serve as a form of insurance against his being rendered infertile by illness or accident, or most common, prior to undergoing a vasectomy.(42) This precaution will enable the spouses to replace a child who had been killed or died of an illness, or to increase their family should they so desire after the vasectomy. It will also permit a widow to have her husband's child by AI after his death should she so desire.(43)

Nor are we dealing with mere idle theories, posthumously conceived children are a reality. The best publicised example being the son born to Mrs Kim Casali, the well-known cartoonist ('Love Is') in July 1977, sixteen months after her husband had died of cancer.(44)

4.4. Problems involved with posthumously conceived children

Cryobanking solves a number of problems for parents but it also creates a number of problems, eg what are the rights of the posthumous child to inherit in terms of his father's will? How long can or should frozen sperm be kept?

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(40) M S Frankel 'Human Semen Banking : Social & Public Policy Issues', (1976) 1 Man and Medicine 289.

(41) E Jacobson 'Up 400% : Artificial Insemination' (1976) 10 Hospital Tribune 9.

(42) Frankel (1979) Legal Medical Q at 93.

(43) Frankel ibid.

(44) (16 July 1977) 264 The Economist 23, 24; Carmen Nathan 'Extra-marital parenthood' (1981) 10 Businessman's Law 121 at 122 is of the opinion that this child would not be legitimate since his parents were not married at the time he was conceived nor was it possible for them to marry at any time after that.

Can such a child be classed as 'issue' of his father? It will not be easy for our common law to adapt to problems of this nature and yet the law[45] will most certainly be called upon to deal with these problems within the next decade.[46]

4.4.1. Posthumous child's right to succeed - current legal position

A testator makes a sperm bank deposit prior to his death, and then makes a will leaving property 'to all my children'. If there are children alive at the testator's death it is submitted that they will be the sole heirs and that posthumously conceived children will be excluded in terms of the nasciturus rule which stipulates that only children who are already conceived at the death of the testator are eligible to inherit from him,[47] and in terms of the presumption which operates in our law that reference to 'child' or 'children' in a will includes only legitimate children.[48]

The provisions of the draft Child Care Bill,[49] it is submitted, would not alter this position. Section 39 stipulates that one of the conditions under which

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(45) It is submitted that the cryobanking of a husband's sperm and its subsequent use to artificially inseminate his wife is not illegal nor does it require special permission in terms of The Anatomical Donations and Post-Mortem Examinations Act No 24 of 1970.

(46) W D Thies 'A look to the Future : Property Rights and the Posthumously Conceived Child' (Nov 1979) Trusts & Estates 22; C Sappideen 'Life After Death - Sperm Banks, Wills and Perpetuities' (1979) 53 Australian Law Journal 311.

(47) Spiro Parent & Child 3rd ed (1971) at 27.

(48) In the above example the wife is inseminated with her husband's semen ie AIH, yet if we apply the accepted test for legitimacy in our law, viz, that a legitimate child is one whose parents were married to each other at the time of his conception or birth, then the fact that she is inseminated after her husband's death, means that the child conceived in this way is in fact illegitimate (see the Kim Casali case supra). Van der Vyver (1980) 43 THRHR 88 at 90.

If the child's mother had not remarried to a husband who had consented to the insemination the child born in this way would be a true filius nullius, a child with no father.

(49) Section 39(1) in (28 October 1981) Government Gazette No 7864.

the status of legitimacy would be conferred upon a child conceived by artificial insemination (ie AID or AIH) was that the child should have been conceived 'in wedlock'. It is submitted that the terms of this provision are such that our parliamentary draftsmen do not consider the donation of genetic material by spouses during the subsistence of a marriage as being sufficient ground to legitimate the child which was born after the death of one of the spouses; the child having been conceived from the genetic material of the deceased spouse. It is submitted that an infant conceived by AID only becomes the 'legitimate child' of its parents where it was conceived during a subsisting marriage.(50) It is therefore submitted that the draftsmen should consider this problem and attempt to incorporate a solution to the status of children born of parents who had predeceased them, in the Draft Child Care Bill.

4.5. The Posthumous Child - Problems of Succession

Until the position of the posthumous child is regulated by legislation it is submitted that the donor's wife and her husband should be advised by their attorney to take the following steps when contemplating the possibility of such a child.

4.5.1. It is submitted that the testator (semen donor) should regulate the conditions under which his semen is to be used in his will, by including the following (or a similar) clause:

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(50) Sappideen (1979) 53 Australian LJ 311 at 319.

(51) Thies (Nov 1979) Trusts & Estates 922.

'I, John Henry Smith, with the full knowledge and consent of my wife Susan Helen, have deposited a sample of my sperm with XYZ cryobank in order to enable my wife Susan Helen Smith to have a child or children after my death should she so desire.(52) I authorize her to draw upon this sample for AI purposes subject to the following provisions:-

(a) That within three days of being inseminated with my sperm, my wife and the duly licenced medical practitioner who performed the act of insemination shall lodge an affidavit with the Registrar of the Supreme Court with whom my Will is probated, which affidavit shall state that my sperm and no other was used, and the date on which my wife was inseminated therewith.

(b) Should my wife conceive from AI with my sperm and give birth to a live child/children she shall make and deposit with the Registrar within 120 days after such birth, a further affidavit stating the name, sex, date of birth of each child and whether such child survived ninety days. A child so conceived and surviving for ninety days shall be deemed my child for all purposes of this my Will.'

It is naturally possible for the testator to vary such matters as the required survival period and the number of pregnancies permitted his wife. Another matter which could be regulated, should the testator deem it to be necessary, is that his widow's access to his semen deposit should be terminated upon her remarriage.(53)

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(52) In W v H 1965 (3) SA 740 (O) at 741 (B) the court held that:

'The procreation of children is one of the main objects of marriage and to deny the wife stante matrimonio the right to motherhood without good cause is a wrongful refusal of marital rights and is as much a desertion of the wife as a wrongful refusal to have sexual intercourse is.'

It is submitted that this could be the legal basis for sanctioning the wife's right to conceive a child after her husband's death. Admittedly W v H refers to a situation stante matrimonio, but in this situation the husband and wife took the decision and consented to this form of 'fertility insurance' at a stage while they were still married.

(53) Thies (Nov 1971) Trusts & Estates at 922.

4.5.2. The rights of the posthumous child where the will does not cater for him specifically

Legacies or gifts to children in a will are interpreted in our common law as referring to legitimate children only.(54) If the right of a posthumously conceived child to succeed is based on its status alone then it appears to have very little chance of featuring as an heir, because, strictly speaking, the AIH child, posthumously conceived, is illegitimate. Despite the fact that the semen was contributed stante matrimonio the death of the husband (donor) terminates the marriage. Therefore the mother of the child was not married to the father either at its birth or conception. Fulfilment of these requirements is vital in order to acquire the status of legitimacy.(55) (55)

If the widowed wife does not remarry and was inseminated with her deceased husband's sperm within a week or ten days of his death, it is submitted that the onus of proving that the child was not in fact conceived shortly before his death will be very difficult, and in the absence of evidence to prove, that on a balance of probabilities, the child was in fact conceived after her husband's death and not stante matrimonio, a court would, it is submitted, in a dispute rule in favour of the child being declared the legitimate child of its mother and her late husband.(56)

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(54) Corbett et al The Law of Succession in SA (1980) at 552; Brey v Secretary for Inland Revenue 1978 (4) SA 439(C) at 442-3.

(55) Grotius 1.12.2,3; Voet 1.6.6; Van Leeuwen R-HR 1.7.2; Boberg The Law of Persons & The Family (1977) at 7864.

(56) The normal period of a pregnancy is two hundred and seventy days. However our courts have been extremely flexible in this regard and have accepted that a pregnancy of three hundred and twenty days is possible eg Mitchell v Mitchell & Ano 1963 (2) SA 505 (D). It is submitted that in view of the Mitchell decision a pregnancy of 260 days would be quite acceptable.

The glimmer of hope for the status of the posthumous AIH child does not exist for an AID child similarly conceived, as it is in terms of current SA law, illegitimate,(57) and thus disqualified from sharing in a general class gift to children.

In the light of the above, a heavy onus rests upon the testator's attorney to attempt to foresee and provide for all matters affecting the child. If unforeseen problems do arise, it is possible for the widow to lodge an application with the Supreme Court on behalf of the child. Notice of such petition should be sent to all interested parties. The guiding principle which will determine the Court's decision in the dispute will naturally be the testator's intention.(58)

4.5.3. The use of sperm from an anonymous Donor

It rests with the testator's discretion as to whether he is prepared to sanction the use of an unknown donor's sperm if his wife fails to conceive as a result of being inseminated with his own sperm deposit. The following clause is submitted as being suitable for inclusion in his will:

> 'Upon my wife failing to conceive after repeated inseminations using my deposited sperm, I authorize her to use sperm from a donor unknown to her and obtained through medically approved channels, provided that affidavits similar to those specified above are duly filed and in the event of a child being conceived and surviving for ninety days such child shall be deemed to be my child, for all purposes of this my Will.'

4.5.4. The right of the posthumously conceived child to inherit under the wills of third parties

A delicate problem arises in a situation where the property in dispute originates from the estate of eg a grandfather or uncle who in terms of his will has

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(57) V v R supra at 1016(B).

(58) This (Nov 1971) Trusts & Estates at 922'n Sappideen (1979) 53 Australian LJ 311 at 318.

bequeathed his estate to 'issue' or 'descendants' of his son or brother. The problem to resolve is whether it was the intention of the original testator to include a posthumously conceived child amongst his heirs as 'issue', and secondly whether such inclusion at the expense of the collaterals of such posthumously conceived child is in fact equitable.(59)

It is not possible for the posthumously conceived child to claim the benefits of the nasciturus rule(60) because he was not conceived at the time of his father's death. It is therefore submitted that the solution must be sought in legislation determining a cut-off point after which such a child is precluded from inheriting. Such cut-off points linked to wills and succession are not unknown in our law and are applied to restrict the fideicommissum perpetuum.(61) It is submitted that the result of not limiting the time within which a posthumously conceived child could qualify to inherit places an undue restriction on existing heirs. Practically speaking it would be a time between the husband's death and the wife reaching menopause and thus becoming incapable of conception and birth.

4.5.4.1. Possible guidelines to devise a cut-off point

The following are submitted as possible solutions to determine the cut-off point:

(a) That the child must be born of the testator's widow

This solution seems to be in keeping with the spirit of the testator's intention, with current family norms and with the particular problem in the family viz.,

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(59) Thies (Nov 1971) Trusts & Estates at 922; Sappideen (1979) 53 Australian LJ 311 at 318.

(60) Spiro Parent & Child 3rd ed (1971) at 27.

(61) Section 6 of Immovable Property (Removal or Modification of Restrictions) Act 94 of 1965.

(i) The testator-donor's death is deemed to be a premature tragedy affecting his widow and surviving children (if any);

(ii) By resorting to AI with his frozen sperm she was merely having the children they had planned to have or replacing the children who might have been killed with her husband in the same accident;

(iii) If the object of having posthumous children was to create the family which the spouses had planned but which fate had prevented them from fulfilling, then to allow any female other than the testator's widow to conceive the child amounts to an unnatural contrivance which is contrary to the current western norms of a nuclear family.(62)

(b) A time limit could be imposed

The legislature could decide on a particular number of years eg 10 or 20 after the donor-testator's death within which the child must be born. Alternatively the legislature could invoke a quasi-presumption that it is unusual for a man over 70 to father a child and consequently stipulate that to qualify for inheritance the child should be born before the 71st anniversary of the testator's birth.(63) Provision must be made for winding up the testator's estate in the normal way, subject to security to ensure the rights of posthumously born children.

5. The Right of the IVF & ET Child to inherit

5.1. General principles

Subject to certain statutory limitations(64) South African law recognises complete freedom of testation.(65) In other words there is no prohibition upon a testator instituting a child born to his wife from a donated oocyte as his heir.

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(62) Thies (Nov 1971) Trusts & Estates 690; B Leach 'Perpetuities in the Atomic Age : The Sperm Bank and the Fertile Decedent' (1972) 48 ABAJ at 944.

(63) Thies (Nov 1971) Trusts & Estates at 906; Leach (1962) 48 ABAJ at 944.

(64) A few examples of statutory limits are The Immovable Property (Removal or Modification of Restrictions) Act 94 of 1965 section 3; Subdivision of Agricultural Land Act 70 of 1970; The Mineral Laws Supplementary Act 10 of 1975 section 3. See also Corbett et al The Law of Succession in SA (1980) at 34.

(65) H R Hahlo (1959) 76 SALJ 435 and (1962) SALJ 361; I B Murray (1962) Annual Survey of SA Law 273; (1963) Annual Survey of SA Law 335.

However problems of interpretation will arise when he institutes a class of persons viz 'my children', or 'my issue' as his heirs(66) and one or all of his children were born from donated oocytes. The question then arises as to whether they are legitimate, if not, they do not resort under the genre of 'children' or 'issue' which in terms of our current law is limited to legitimate children.(67) Our law of intestate succession is regulated by a set of rules or legal principles essentially based on blood relationship.(68) Consequently an ET child's right to succeed to its father hinges on whether it is deemed to be legitimate or not.

I will not discuss the possibility of children who are posthumously conceived by frozen oocytes because as yet no ova banks have been established.

5.2. In vitro fertilisation

5.2.1. Wife's oocyte, husband's sperm

The vast majority of candidates for IVF will be women with occluded oviducts who are physically competent to carry a foetus to term if conception did occur. No biological third party would be involved in these in vitro fertilizations.(69) Clearly a child born via such a technique would not be burdened with metaphysical doubts about his ancestry as biological and legal parenthood would coincide. This is the female counterpart of AIH and this technique has also been likened to the procedure of facilitating birth by Caesarian section.(70)

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(66) Corbett et al The Law of Succession in SA (1980) at 552.

(67) Ibid.

(68) Voet 38.17.19; Green v Fitzgerald 1914 AD 88; Corbett et al The Law of Succession in SA (1980) at 586.

(69) Reilly Genetics and the Law (1975) 359 at 367; P Ramsay 'Shall we "reproduce"? The Medical ethics of in vitro fertilization' (1972) 220 Journal of the American Medical Association 1346.

(70) Reilly Genetics and the Law (1975) 359 at 367.

A child born by this method will undoubtedly be legitimate and will qualify to inherit according to any criteria eg it will qualify under the generic heading of 'issue' or 'children' in a will, or because it was the legitimate child of the spouses it would be in line to succeed ab intestato to either of them.(71)

5.2.2. Wife's ovum, donor's sperm, wife carries the child

The necessity for spouses to resort to this particular combination arises, when the husband is infertile and the wife suffers from tubal occlusion but is capable of carrying a foetus to term. The child's biological father is the sperm donor who is not married to its mother at either birth or conception. Consequently the child is illegitimate according to our law.(72)

The child is thus precluded from inheriting ab intestato from its father to whom it is not related, but may qualify to inherit from its mother in terms of the moeder maakt geen bastaard rule.(73)

If the father had specifically included the child in his will it would naturally inherit, however because of its illegitimate status it would not inherit if the heirs were instituted generically eg 'my children'.(74)

5.2.3. Husband's sperm, oocyte donated, wife carries the child

This mode of conception would be resorted to in situations where a woman is capable of carrying a foetus to term, but was unable or unwilling to supply an egg. This would include women with primary ovarian dysgenesis (such as Turner's syndrome) older infertile women, known carriers of X-linked genetic disease and persons at risk for late onset dominant disorders.(75)

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(71) Rosettenstein (22 Oct 1981) New Law Journal 1095 at 1096.

(72) Oakley (1974) 8 Family Law Q 385 at 391.

(73) Corbett et al The Law of Succession in SA (1980) 586.

(74) Ibid at 552.

(75) Reilly Genetics and the Law (1975) 359 at 369.

Ovum donation (OD) is the female counterpart of AID, but for two reasons it is significantly different:

(a) First, unlike sperm donation or blood donation, oocyte donation requires surgical intervention which presupposes physical discomfort and risk. For the immediate future it will be possible to secure the necessary oocytes from women undergoing surgery for other reasons, but because this is an erratic and limited source, it confines the size of the available donor pool which in turn limits the choice which donee couples can exercise.(76)

(b) A second difference which in fact encourages the need to regulate the practice of OD is that it will be much more difficult to maintain donor anonymity than it has been for AID conceptions. The need for surgical ooctye harvest, a clinical preference for an immediate effort to achieve IVF, and the necessity of hormonally preparing the donee for implantation suggest that the parties involved will be attending the same fertility clinic at about the same time. This will to some extent increase the possibility that the ovum donor will later be able to contact the child conceived with her germ cell.(77)

This form of conception challenges an until now hallowed and inviolable rule viz that 'n moeder maakt geen bastaard but due to the fact that the child is the genetic product of a husband and a woman to whom he is not married at either conception or birth the child will according to current SA Law be illegitimate(78) and hence disqualified from inheriting ab intestato, not only from the father but also from his wife. He is in fact the illegitimate child of the ovum donor.(79)

If however the spirit of the Child Care Bill(80) is applied to this situation, placing as it does the emphasis on consent and wedlock, then a child conceived

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(76) Reilly Genetics and the Law (1975) 359 at 369; see also Oakley (1974) 8 Family Law Q 385 at 391.

(77) Reilly loc cit; Rosettenstein (22 Oct 1981) New Law Journal 1095 at 1096.

(78) Boberg The Law of Persons and the Family (1977) at 318.

(79) Oakley (1974) 8 Family Law Q 385 at 391.

(80) (28 October 1981) Government Gazette No 7864.

and born in this way will also be legitimate and entitled to the same rights of inheritance as is a legitimate child.

5.2.4. Wife's ovum, husband's sperm, hostess mother

Some women may be physically incapable of carrying a foetus to term. Cardiac disorders, partial paralysis, history of miscarriages or a variety of other medical disorders may suggest that women who wish to be genetic parents should enlist the aid of surrogate mothers.(81)

In the above situation the child is genetically that of the spouses and as such would, according to our law, be their legitimate child(82) and entitled to inherit from them according to a testamentary instrument and via intestate succession. Once again this mode of conception disproves the maxim that 'n moeder maakt geen bastaard.

5.2.5. Wife's ovum, donor's sperm, hostess mother

If we apply the accepted criteria for determining legitimacy, and hence the right to succeed, to the above situation, then no matter which permutation one applies, the child is clearly illegitimate and unless it has been clearly and intentionally instituted as an heir in the will of one of the spouses it will be excluded by generic terms such as 'children' or 'issue'. Its only hope to succeed would be ab intestato to its biological mother whose illegitimate child it is.

5.2.6. Wife's ovum, donor's sperm, hostess mother (donor and hostess are married)

In terms of current S A law the child is the illegitimate child of the hostess mother and her husband who is also the sperm donor.(83) It is submitted however that this particular combination of parties should be avoided because of the extremely close relationship between the hostess and the donor. The

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(81) Reilly Genetics and the Law (1975) 359 at 370.

(82) See above page 263-264.

(83) See above page 264.

relationship coupled with the fact that the wife is actually carrying her husband's child would place a severe strain on their marriage, particularly when it came to surrendering the child to the other couple.(84)

It is submitted that the child is the illegitimate child of the ovum donor and would be entitled to inherit ab intestato from her while it is capable of succeeding in the will of both its genetic mother and genetic father if it was instituted as an heir in terms other than generic.(85)

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(84) N P Keane 'Legal Problems of Surrogate Motherhood', (1980) 2 Southern Illinois University Law Journal 147 at 167.

(85) Robertson (1978) Encyclopedia of Bioethics 1468.

CHAPTER 11

STATE CONTROL OF HUMAN FERTILITY - AID, ET and LEGISLATION

1. Is legislation necessary?

AID and ET are currently voluntary techniques of life control which may be the archetype of what has been termed 'the second Genesis'.(1) The various motivations for the voluntary use of these techniques have already been canvassed.(2) The question then arises that if the procedures are entirely voluntary, why is it relevant to discuss state power over human fertility? The answer, it is submitted, lies in the fact that if AID and ET are approved and encouraged by the state it will upset the traditional, totally private, monogamous method of human reproduction.(3) By sanctioning the intervention of a third party (the sperm or oocyte donor) into the process, the state is approving a trend toward treating reproduction as a social rather than a private act.(4) AID and ET by their very natures also create the potential for direct state intervention in the reproductive process.(5)

In microcosm, the practice of AID has already confronted the law with problems which the biological revolution promises to magnify many times over. The existing body of cases on AID in Anglo-American jurisprudence is not extensive, yet they clearly reflect judicial confusion in dealing with the clash between the power of science over human reproduction and traditional family values.(6)

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(1) A Rosenfeld The Second Genesis (1969)

(2) See Chapter 2.

(3) R Francoeur Utopian Motherhood (1970) 113.

(4) C Kindregan 'State Power Over Human Fertility and Individual Liberty' (1972) 23 Hastings Law Journal 1401 at 1409.

(5) Ibid.

(6) R Sonnenborn (editor) The Control of Human Heredity & Evolution (1965).

Legislatures often take a conservative 'wait and see' approach before acting affirmatively in a new area. They are interested in first observing how the courts handle a specific problem before actively intervening.(7) In the rather unsettled area, legally speaking, of AID/ET it is understandable why the various legislatures have largely adopted a policy of conscious abstention, particularly after their initial efforts were rebuffed.(8) For a long time it was left entirely to the courts to fashion remedies as best they could in the light of existing and often inadequate legal principles.(9)

There are also other limitations faced by the courts. They are adapted to deciding, narrowly, those specific issues with which they are presented. Slowly, case by case, the law, in a given area, evolves towards certainty but at the expense of the flexibility that accompanies uncertainty. When courts are presented with situations unknown to the common law, the precedential value of prior cases is questionable and the judicial machinery lacks the resources necessary to decide the novel issue. It is usually at this point that the legislature, in response to pleas by the courts, the legal community, and the public is expected to galvanise itself into action and by way of appropriate legislation to delineate the required guidelines. The legislature is better equipped for the task than a court, because operating in a more leisurely manner, unharassed by the urgency of disposing of a case at hand it can examine and analyse the problem and formulate a comprehensive solution. Furthermore, where public opinion is not firmly settled in a particular direction, the legislature is presented with the opportunity of guiding the mores of its community in a selected direction.(10)

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(7) Klayman (1970) 39 Cincinnati LR 291 at 320.

(8) See Indiana H.R. 350 (1949); Virginia S.B. 745 Gen. Sess (1948); Wisconsin Bill 407 (1949) para 237.065; Minnesota Bill 1090 (1949).

(9) Weinstock (1971) 5 Family LQ 369 at 391.

(10) Drumheller (1968) Un of Illinois LF 203 at 228.

After the failure of the initial attempts at legislation in the USA, the state of Georgia became the first to succeed in passing an act on the subject of AID in 1964.(11) The earlier unsuccessful attempts(12) at AID legislation had taken place in the late 1940's, at which stage public opinion was obviously not yet ready for such a radical innovation, yet twenty years later a more enlightened public accepted this legislation with barely a murmur of dissent.(13)

It is submitted that the reason for the lack of controversy is to be found in the fact that the potential sources of opposition to the act did not see in it a threat to their vital interests. Whereas a subject such as abortion or birth control directly affects the behaviour of numerous members of society, AID and ET at present affect relatively few. In other words AID and ET have as their objective to uphold the family and family life whereas abortion and birth control indirectly challenge the continued existence of the family.(14)

The changing sexual values of our society are also of importance as there is an increasing emphasis being placed on the freedom of individuals to pursue their own sexual values as long as they do not infringe on what are determined to be vital societal interests. As an alternative to childlessness, AID and ET do not appear to transgress societal interests and, in fact, are compatible with the social value placed on child bearing. The Georgia legislation and all subsequent legislation has been essentially permissive in character and thus in step with the changing system of social values.(15)

A further factor which has encouraged legislative action is that the 20 years of inactivity and delay on their part resulted in substantial harm to the interests of litigants in the AID field, particularly the interests of children.(16)

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(11) Georgia Code Ann 74-101.1 (1964).

(12) See note 8 supra.

(13) Dienes (1968) 54 Iowa LR 253 at 308.

(14) Ibid.

(15) Kamlet (1975/24 Cleveland State LR 341 at 350.

(16) Kindregan (1972) 23 Hastings LJ 1401 at 1409.

2. Legislative options available

Should our legislature address itself to the problem of AID there are five possible courses open to it viz

(i) comprehensive legislation including administration

(ii) to prohibit AID and declare its practice a criminal offence

(iii) to refrain from legislating

(iv) limited legislation to regulate specific problems

(v) regulation of the practice by the SA Medical and Dental Council.(17)

2.1. Comprehensive legislation

Legislation of this nature would probably result in AID/ET being completely institutionalized under the Department of Health which would in turn be responsible for maintaining a central record, procuring and distributing semen and oocytes and exercising administrative supervision over the medical profession. Such a scheme would also have to contain an elaborate description of the rights and duties of the parties involved.(18)

It is submitted that this proposal creates more problems than it solves. It would firstly involve some form of agency within the Department of Health whose task it would be to regulate and document the practice(19) and in addition to make the policy decisions now being taken by individual practitioners. Such an agency would of course have to be extensively staffed to ensure its

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(17) See Medical, Dental and Supplementary Health Service Professions Act No 56 of 1974.

(18) Carr (1973) 26 Alabama LR 120 at 160.

(19) This form of control would probably require the spouses to appear before a government or court official in order to process their application for AID/ET. This form of investigation would constitute an infringement of their privacy in a delicate matter and would probably prove to be unacceptable to both the spouses and the practitioner. A likely consequence of such an official procedure is that it would be disregarded by spouses in order to preserve their privacy and dignity. The ultimate result would thus be to drive these practices underground.

efficient operation and to avoid any compromise in anonymity. This would in turn necessitate a large expenditure of public funds, thus rendering it a costly, ineffective operation likely to raise public antipathy because the cost of expensive and exotic therapy for a minority of the population becomes a tax burden to the majority.(20)

Legislation of this nature would also constitute an unprecedented infringement of the time honoured freedom of a doctor to prescribe treatment which he considers to be in the best interests of his patients within the parameters of accepted medical practice and ethics.(21)

It is further submitted that control of these medical techniques by legislation would be unwise and unjustified and that the decision as to whether to execute AID or ET, and to which patients, should be left to the freedom of conscience of the individual practitioner. This would eg allow Catholic doctors who have moral objections to the practice to refuse to participate in it.(22)

2.2. Prohibit AID and ET

Certain legislatures(23) and theologians(24) have advocated that by proscribing AID by legislation and thus making it a criminal practice(25) it would

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(20) Carr (1973) 26 Alabama LR 120 at 160.

(21) Feversham Report 75.

(22) Ibid at 78.

(23) See Minnesota House Bill 1090 (1949) and Ohio Senate Bill 93 (1955) both of which failed in their attempts to outlaw AID.

(24) Report of a Commission Appointed by His Grace the Archbishop of Canterbury on Artificial Insemination (1948); Pope Pius XII in a Discourse to the Fourth International Congress of Catholic Doctors Rome 29 September 1949.

(25) To prohibit AID by statute it would be necessary to make it a criminal offence for any person artificially to inseminate a woman with the semen of anyone other than her husband, and for the woman to be thus inseminated. If AID were made a criminal offence it would be extremely difficult to obtain a conviction because the practice is very rarely revealed and if it became criminal it would no doubt be even more carefully concealed. Furthermore while cases of criminal abortion are normally revealed only because of the death or serious illness of the woman, AID is rarely attended by any medical complications.

serve to show society's disapproval of the practice, with the medical result that practitioners would no longer offer it as a therapy for sterile patients. I submit, however, that such a prohibition will have as little success in terminating AID as the outlawing of abortion[26] in South Africa has had in stopping that practice. The most likely result as has happened with abortion, will be to drive it underground and increase the costs of the treatment. Furthermore it would probably end up in the hands of unscrupulous persons, where its consequences will be far more dangerous than if it had not been prohibited. Prohibition of AID would merely provide additional scope for blackmailers and other mischievous persons with the possibility of unfortunate consequences for the child.

Legislation should only proscribe practices which constitute a harm to the general health and morals of society.[27] It is submitted that AID and ET do not fall within this ambit, and that its prohibition would not be consistent with the function of the criminal law as it is understood in South Africa. By analogy, adultery, which occurs far more frequently than AID and is more often liable to result in undesirable consequences for the marriage and the children and hence for society, is no longer a criminal offence.[28]

While I concede that there are many people who condemn the morality of AID and ET I submit that it is not the function of the State, in a situation like this, to impose a uniform morality by means of the criminal law[29] and furthermore to interfere with the individual's privacy and freedom to procreate within a marriage, albeit by an unusual means.

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(26) Abortion and Sterilization Act No 2 of 1975.

(27) The pros and cons of enforcing morality via the law has led to a number of celebrated debates over the years eg by John Stuart Mill (On Liberty (1859)) and Sir J F Stephen (Liberty, Equality, Fraternity (1873)) and more recently between Prof H L A Hart (Law, Liberty and Morality (1962) and The Morality of the Criminal Law (1965)) and Lord Devlin (The Enforcement of Morals (1959)).

(28) Green v Fitzgerald 1914 AD 88.

(29) Feversham Report 72; see also Hart ibid; Mill ibid.

Artificial insemination should be a lawful practice[30] in every regard and if properly utilized under the careful and sincere guidance of the medical profession it can be of great service to our society.

2.3. Refrain from legislation

The legislature in South Africa in keeping with that in the United Kingdom, Australia and New Zealand has to date refrained from passing legislation appertaining specifically to AID or ET. The S A legislature has thus adopted the approach of neither condemning nor condoning AID or in vitro fertilization.[31] This policy of benign neglect in South Africa functioned satisfactorily for many years because our judiciary were not called upon to adjudicate upon a case involving AID or ET until the V v R[32] case was heard before the TPD in 1979. This case revealed the basic inadequacy of certain aspects of our common law to cope equitably with the problems raised by AID. Steyn J, faced by the issue of the AID child's legitimacy, found himself trapped in a maze of historical precedent and no matter how valiantly he sought an exit which would enable him to hand down the equitable judgment he instinctively felt was right, he was frustrated at every turn and was inevitably forced to surrender to the existing inflexible terms of our common law which dictated the decision that the AID child is illegitimate.[33]

2.4. Limited legislation

It is submitted that a certain degree of legislation is necessary to resolve problems such as those raised by the V v R[34] case, but that it should be limited

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(30) Feversham Report 72.

(31) It was held in V v R 1979 (3) SA 1006 (T) at 1009E that the provisions of section 7(1) of the Anatomical Donations and Post-Mortem Examinations Act No 24 of 1970 were not in any way applicable to AID. See also Strauss Doctor, Patient and the Law (1980) 147. It is further submitted that the provisions of the above section are not applicable in cases of the in vitro fertilization of a wife's oocyte with her husband or a donor's semen and the reimplantation of the blastocyst into her uterus. The transfer of her fertilised oocyte into a hostess mother would require the consent of the Minister of Health. See further, above at 98-99.

(32) V v R supra.

(33) V v R supra at 1016G. See further, above 254-256.

to the barest essentials[35] in order to retain the hallowed principle of privacy of doctor and patient relationships and the freedom of the doctor to prescribe the therapy he deems to be most desirable for his patient. The specific procedures relating to AID should be left to the discretion of the medical profession whose members are best qualified to deal with them, without excessive legislative interference.[36]

It would seem that our legislature, spurred on by the problems raised in the V v R case and by a desire to protect the offspring of an AID conception against hardship, has grasped the nettle and in the Draft Child Care Bill[37] proposes that an AID child conceived in wedlock with the consent of both spouses shall be deemed to be legitimate '... for all purposes whatsoever in law ...'[38] The wording of section 39 of the above Bill is similar to that contained in the Uniform Parentage Act[39] and various state laws[40] in the USA.

An additional clause not contained in section 39, which it is submitted would be useful in establishing claims of disputed paternity in AID cases, is in relation to blood and tissue tests.[41] These tests are vital to resolve paternity disputes but are not enforceable if the spouse/s decline to submit to them.[42] A section authorising a court to compel parties to submit to such tests would

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(35) For example (i) The question of legitimacy (ii) the requirement of mutual consent (iii) the need for adequate regulation and control of suppliers of human semen.

(36) Carr (1973) 26 Alabama LR 120 at 161.

(37) Cf section 39, Published in (28 October 1981) Government Gazette No 7864.

(38) A straight forward declaration that the AID child is legitimate would eliminate the potential harm to the child which could arise if his status is revealed in litigation concerning his rights to an inheritance or of maintenance.

(39) See section 5.

(40) eg Oklahoma Stat Ann tit 10 ss 551-3 (Supp 1967); California Civil Code Amendment 196(b) 1969.

(41) eg where an husband suspects that a child born to his wife was not fathered by him but was the result of AID undertaken without his consent.

(42) Ranjith v Sheela 1965 (3) SA 103 (D); Van der Harst v Viljoen 1977 (1) SA 795 (C).

allow for accurate decisions by the court in such disputes.(43)

2.5. Regulations issued in terms of Act 56 of 1974(44)

It was my submission supra that although legislation is necessary it should be kept to the minimum suggested. It is my further submission that, should it be deemed necessary in future to extend the control or guidelines, the Act makes provision for the Minister of Health to issue regulations(45) to practitioners. This, it is submitted, would be the preferable way of initiating any further control of AID and ET.(46)

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(43) Our courts do not have the authority in civil cases to compel the parties to submit to a blood or tissue test cf R W Darroll (1965) 82 SALJ 317 at 322. In the United Kingdom section 20(1) of the Family Reform Act 1969 gives the courts a discretionary power to enforce blood tests if they think the circumstances warrant it cf Mary Hayes 'The Use of Blood Tests in the Pursuit of Truth' (1971) 87 Law Quarterly Review 86. In North Carolina statutory authority (North Carolina General Statutes 47-49) exists for ordering blood tests for mother, child and alleged father in cases of paternity disputes. 'The results of such blood grouping tests shall be admitted in evidence when offered by a duly licensed practising physician or other qualified person', but there is no statutory provision dealing with the weight to be given to such evidence.

In State v Camp 286 WC 148, 209 SE 2d 754, 1974 the Supreme Court of North Carolina dealt with the weight to be given regarding properly administered blood tests that reveal non-paternity. The trial court's decision was taken on appeal and the jurors were instructed that if they believed the testimony of the doctor and believed that the tests were properly administered that it would be their duty to return a verdict of not guilty. See also sections 11 & 12 of the Uniform Parentage Act 1974 (USA).

(44) Medical, Dental and Supplementary Health Service Professions Act, section 61(f) (s) & (t).

(45) Act No 56 of 1974:

'61(1) The Minister may, on the recommendation of the council, make regulations relating to -

(s) any matter which in terms of any provision of this Act is required to be or may be prescribed by regulation;

(t) generally, all matters which he considers it necessary or expedient to prescribe in order that the purposes of this Act may be achieved.'

(46) The Feversham Report at p 80 classified AID as falling into a category of actions identified jurisprudentially as 'liberties'. This type of action is categorised as being of such a nature that it is not prohibited by the law on the one hand, while on the other hand it is not afforded any support or encouragement either. The Committee elaborated by describing 'liberties' (AID) as falling within the ambit of behaviour which a majority of the community would deem to be immoral, but which ought not to be classed as criminal.

Factors which lend themselves to this type of regulation are the following:

(i) that only registered doctors should be permitted to collect semen and perform AI.(47)

(ii) in order to ensure the birth of a healthy child, the doctor should subject the donor to a serological test for syphillis and take a smear and culture for gonorrhea within a week prior to accepting his donated seminal fluid. Immediately prior to taking his seminal fluid the doctor should give the donor a complete medical examination devoting special attention to his genitalia.

(iii) that in order to ensure the Rh compatibility of the donor and recipient they should each have a blood test prior to AI being attempted. If the proposed recipient is negative for the Rh factor, only seminal fluid from a donor who is also negative for the Rh factor should be used;

(iv) donors who are affected with venereal disease, tuberculosis, brucellosis or who have any congenital disease or defect should be turned away and their semen should not be used.(48)

Factors such as the suitability of the couple requesting AID or ET both medically, genetically and psychologically should be left entirely in the discretion of the doctor.(49) The thought of state control of AID and ET via a board or agency with power to screen recipient couples, the selection of donors, the collection, storage and supply of semen raises spectres of an Orwellian society or the perverse eugenic program conducted by the Nazis. Thus my submission is

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(47) This regulation would ensure that 'do it yourself' AI situations like that in CM v CC supra did not occur.

(48) New York City Health Code art 21 (1949).

(49) Feversham Report 76 80; Carr (1973) 26 Alabama LR 120 at 156.

that AID and ET should remain what they are now, viz, medical techniques for overcoming sterility, and in order to retain them as benign therapeutic treatments they should remain firmly within the control of the medical profession and not be allowed to become sinister political tools in the hands of unscrupulous governments.

2.5.1. Suggested Code of Practice for AID[50]

The following code of practice was prepared by a committee consisting of lawyers, gynaecologists and geneticists at the request of the National Health Laboratory Service of the Department of Health.

'The Donor

A donor service. Centralization of strictly controlled donor services is recommended. An adequate supply of donors is necessary and they should be recruited by a medical practitioner attached to an AID service. This is best run by an organization possessing the necessary facilities, which should include genetic and laboratory services (the latter is required, for example, for culturing of semen for gonococci) and medical personnel. There would be no objection if this procedure was carried out by private practitioners, provided the code of practice was adhered to. In general, frozen semen from a sperm bank is preferable to fresh semen, but fresh semen may be used under certain circumstances. Serious consideration should be given to establishing semen banks in the major centres of South Africa.

Selection of donor. Donors must be carefully selected after a medical examination and the taking of a detailed family history, with particular reference to inherited and psychiatric disorders. Potential donors should undergo semen analysis, a standard serological test for syphilis and culture for gonorrhoea not less than 7 days before the seminal fluid is obtained from them, if the history suggests that they might be suffering from gonorrhoea. In the event of a repeat donation a medical history should again be taken. No person suffering from any venereal disease, hepatitis or other serious infectious disease, or suffering from any disease or congenital defect known to be transmissible by the genes, should be used as a donor. If, in these circumstances, a potential donor is not accepted he should be referred for appropriate advice.

Anonymity of the donor. The medical practitioner or other person who receives semen from the donor shall not disclose the identity of the donor to the medical practitioner effecting the insemination, nor shall any person disclose his identity to the recipient of the semen or her husband.

Reimbursement. Donors should not be paid but are entitled to reimbursement in respect of expenses incurred in connection with the donation of semen. The donor shall be informed by the practitioner that the semen obtained from him is intended for the purpose of artificial insemination.

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(50) Published in (8 Nov 1980) S A Medical Journal 781 & 782.

Maximum number of donations. The medical practitioner who issues the semen shall ensure that not more than five successful inseminations are effected with semen obtained from any particular donor.

The Recipient and her Husband

Selection and counselling of recipient couple. AID should be performed only on a married woman and upon her and her husband's express wish. Before a decision is made to proceed with AID, the couple should be investigated medically. If AID is requested on account of suspected infertility, the husband should have a general medical examination and at least three semen analyses. For the wife a general gynaecological examination and confirmation of ovulation should be routine. Even in the absence of any history of pelvic or abdominal disease or operation, tubal patency testing should be mandatory. Once infertility is established, or AID is indicated for other reasons, a final decision to undertake the procedure should be deferred until the practitioner has discussed the implications of AID in detail with the couple. This discussion should involve both partners from the start. The practitioner should assess the couple's social and psychological attitudes and not perform AID unless he has satisfied himself that they are apparently living together in a state of harmony and are capable of accepting the responsibilities associated with parenthood. If he deems it necessary, the practitioner may refer the couple to their family doctor and/or psychiatrist, clinical psychologist, social worker or minister of religion to assist them in arriving at a responsible decision.

Written consent from recipient couple. If, after medical assessment and counselling of the couple, the indications for AID are favourable, treatment should start as soon as possible. The practitioner carrying out the insemination should obtain consent in writing from the woman and her husband beforehand. In effecting AID he should respect the wish of the couple in regard to the population and religious groups to which the donor shall belong, provided he does not act in contravention of any law. The wish of the spouses should be stated in writing and signed by both, the document being retained by the practitioner for a reasonable period.

Anonymity of the recipient and her husband. The medical practitioner who carries out the insemination should not disclose the identity of the recipient or her husband to the donor, if known to him, or to the doctor or any other person who obtains semen from a donor. The fact that the child is the product of AID should not be disclosed to anyone else either.

Donor/Recipient Matching

Some matching is desirable but recipients should not be given the impression that it is in any way comprehensive. Nevertheless, matching should be done for population group, colour of hair, eyes and skin, as well as for the ABO and Rh blood groups. Blood grouping should be done in a recognized serology laboratory. If the woman to be inseminated is Rhesus negative, a Rhesus-negative donor will be used. If the woman comes from a population group in which there is a high frequency of a particular disease (eg Tay-Sachs disease in Ashkenazi Jews; thalassaemia in Greeks, Indians, Italians and Chinese) she should be tested for the trait and, if positive, the donor should be selected only if he does not possess the particular gene.

Follow-up

The doctor who selected the donor should be informed of any untoward outcome of a pregnancy resulting from AID. This information should be passed on to the donor if it may be of relevance to his future progeny.'

3. Suggested guidelines for legislation on Embryo Transfer

It is submitted that the problems involved in ET are more complicated than those attached to AID and as a result necessitate a more complex form of legislation to regulate the many anticipated problems. I would thus submit that the following guidelines should form part of some future Act, preferably the Human Tissue Bill[51] (as it is now):

(a) IVF and ET should not be prohibited, such action would infringe a fundamental interest of infertile women viz their right to bear children.[52] It is clear from the provisions of the Human Tissue Bill that it is not the government's intention to prohibit either AID or ET.[53]

(b) The donor of a human egg should have absolutely no legal interest in a child born from that egg except of course in a situation where the donor has contracted with a hostess to carry the child for her, nor should the child have any legal interest in the donor.[54] Interest in the integrity of the family of which the child is a member offers an overriding rationale for this rule.

(c) Ova donation should be regulated in such a way as to negate the profit motive completely.[55] Because discomfort and risk are involved potential donors should be discouraged from undergoing unnecessary surgery. Oocytes should rather be collected from women who are undergoing appropriate surgery for other reasons.[56]

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(51) (14 August 1981) Government Gazette 7722.

(52) A M Capron 'Legal Rights and Moral Rights' in Biomedical Ethics and the Law edited by J M Humber and R F Almeder (1976) at 387; R P Richards 'Ethical and Theological Aspects (1971) Soundings 315 at 318; D J Keefe 'Biblical symbolism and the morality of in vitro fertilization' (1974) Theology Digest 309.

(53) (14 August 1981) Government Gazette 7722, see section 18 at page 21.

(54) Reilly Genetics and the Law (1975) 372.

(55) See section 16(1) of the Human Tissue Bill.

(56) R G Edwards and D J Sharpe 'Social Values and Research in Human Embryology' (1971) 231 Nature 87; D Rorvik (June 1975) 180 Good House keeping 78 at 127. It is submitted that if the operative procedure is

(continued on the next page)

(d) The parents of a child born to a surrogate mother are its genetic parents. A surrogate who has been specifically employed for this purpose should have absolutely no legal interest in the child nor the children in their surrogate.(57) The name of the surrogate should not appear on the birth certificate, nor should it be recorded on any other document. The best interests of the child require the utmost concern for confidentiality.(58)

(e) Surrogate motherhood should be regulated in such a way as to guarantee the best interests of the developing foetus.(59)

4. Existing Legislative Control of Fertility in S.A.

There seems to have been very little conscious or premeditated effort to regulate fertility by way of legislation in S.A. law. However two of the most blatently racist statutes, viz the Immorality Act(60) and the Prohibition of Mixed Marriages Act,(61) which were initially passed to appease the narrow sectarian fears of a minority of the population, can also be interpreted as legislation with

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(56) (continued from the previous page)
performed not for purposes of maintaining or improving the patient's health but solely to recover oocytes for culture, fertilization and transfer the issues are compounded. It is submitted that one would then be obliged to consider a more complex risk-benefit ratio. In the initial phases of experimentation the experimenter would have to balance the following interests viz the risk to the mother (in the procedure itself) against the benefits to her (a successful pregnancy) as well as the risk to the foetus (possibility of deformity).

(57) Oakley (1974) 8 Family Law Q 385 at 393; Cusine (28 June 1979) New Law J 627 at 628; Erickson (1978) 65 California LR 617 619-620; Gerda Range 'Surrogate Mother is Recruited by Ad for Artificial Insemination' (1976) 11 Ob Gyn News 36; 'Test Tube Babies' (1977) 42 U.S. Catholic 9; Gerda Range 'Surrogate Mother Delivered : Legal Cautions Voiced' (1977) 12 Ob Gyn News 19; Noel P Keane (1980) 2 S Illinois Un LJ 147 at 153.

(58) Klayman (1970) 39 Cincinnati LR 291 at 296; Shaman (1979/80) 18 J of Family Law 331 at 338.

(59) Reilly Genetics and the Law (1975) 372; Sergeant (1970) 19 Drake LR 409 at 433; Jacobs & Luedtke (1965) Wisconsin LR 859 at 880; Sagall (1973) 9 Trial 59 at 61.

(60) Act No 23 of 1957.

(61) Act No 55 of 1949; See also S Rose, J Hambley and J Haywood Science, Racism & Ideology (1974) 255.

a positive eugenic basis viz to improve and promote the genetic transmission of desirable traits in the white population group by a process of selective breeding. These Acts thus clearly have a limiting or controlling effect on fertility in S.A. by restricting an individual's freedom of choice of a marriage or breeding partner.

The Abortion and Sterilization Act(62) narrowly circumscribes the circumstances under which abortion will be permitted in S.A. law.(63) This indicates an encouragement of fertility by affording very strict protection for a foetus. We have also analysed the Anatomical Donations and Post-Mortem Examinations Act(64) and seen that it does not apply to AID and that it controls but does not prohibit ET. The potential practice of ET is regulated by the provisions of section 7(1) & (2) of this Act(65) and depends on written authority being granted by the Minister of Health. He will in turn presumably be advised by the Council of the Medical and Dental profession. This again demonstrates a fairly liberal attitude to these modern techniques for combatting sterility and encouraging fertility.

The controls over fertility exercised by our common law are sensible and can be described as encouraging fertility. The common law prohibits marriage between parties who are below the age of puberty(66) which is deemed to be 12 years for girls and 14 years for boys. While in terms of section 26 of the Marriage Act(67) boys below the age of 18 and girls below the age of 15 require the written permission of the Minister of the Interior in order to marry.

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(62) Act No 2 of 1975.

(63) Cf section 3(a) (b) (c) (d) of the Act.

(64) Act No 24 of 1970.

(65) Act No 24 of 1970.

(66) Van der Vyver & Joubert Persone & Familiereg (1980) 433 434; Spiro Law of Parent and Child 3rd ed (1971) 56; contra Hahlo Husband and Wife 4th ed (1975) at 87.

(67) Act No 25 of 1961; Hahlo op cit at 66.

It is submitted that there is currently a dangerous lacuna within the scope of IVF in that our current law does not define the legal status of the blastocyst or offer it any protection during its stay in the laboratory. Furthermore the legal relationship between children born via IVF, the physician (and laboratory) who mediated the pregnancy, the gamete donor and the parents (ie the couple who desire to be parents) should be defined.

5. Legal status of the human blastocyst after test tube fertilization, but prior to uterine transfer

Whether a physician in charge of an IVF culture or a third party has a special duty of care in regard to the blastocyst can only be determined if the legal status of a human blastocyst has been determined.

Philosophically, the moment at which a foetus becomes a human being remains controversial.(68) From a scientific basis, one cannot reject the idea that after the egg has been fertilized it becomes a human product.(69)

This very issue formed the subject of litigation when Doris and John Del Zio sued the Columbia Presbyterian Medical Centre(70) for $ 1,5 million arising from the actions of the Chairman of the Department of Obstetrics, Dr Raymond van de Wiele.

The couple were married but infertile and in 1974 Dr Landrum Shettles undertook to attempt IVF and ET using their gametes. The oocytes were successfully aspirated from the wife and fertilised with her husband's semen in vitro.

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(68) D J Horan 'The unborn's civil rights' (1972) 72 Wall Street Journal 18; P Ramsay 'Shall we "reproduce"? The medical ethics of in vitro fertilization' (1972) 220 JAMA 1346-1350; L R Kass 'Babies by means of in vitro fertilization: Unethical experiments on the unborn?' (1971) 285 N Engl J Med 1174-1179.

(69) Sir Harold Himsworth 'The Human Right to Life : Its Nature and Origin' in Biomedical Ethics and the Law (1976) 169 at 171.

(70) Del Zio v Presbyterian Hospital 74 Civ 3488 (SDNY Apr 12 1978); see also Shapiro & Spece Bioethics & Law (1981) 522-527.

The Chairman of the Department upon learning of Dr Shettle's undertaking decided that it was in conflict with federal regulations on human research, and destroyed the cleaving blastocyst in the test tube.(71)

How would a SA court decide a similar case? It is submitted that prior to its implantation the blastocyst, which consists of gametes drawn from the bodies of the spouses, should be considered to be their 'property' and that the principles of Aquilian liability should apply in determining delictual liability for damage occasioned to it.(72) It is further submitted that although the blastocyst cannot be considered to be a foetus until it is successfully implanted in the mother's uterus and though it does not acquire legal personality until it is born alive,(73) yet because of the intimate connection between it and the germ cell donors the blastocyst is imbued with great value, one that any reasonable person would be expected to anticipate.(74)

It is submitted that once the blastocyst has been implanted and the process of pre-natal development has been initiated the normal rules of SA law will apply viz that it will be protected from being aborted by the provisions of Act No 2 of 1975(75) and any rights which accrue to the unborn child will be held in abeyance according to the rules of the nasciturus fiction.(76)

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(71) Reilly Genetics and the Law (1975) 367.

(72) I make this submission because the cleaving blastocyst cannot yet be considered to be a foetus whose interests are protected by the nasciturus fiction; see Pinchin NO v Santam Insurance Co Ltd 1963 (2) SA 254 (W): Stevenson NO V Transvaal Provincial Administration 1934 TPD 80, 85; Strauss Doctor, Patient and the Law 1980 at 162, 163.

(73) D 1.5.7; 1.5.26; 50.16.231; Grotius Inleiding 1.3.4; Voet Commentary 1.5.5; 39.5.12; Boberg The Law of Persons and the Family (1977) 8-12; Stevenson NO v Transvaal Provincial Administration supra.

(74) Reilly Genetics and the Law (1975) 367; Wolfgang Friedmann 'Interference with Human Life : Some Jurisprudential Reflections' (1970) 70 Columbia Law Review 1058 at 1067.

(75) The Abortion and Sterilization Act.

(76) See notes 72 and 73 supra.

6. Possibility of extended State Control of AID and ET

The scope of this thesis and certainly of this sub-section does not extend to an extensive discussion of the merits or demerits of genetics or more especially eugenics. However it is difficult to divorce AID and ET from these topics completely; hence this very brief excursus on the relevance of these disciplines to AID and ET.

The practice of AID and ET are currently entirely voluntary processes, the advisability and feasibility of which are decided upon by the spouses themselves in conjunction with their doctor. If the doctor decides that they are medically and psychologically suitable he will acquire the semen or ova from donors whose identity he will conceal from the recipient. In view of the expense involved in the IVF and ET process when compared against the many basic medical needs which large sections of SA's population have to manage without, it is submitted that State assistance should not be given to assist research in this regard but that it should remain within the domain of private medicine and medical research.

There is currently no legislation in SA which seeks to establish or control sperm or ova banks which will secure, store and distribute germinal materials. Should such legislation be introduced[77] giving the state or its representatives

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(77) But see the Draft Human Tissue Bill (14 August 1981) Government Gazette No 7722. Section 18 provides for 'authorised institutions' to collect, preserve and issue human tissue.

18(1) An authorised institution may receive, acquire, preserve or use any tissue which has been imported in terms of section 17 or which has been lawfully removed from

(a) the body of a deceased person under the provisions of this Act; or

(b) the body of a living person.

(2) An authorized institution may at any time issue any tissue in its possession to a medical practitioner or dentist for any therapeutic or scientific purpose.'

In its current form section 18 does not prohibit a practitioner from obtaining semen or ova from his own sources, but this can easily be achieved by amending section 18 by merely prefixing 'An authorised institution' with the word only.

It is a chilling thought that should this Bill become law in its present form that one word stands between our current Christian ethics on reproduction of the human species and a possible 1984 scenario.

monopolistic control over the selection, storage and distribution of genetic materials, with its inherent authority to enforce the provisions of such legislation, then it is obvious that the step from voluntary use of AID and ET to government control is a very small one.(78)

For example, government officials in the Department of Health are unlikely to restrain the tendency to make qualitative judgments(79) once they begin to regulate the practice by which germinal materials are selected. If the government regulates the storage and distribution of sperm and ova, will it be capable of refraining from deciding whose sperm and whose ova are worthy of storage?(80)

The current status of AID and ET is that they are entirely voluntary procedures in which the state is marginally involved via a limited element of legislative control. It is submitted that eugenics plays a very limited role in the approach of physicians who currently utilise these techniques but that their concern is solely to help their patient conceive a child. The donor is anonymous, few detailed records are kept, and everything is done as secretly as possible.(81)

However the potential of using AID as a tool of eugenic improvement of the race was recognised many years ago when Nobel Laureate Herman J Muller(82) propounded the advantages of 'germinal choice'.(83) He suggested a plan which

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(78) Kindregan (1972) 23 Hastings LJ 1401 at 1413.

(79) Homer H Clark 'Law as an Instrument of Population Control' (1968) 40 University of Colorado Law Review 179.

(80) It has been suggested that in the event of widespread nuclear contamination that a government in order to ensure the stable eugenic progress of the nation and to prevent deformed or abnormal children being born, might forbid the conception of children except by use of genetic materials issued by the government from pre-stored and hence uncontaminated stocks. Cf G Taylor The Biological Time Bomb (1968) 34; George Wald 'The Evolution of Life and the Law' (1967) 19 CaseWestern Reserve L.R. 17 at 18.

(81) Mastroianni Encyclopedia of Bioethics (1978) 1450.

(82) H J Muller 'Genetic Progress by Voluntarily Conducted Germinal Choice' in Man and His Future ed G Wolstenholme (1963) 247.

(83) H J Muller 'Means and Aims in Human Genetic Betterment' in The Control of Human Heredity and Evolution ed T Sonnenborn (1965) 100;

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would result in up-grading the genetic quality of the human genetic stock by encouraging the use of AI with the sperm of genetically well-endowed donors.(84) Other leading figures from the world of science who have supported this concept of voluntary germinal choice include Julian Huxley and F H Crick.(85) The proponants of utilising AID as a eugenic tool see it as a means of helping 'mankind progress toward a higher estate under scientific guidance.'(86) Their submission is that by eliminating undesirable traits and using only those sperm and/or embryo donors having desirable physical and mental characteristics the stock would be improved. Their views did not meet with universal acceptance amongst their fellow biologists, some of whom roundly condemned them, as being 'dehumanising',(87) as 'diminishing the genetic diversity'(88) of the population, and as requiring a wisdom in the selection of the desirable genetic traits which has not yet been developed.(89)

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(83) (continued from the previous page)
'If the opportunity of germinal choice were opened, a gradually increasing number of seemingly 'normal' couples, in addition to a large proportion of those afflicted with seminal inadequacy or obvious genetic defect, would elect to use this means of having at least a part of their family. Moreover, as the saying goes, "nothing succeeds like success" and the obvious successes achieved by this method would within a generation win it still more adherents'(at p 116.)

(84) The existence of The Repository for Germinal Choice was reported in Time 10 March 1980, at 49, and 'A Bank for Nobel Sperm', (1980) 207 Science 1326. It was established by a wealthy eugenicist largely as a philanthropic project. This eutelegenic sperm bank has collected and frozen the semen of at least five Nobel Prize laureates. Advertising its services through MENSA, an international society consisting of members selected for their exceptional intelligence, the Repository for Germinal Choice sends select applicants anonymous profiles of its sperm donors for their choice. As of March 1980, three women had become pregnant through this process.

(85) D Rorvik Brave New Baby (1971) 189; 'Comments on Genetic Evolution' (1961) 90 Daedalus 451-476.

(86) R Dubos Man Adopting (1965) 432; James D Watson 'Children from the Laboratory' (1973) Prism 11 at 13.

(87) C Lasch Haven in a Heartless World (1977).

(88) P Medewar The Future of Man (1960); L S Penrose The Social Impact of Modern Biology (1968) 94.

(89) R Dubos op cit 435; John Maynard Smith 'Eugenics and Utopia' (1965) 94 Daedalus 487 493-500.

It is submitted that any decision to carry out a sustained programme of germinal selection via AID or ET cannot be conducted successfully on a voluntary basis. In order to encourage widespread participation the government would have to get involved in a programme in which the population is educated as to the 'advantages' of this revolutionary form of procreation and in addition provide a system of penalties and incentives via legislation.(90) It is highly unlikely, however, in a situation where for example the government already controls the source of genetic materials via its semen and ova banks and where it is now within the grasp of scientists to eliminate pregnancy by the perfection of the artificial wombs(91) with which they are now experimenting, that they would leave the planning, direction and control of the imminent genetic revolution to the discretion of scientists.

It is thus submitted that to expect a state to leave in the hands of private parties the power of radically altering the genetic quality of the population where their existing control is already well-established, would require an act of political self-restraint of a character unknown in human history.(92) Where the state did exercise its prerogative to control procreation would it adhere to goals which are humanly and ethically desirable or would their motivation be primarily political?(93) In other words, would they create a Shangrila or

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(90) P Reilly Genetics, Law and Social Policy (1977) 207; J Lederberg 'Egg Transplants : Not the End of the World: (1971) 14 Current Contents 5; Horace Krever QC 'Some Legal Implications of Advances in Human Genetics' (1975) 27 Canadian Journal of Genetics & Cytology 283 at 285-7. Albert P Blaustein 'Arguendo : The Legal Challenge of Population Control' (1968) 3 Law and Society Review 107, 111; Robert M Park 'Not Better Lives, Just Fewer People : The Ideology of Population Control' (1974) 4 Int J of Health Services 691, 693; Robert C Cook 'World Population Prospects' (1966) 27 Ohio State LJ 634, 642; Richard A Falk 'World Population and International Law' (1969) American J of Int Law 514 518.

(91) D Rorvik op cit 189; A Rosenfield The Second Genesis 1969 118-120.

(92) W T Vukowich 'The Dawning of the Brave New World - Legal, Ethical and Social Issues of Eugenics' (1971) 2 Univ of Illinois Law Forum 189 201 207; F P Grad 'Legislative Responses to the New Biology : Limits and Possibilities (1968) 15 UCLA Law Review 480 at 491.

(93) John V Tunney and Meldon E Levine 'Genetic Engineering' (1972) Saturday Review of Science 23 at 24 25; Ernest B Attah 'Racial Aspects of Zero Population Growth' (1973) 180 Science 1143.

a Brave New World? Should any government thus embark on a programme of germinal selection they will create a situation which will severely test the ability of that society to govern itself efficiently and still maintain individual liberty.(94) Even if the eugenic program is voluntary and not compulsory it is doubtful whether a society would be able to maintain the currently cherished values of a free society while using its powers of persuasion to channel its citizens' breeding and family practices into preordained eugenic patterns.(95)

It is thus submitted again that legislative control of human reproduction is a slippery slope and that too rigid a control of AID and ET can easily lead to government control in the fields of genetics and eugenics.(96)

Should the state decide to take positive steps to improve the genetic composition of man, it is submitted that their action will be based on the following three premises.

First, that through the many and varied research programs being conducted by biologists worldwide, man will achieve technical mastery over human reproduction(97) within the next thirty to fifty years. Although no artificial womb has yet produced a viable human child, such a womb for human embryos has been constructed at Stanford University by Robert Goodlin.(98) At the National

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(94) Grad op cit 491; L E Rosovsky 'Legal Aspects of Human and Genetic Engineering' (1975) 2 Manitoba LJ 291 at 296.

(95) M H Shapiro 'Who Merits Merit? Problems in Distributive Justice and Utility Posed by the New Biology' (1974) 48 Southern California LR 318 at 323; Catherine S Chilman 'Public Social Policy and Population. Problems in the United States' (1973) 47 Social Services Review 511 at 517.

(96) Vukowich op cit 200; Melanie Fong & Larry O Johnson 'The Eugenics Movement: Some Insight into the Institutionalization of Racism' (1974) 9 Issues in Criminology 89 at 92-100.

(97) James M McCullough 'Genetic Engineering. A brief review' (1970) Library of Congress Legislative Reference Service; Bernard D Davis 'Prospects for Genetic Intervention in Man' (1970) 170 Science 1279 at 1280.

(98) C Rivers 'Genetic Engineering Portends a Grave New World' (1972) 55 Saturday Review 23; Leah L Curtin & Hoseph N Petrick 'Reproductive Manipulation' (1977) 16 Nursing Forum 7 at 17; Shapiro & Spece Bioethics & Law (1981) 516-517.

Heart Institute in Bethesda an artificial womb for lamb foetuses has succeeded in keeping such foetuses alive and aided in their development. However, to date none have survived to the end of their normal gestational time.(99) The results of this biological research will be to ultimately give man control over the transmission of life through asexual means of reproduction like cloning(100) nuclear transplantation(101) and parthenogenesis.(102)

Second, having gained control of a superior means of reproduction, the state will move to destroy the nuclear family(103) as a unit and as a source of population supply.(104)

Third having gained control of the process of reproduction the state is likely to prohibit private reproduction by removing the right to reproduce from the realm of private choice.(105) Once those in power realize that they have the means to produce a carefully selected generation of citizens, a strong secondary motive will be to accomplish specific political and social goals eg a population

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(99) P Stoler 'Man into Superman : The Promise and Peril of the New Genetics' (1971) 97 Time 33; Shapiro & Spece Bioethics & Law (1981) 516-517.

(100) Cloning is a method of asexual reproduction in which cell tissue from an adult organism is developed into a separate, but genetically identical organism. See Robert L Sinsheimer 'Asexual Reproduction' in Encyclopedia of Bioethics (1978) 1451-2.

(101) Nuclear transplantation is a form of reproduction without fertilization. It is accomplished by the removal of the haploid nucleus from an unfertilised ovum and the implantation of a diploid nucleus into the ovum. See Sinsheimer ibid.

(102) Parthenogenesis is any manner of reproduction by the female alone, without the use of male germinal materials. See Kindregan (1972) 23 Hastings LJ 1401 at 1418.

(103) F Lundsberg The Coming World Transformation 1963 295; B Lindsey & W Evans The Companionate Marriage 1927.

(104) Richard A McCormick 'Reproductive Technologies - Ethical Issues' in Encyclopedia of Bioethics (1978) 1455; Fong & Johnson (1974) 9 Issues in Criminology 89 at 96.

(105) Linda Gordon 'The Politics of Population : Birth Control and the Eugenics Movement' (1974) 8 Radical America 61 at 97.

produced by genetic engineers could be programmed to suit the needs of a particular society.(106) Thus by careful selection, classification and manipulation of genetic materials, government planners could produce qualities it desired in its citizens.(107)

7. Foetal and Embryo Research

Foetal and embryo research is a tightly controlled and emotive area of medicine. In the USA and Britain legislation has been enacted to control research in these areas.(108)

The British guidelines were developed and drafted by an expert advisory group appointed by the Government and chaired by Sir John Peel, a Fellow of the Royal College of Obstetrics and Gynaecology.(109) Their report is known as the 'Peel Report' after the chairman. The Peel Report stated that a foetus of a gestational age of over 20 weeks would be regarded as viable for purposes of research policies and that research on such a foetus was prohibited unless

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(106) Rebecca J Cook 'Formulating Population Policies : A Legal Approach' (1973) 4 Lawasia 86 90-107; Edmund H Kellog 'Reform of Laws Affecting Population Growth ; Recent Developments' (1975) 10 Journal of Int Law and Economics 1 at 2-21; Rebecca J Cook 'Formulating Population Policy : A Case Study of the United States (1974) 3 Environmental Affairs 47 48 51; Kenneth A Yates 'Population Policy-Making : Reproductive Freedom and the Compelling State Interest' (1973) 42 UMKC Law Review 201.

(107) J D Watson 'Potential Consequences of Experimentation with Human Eggs' paper presented before the Committee on Science and Astronautics, U.S. House of Representatives on 28 January 1971; James M Dunlop 'Genetic Engineering' (1976) Nursing Times 169 170; Joseph Greenfeld 'Advances in Genetics that can Change Your Life' (1973) Today's Health 20 at 22; Edmond A Murphy 'The Normal Eugenics and Racial Survival' (1975) 136 The John Hopkins Medical Journal 98-106.

(108) G J Annas, L H Glantz & B F Katz Informed Consent to Human Experimentation ' The Subject's Dilemma (1977) 206; Sheila A M McLean (editor) Legal Issues in Medicine (1981) 96 and 163; James M Humber and Robert F Almeder (editors) Biomedical Ethics and the Law 2nd ed (1979) 285-295.

(109) 'The Use of Foetuses and Foetal Material for Research' Report of the Advisory Group Chaired by Sir John Peel Cmnd No 3201 HMSO, London 1972.

'consistent with treatment necessary to promote life'.[110] The guidelines of the Peel Report, set out below,[111] are those applicable in Britain today:

'1. In utero research is only permissible if its purpose is to benefit the mother or the fetus. Any other in utero research is impermissible even if the mother intends to have an abortion.[112]

'2. Only procedures that are performed to promote the life of the fetus are permissible on viable fetuses after delivery. According to the Peel Report evidence of a period of gestation of twenty weeks (approximately 400-500 grams) should be regarded as prima facie proof of viability.[113]

'3. Virtually any procedure may be performed on a previable ex utero fetus as long as it is found by the hospital ethics committee that the research is "valid," that the sought after information cannot be obtained any other way, and that investigators have the necessary facilities and skills. However, to ensure an extra margin of safety, only fetuses weighing 300 grams may be used for such research.[114]

'4. The issue of consent is treated very differently in the British guidelines than in the United States guidelines. The Peel report finds that when the fetus is viable, the parent's consent to procedures that promote and preserve the fetus' life can be "inferred." In the H.E.W. guidelines consent is never inferred. When the procedure will neither benefit nor harm the fetus, the Peel Report requires the consent of one parent.[115]

'5. All fetal research must be approved by an "ethical committee" within the institution in which the research is to be conducted. These committees are to consist of only physicians.'[116]

It is submitted that these provisions do not exclude research on embryos and blastocysts and it is in this sphere that researchers need to do a great deal of work to perfect the IVF and ET process.

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(110) Peel Report ibid.

(111) The summary quoted infra was published in Annas et al Informed Consent to Human Experimentation : The Subject's Dilemma 1977 at 210.

(112) See Peel Report para 26.

(113) See Peel Report paras 28-31.

(114) See Peel Report paras 32-35.

(115) See Peel Report paras 41-42.

(116) See Peel Report paras 47-48.

In the USA the decision in Roe v Wade[117] which legalised abortion resulted in an increased number of foetuses, the products of legalised abortions, becoming available for research. The issue as to whether such research should be prohibited rapidly came to the forefront. The public outcry which ensued resulted in the imposition of a moratorium on all subsidies for foetal research and the establishment of the Commission for the Protection of Human Subjects of Biomedical and Behavioral Research which was mandated to study the issues involved in foetal research and to report to the Secretary for Health, Education and Welfare its conclusions on whether or not such research should be funded and, if so, within what limitations:[118]

> 'On July 29, 1975, the Secretary of Health, Education and Welfare lifted the ban on funding of projects involving fetal research that comply with regulations issued by him on that date. After provision for review of applications for funding of fetal research projects by ethical advisory boards, the regulations delimit the specific boundaries of permissible research as follows:
>
> s 46.206 General limitations.
>
> (a) No activity to which this subpart is applicable may be undertaken unless' (1) Appropriate studies on animals and nonpregnant individuals have been completed; (2) except where the purpose of the activity is to meet the health needs of the particular fetus, the risk to the fetus is minimal and, in all cases, is the least possible risk for achieving the objectives of the activity; (3) individuals engaged in the activity will have no part in: (i) Any decisions as to the timing, method and procedures used to terminate the pregnancy, and (ii) determining the viability of the fetus at the termination of the pregnancy; and (4) no procedural changes which may cause greater than minimal risk to the fetus or the pregnant woman will be introduced into the procedure for terminating the pregnancy solely in the interest of the activity.
> (b) No inducements monetary or otherwise, may be offered to terminate pregnancy for purposes of the activity.
>
> s 46.207 Activities directed toward pregnant woman as subjects.
>
> (a) No pregnant woman may be involved as a subject in an activity covered by this subpart unless: (1) The purpose of the activity is to meet the health needs of the mother and the fetus will be placed at risk only to the minimum extent necessary to meet such needs, or (2) the risk to the fetus is minimal.

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(117) 410 U.S. 113 (1973).

(118) Annas, Glantz & Katz Informed Consent to Human Experimentation : The Subject's Dilemma (1977) 200-210; A R Hodder Legal issues in Pediatrics and Adolescent Medicine (1977) 89-101.

(b) An activity permitted under paragraph (a) of this section may be conducted only if the mother and father are legally competent and have given their informed consent after having been fully informed regarding possible impact on the fetus, except that the father's informed consent need not be secured if: (1) The purpose of the activity is to meet the health needs of the mother, (2) his identity or whereabouts cannot reasonably be ascertained, (3) he is not reasonably available, or (4) the pregnancy resulted from rape.

2 46.208 Activities directed toward fetuses in utero as subjects.

(a) No fetus in utero may be involved as a subject in any activity covered by this subpart unless: (1) The purpose of the activity is to meet the health needs of the particular fetus and the fetus will be placed at risk only to the minimum extent necessary to meet such needs, or (2) the risk to the fetus imposed by the research is minimal and the purpose of the activity is the development of important biomedical knowledge which cannot be obtained by other means.
(b) An activity permitted under paragraph (a) of this section may be conducted only if the mother and father are legally competent and have given their informed consent, except that the father's consent need not be secured if: (1) His identity or whereabouts cannot reasonably be ascertained, (2) he is not reasonably available, or (3) the pregnancy resulted from rape.

s 46.209 Activities directed toward fetuses ex utero, including nonviable fetuses, as subjects.

(a) No fetus ex utero may be involved as a subject in an activity covered by this subpart until it has been ascertained whether the particular fetus is viable, unless: (1) There will be no added risk to the fetus resulting from the activity, and (2) the purpose of the activity is the development of important biomedical knowledge which cannot be obtained by other means.
(b) No nonviable fetus may be involved as a subject in an activity covered by this subpart unless: (1) Vital functions of the fetus will not be artificially maintained except where the purpose of the activity is to develop new methods for enabling fetuses to survive to the point of viability, (2) experimental activities which of themselves would terminate the heartbeat or respiration of the fetus will not be employed, and (3) the purpose of the activity is the development of important biomedical knowledge which cannot be obtained by other means.
(c) In the event the fetus ex utero is found to be viable, it may be included as a subject in the activity only to the extent permitted by and in accordance with the requirements of other subparts of this part.
(d) An activity permitted under paragraph (a) or (b) of this section may be conducted only if the mother and father are legally competent and have given their informed consent, except that the father's informed consent need not be secured if: (1) His identity or whereabouts cannot reasonably be ascertained, (2) he is not reasonably available, or (3) the pregnancy resulted from rape.

s 46.210 Activities involving the dead fetus, fetal material, or the placenta.

Activities involving the dead fetus, macerated fetal material, or cells, tissue, or organs excised from a dead fetus shall be conducted only in accordance with any applicable State or local laws regarding such activities.

> s 46.211 Modification or waiver of specific requirements.
>
> Upon the request of an applicant or offeror (with the approval of its Institutional Review Board), the Secretary may modify or waive specific requirements of this subpart, with the approval of the Ethical Advisory Board after such opportunity for public comment as the Ethical Advisory Board considers appropriate in the particular instance. In making such decisions, the Secretary will consider whether the risks to the subject are so outweighed by the sum of the benefit to the subject and the importance of the knowledge to be gained as to warrant such modificaiton or waiver and that such benefits cannot be gained except through a modification of waiver. Any such modificaitons or waivers will be published as notices in the Federal Register.'(119)

For the most part, the Secretary adopted the recommendations of the Commission. The Department of Health, Education and Welfare regulations, however, require paternal consent for nontherapeutic research on the pregnant woman or on the fetus in utero. These requirements apply unless the father's identity or whereabouts cannot reasonably be ascertained, he is not reasonably available, or the pregnancy resulted from rape.(120)

The physician who is called on to determine the legal definition of "reasonably available" may presumably wonder if the father is to be considered unavailable if he is out of the room when consent is requested or if the man must be proved to be on a submarine cruise or lost in Tibet.(121)

Furthermore, with regard to research on the fetus in utero, consent may be given only if the mother and father are "legally competent," without any definition of the term. This requirement may mean that only fetuses of adult women of sound mind may be used in research; it may include fetuses of minors emancipated in fact; it may include only fetuses of legally emancipated (i.e., married) minors and adults; or it might be argued that it would apply to any fetus of any pregnant woman who had not been declared mentally incompetent.'(122)

It is submitted that the American provisions likewise do not ban embryo and foetal research which is capable of adding to the knowledge necessary to perfect IVF and ET.

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(119) Hodder op cit at 98-100. Fetus and fetal are 'Americanisms' and are quoted verbatim.

(120) Ibid.

(121) Ibid.

(122) Ibid.

The provisions of the Anatomical Donations and Post-Mortem Examinations Act[123] do not prohibit the use of oocytes for research ex utero and it is submitted that in South Africa non-therapeutic medical research on foetuses and embryo's would be justified where there is firm medical and ethical support for the research which promises important new knowledge of benefit to science and mankind and where there is a negligible risk of a defective child subsequently being born.[124]

8. Conclusion

I accept the necessity of limited legislative control of certain aspects of human fertility but I have also attempted, albeit very briefly, to point out the dangers to our current freedom to reproduce and raise children in a family should the state usurp total control of the process of reproduction.[125]

The issue thus boils down to a conflict between the following interests. On the one hand, we have the private values of family, sex and human reproduction which presently are universally accepted human rights[126] which will be forced to strike a balance with the needs of the community and the state on the other hand. In the coming decades the right of the individual to live, love and procreate will be put in issue as never before in human history. The pressure of supposed necessity will create a great temptation to sacrifice the individual, his family and sexual freedoms.[127]

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(123) Act No 24 of 1970.

(124) J M Burchell 'Non-Therapeutic Medical Research on Children' (1978) 95 SALJ 193 at 213; Smit (1977) 51 SA Medical Journal; Strauss Doctor, Patient and the Law (1980) 353-355.

(125) Krever (1975) 27 Canadian J of Genetics and Cytology 283 et seq.

(126) Article 16 Universal Declaration of Human Rights (1948) G.A. Resolution 217(A III.

(127) Kindregan (1972) 23 Hastings LJ 1401 at 1425.

The biological revolution will create new powers for man[128] but these powers may also be used to limit individual freedom and to control human fertility.[129] Ultimately, however, man must consider very carefully whether his attempts to control his genetic destiny by eliminating the individual's choice to reproduce with the partner of his choice may in fact not lead to the obliteration of human rights as we know them and the advent of a new technological dark age.[130]

Yet, having raised that gloomy possibility, I must balance it by pointing to the great potential for the upliftment of mankind that the advancements of science and particularly biology offers us in prospect, if properly and carefully managed and more particularly if the public is informed and educated to anticipate this potential. Dr Andre Helliegers,[131] has also testified to the importance of creating closer links between the biomedical sciences and society:

> '... nothing could be worse than that society should come to fear scientific progress .... I can foresee that the occasional, seemingly sensational, scientific episode will so frighten society as to undermine the very support [that] science needs in order to continue to make contributions to improve the lot of mankind .... It is high time that there be started an educative process that explains to the country the precise nature and limitations of the scientific process and the place it occupies in man's control of his environment .... No segment can stand apart in this interdependent society. If it attempts to do so, it is bound to cease being supported. The sooner the relationship of science to society is examined and explained for all to see, the better it will be both for science and for society.[132]

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(128) Emerine Glowienka 'A Brighter Side of the New Genetics' (1975) 25 Bio Science 94 at 95.

(129) Kindregan (1972) 23 Hastings LJ 1401 at 1411; Reilly Genetics and the Law (1975) 207; Vukowich (1971) 2 Univ of Illinois LF 200; Maurice E Solomon Population Dynamics (1971) 8 23; Larry D Barnett 'The Constitutionality of Selected Fertility Control Policies' (1977) 55 North Carolina LR 357.

(130) Kindregan (1972) 23 Hastings LJ 1401 at 1426.

(131) Director of the Joseph and Rose Kennedy Institute for the Study of Bioethics and Human Reproduction at Georgetown University.

(132) Testimony delivered before the Senate of the United States of America.

CHAPTER 12

CONCLUSION

1. General

In the course of each of the preceding chapters I have discussed the problems arising in relation to the issue dealt with in that chapter and made appropriate submissions in regard to them. It is not therefore my intention to repeat all these submissions at length in this conclusion, but I will, instead, re-emphasise the main themes running through the work and refer to some of the submissions made in the relevant chapters.

It is a universally accepted fact in the Western world that the family is at once the most closely knit, the smallest and the most enduring of the various social groups within the State.(1) Furthermore, the basic philosophy upon which Western society, and hence the State, is founded and endures is that it will be sustained by the family.(2) It is thus not surprising to find that the right to found a family is enshrined in the Universal Declaration of Human Rights.(3)

Another basic principle which is generally true of the Western family is that the union is monogamous and it is created through a solemn and officially sanctioned pact, which, theoretically at least, creates a bond for life between the spouses.(4) This bond in turn brings about a number of mutual rights and obligations eg material support, sexual fidelity, and certain duties in regard to the children's maintenance and education.(5) Sexual or other intimate relations

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(1) Friedman Law in a Changing Society (1964) 172.

(2) Ibid.

(3) Article 16 Universal Declaration of Human Rights (1948) G.A. Resolution 217 (A) III.

(4) Friedman op cit 173; Inst 1.9.1; Grotius 1.5.1; Seedat's Executors v The Master 1917 AD 302 at 309.

(5) Hahlo The S A Law of Husband and Wife 4th ed (1975) 29.

outside the marriage not only entail legal sanctions for the responsible party himself, but, if any children are born of an illegitimate union, the law draws a rigid distinction between their status and that of a legitimate child.(6)

If one attempts to solve the problem of either male or female sterility by employing the latest methods of fertiliy therapy viz AID or IVF and ET, one is faced by the problems inherent in the concept of the Western family viz sexual exclusiveness and therefore parental affinity linked to genetic ties, which in turn result in the child born to the spouses suffering the handicap of illegitimacy.(7) These techniques thus solve the sterility problem but in doing so create a legal problem.(8)

The solution to the legal problem is complicated by the fact that the basic legal principles which regulate our family law in the vital areas mentioned supra, were enunciated at a time when AID and IVF and ET had not yet been developed.(9) Consequently our precedent is a statement of the principles of our common law which at this stage of its development, are not easy to adapt in such a way as to cope with the radical problems raised by AID and ET.(10)

If the various problems arising from these methods are left in the hands of a very cautious judiciary to solve in piece-meal fashion it could take scores of years before the law is settled in such a manner as to cover the entire problem.(11) It is thus submitted that in those areas where the judiciary is hide-bound by precedent that the legislature should act in order to secure the position

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(7) Friedman op cit 209.

(8) Report of Panel on Human Artificial Insemination (7 April 1973) British Medical Journal Supplement 3.

(9) Strauss Doctor, Patient and the Law (1980) 153; Strauss (28 Oct 1978) SA Mediese Pos 7.

(10) Pauw (1980) TSAR 192 at 193; Wangard (1968) Univ of Illinois LF 203 at 231.

(11) Shell (1955) 8 Univ of Florida LR 304 at 317.

of the AID and ET child, with the proviso that the extent of the legislation should be limited to the minimum necessary for this purpose.

The suggestions for legal regulation of AID and ET and of the other possible common law solutions are aimed at preventing the stigma of illegitimacy and the heartaches of courtroom battles over custody, visitation rights, and the support of innocent children.(12) Whatever the solution may be and however its purposes may be carried out, the problem should be solved today, not tomorrow when its results will have permanently affected the lives of many persons.(13)

2. Prohibition of AID and ET

AID has to date not been prohibited in South Africa(14) and is in fact becoming more widely accepted and practised each year.(15) In order to prohibit AID by statute it would be necessary to make it a criminal offence for any person artificially to inseminate a woman with the semen of anyone other than her husband, and for a woman to be thus inseminated.(16) If AID were made a criminal offence it would be extremely difficult to obtain a conviction. Because of the general secrecy surrounding the practice, AID births are rarely publicised, and if it became criminal, it would no doubt be even more carefully concealed.(17) Cases of criminal abortion are usually revealed only because of the death or serious illness of the woman. AID on the other hand is not normally attended by any medical complications.(18)

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(12) Kindregan (1972) 23 Hastings LJ 1401 at 1425.

(13) Turner (1981) 58 J of Urban Law 459 at 489.

(14) Van der Vyver 1980 (43) THRHR 89 at 91; V v R supra 1009; section 7(1) Act 24 of 1970.

(15) According to Strauss Doctor, Patient and the Law (1980) at 152 ± 400 women per year resort to AID in the Johannesburg area alone.

(16) Feversham Report 69.

(17) Ibid at 71.

(18) Reilly Genetics and the Law (1975) 369.

IVF and ET of the variety practised to date are not prohibited by existing legislation, because the oocyte which is removed from the wife is reimplanted in her own uterus. It is only in a situation where an oocyte is implanted into a woman from whose body it did not originate that permission is required from the Minister of Health in order to carry out this procedure.(19)

It is submitted that the prohibition of AID and ET is not consistent with the function of the criminal law.(20) Adultery, for example, exists on an infinitely greater scale than AID or ET and is more often liable to have undesirable consequences both for the marriage and for any children of the marriage, and hence for society as a whole.(21) Yet adultery is no longer a criminal offence(22) because it was considered to be an unjustifiable encroachment on the freedom of the individual in a sphere of behaviour where the law does not usually intrude.(23) While adultery is generally a private matter between two persons only, AID and ET required the co-operation of a combination of a donor, a doctor and the spouses.(24) It is submitted that AID and ET (using the wife's own oocyte) constitute procedures which, regardless of what the public may think of them in general, are not in any particular way offensive to public order or decency.(25)

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(19) Section 7(1) Act 24 of 1970.

(20) H L A Hart Law, Liberty and Morality (1963) 31; Sir P Devlin The Enforcement of Morals (1959).

(21) Friedman, Law in a Changing Society (1964) 194.

(22) Green v Fitzgerald supra; Estate Heinamann v Heinamann supra.

(23) Feversham Report 71.

(24) Mastroianni Encyclopedia of Bioethics (1978) 1448.

(25) Ibid.

AID and ET are difficult to detect and are practised on a small scale in relation to natural conceptions and births. Neither method is demonstrably harmful to the community as a whole and were they to be prohibited they are likely to be driven 'underground' into the hands of persons who might resort to blackmailing their patients.(26) It is thus submitted that AID and ET should not be prohibited.

3. The Regulation of AID and ET

It is submitted that the existing legislative control of AID and ET via the Anatomical Donations and Post Mortem Examinations Act is adequate to regulate the current practice of these techniques.(27) As far as the actual medical techniques which are involved in these procedures are concerned, whether in the field of gynaecology, male or female infertility, genetics or psychological medicine - legislation would, it is submitted, be regarded as an unacceptable infringement of the freedom of a doctor to do what he considers to be best for his patients.(28) It is thus submitted that legislation to regulate the medical techniques involved in AID and ET would not be justified.

Although legislation on the medical side of the practice is not deemed to be justified it is submitted that guidelines should be issued to practitioners of AID and ET by an authoritative body within the medical profession in order to ensure the maintenance of standards in regard to such matters as the selection of donors and applicants for AID and ET.(29) It is submitted that doctors require guidance in these fields since they fall outside their field of expertise, yet because the parties involved insist on absolute secrecy they are loathe to approach and confide in persons who are experts in these fields. They prefer to confide in and rely on only one person viz the doctor.(30)

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(26) Feversham Report 74.

(27) Strauss Doctor, Patient and the Law (1980) 152.

(28) Feversham Report 72.

(29) Kamlet (1975) 24 Cleveland State LR 341 at 354.

(30) Turner (1981) J of Urban Law 459 at 472; Reilly Genetics and the Law (1975) 479.

4. AID, ET and the institution of the family

On the one hand the techniques of AID and ET will assist families to have the children they have wanted but could not beget unaided by these scientific developments, yet on the other hand these techniques present issues that involve consideration of the immediate impact of the 'new biology' on the institution of the family.(31)

Both AID and ET can result in a child being born to a married couple where that child does not have genetic links with one of the spouses.(32) This possibility compels us to take another look at the family structure. The question to be resolved is whether the family should continue to be considered as a biological unit composed of a fertile male, a fertile female and children who are their genetic offspring, or, whether in the light of current medical and fertility technology the family should not be deemed to be an essentially consensual unit wherein a man and a woman who are married(33) to each other agree to have and raise children, to regard themselves and the children as a family, and to give each other the comforts of material and emotional support, regardless of genetic links.(34)

In order to bring about an acceptance of some of the more radical aspects of the 'new biology' an enormous shift in the legal values pertaining to family law is going to be necessary to bridge the gap between legal attitudes and

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(31) Grad 'Legislative Responses to the New Biology : Limits and Possibilities' (1968) 15 UCLA LR 480 at 501.

(32) Mastroianni Encyclopedia of Bioethics (1978) 1450.

(33) It is submitted that marriage should be a prerequisite for AID and ET births and that doctors should not allow unmarried couples or lesbian couples to have a child by this method. The legal links and responsibilities forged by marriage provided the child with a greater degree of protection than he would have if his 'parents' were unmarried.

(34) Grad op cit 502.

scientific reality.(35) Although there has been some movement in this regard in American law, the South African judiciary in the pioneering case of V v R(36) displayed a cautious approach to this novel problem and opted, admittedly with misgivings, to stick to our law's current approach which emphasises the purity of blood lines. This seems barely appropriate in the twentieth century, but then the American courts took 14 years to move from the decision in Doornbos v Doornbos(37) in which an AID child was declared illegitimate to People v Sorensen(38) in which the child was declared legitimate. The welfare of the child which is generally said to be the prime consideration of the court in matters related to family law seems to take second place in divorce proceedings between the spouses.(39)

In such a dispute it is possible that the 'father' who had treated the child as his own for years and who had given his consent to its conception could assert his non-paternity as a defence to a claim for maintenance. On the other hand the mother could assert her husband's non-paternity in defence to his claim for custody or access, despite the fact that in asking for these rights he had clearly reaffirmed that he wanted to treat the child as his own and that he regarded himself as the child's father.(40)

From a purely practical point of view the birth of several hundred children each year as a result of AID and ET introduces into SA society a problem regarding their uncertain legal status. This problem should be resolved by legislation

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(35) Grad op cit 503.

(36) V v R 1979 (3) SA L006 at 1015.

(37) 23 USL Week 2308 (Super Ct, Cook County, Ill Dec 13 1954).

(38) 66 Cal Rptr 7 437 P 2d 495 (1968).

(39) Van Oudenhove v Gruber 1981 (4) SA 857 (A) at 867 (A).

(40) People v Sorensen 254 Adv Cal App 869, 62 Cal Rptr 462 (1967); Anonymous v Anonymous 41 Misc 2d 886, 246 NYS 2d 835 (Sup Ct 1964); Gursky v Gursky 39 Misc 2d 1083, 242 NYS 2d 406 (1963).

not only for the sake of the children born of AID and ET who are threatened by disinheritance and illegitimacy but also for the sake of physicians who perform these procedures under the shadow of illegality. Furthermore, the number of children born by these methods is almost certain to increase.(41)

The legislation which is necessary to provide the children born of these medical techniques with full and unquestioned legal status would also result in the necessity for reassessing the family as an institution and of the values which have influenced the law.(42) Family law (particularly with respect to the rights of parents and children) and the law of inheritance (particularly with respect to the rights of illegitimate children) and the legal relationship between a parent (mother and/or father) and their child still places a primary value on the family as a biological or genetic entity. The sort of legislative changes which are necessary to regulate the legal consequences of these medical techniques will require society and the legislature to consider the family less as a genetic or biological entity whose major purpose is to keep established blood lines pure, but rather as a consensual unit to provide the best environment for the raising and development of children to responsible adulthood, and for the safe-guarding and perpetuation of such social benefits as mutual support both emotional and material.(43)

Families in which children are attached to parents other than their genetic or gestational parents are not unusual in western society. There have always been orphans and children abandoned by their own genetic parents who have been adopted or cared for by foster parents. Conversely it is submitted that children conceived in a test-tube and completing their gestation in an artificial womb, could still be the genetic children, ardently loved by the male and female who contributed their chromosomes and genes.(44)

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(41) Grad (1968) 15 UCLA LR 480 at 505.

(42) Grad (1968) 15 UCLA LR 480 at 506.

(43) Grad op cit 507.

(44) E Glowienka 'A Brighter Side of the New Genetics' (1975) 25 Bio-Science 94 at 95.

The most important ingredient which a child needs in order to mature into a responsible member of society is love and care. Who the adults are who give them this care and love varies widely from one society to another; most children receive it from their genetic parents, yet in some societies it tends to come from relatives. For example in matriarchal societies with matrilineal kinship, a male child usually carries his maternal uncle's name and inherits from him. His own genetic father is of little importance and takes no part in the boy's education or family relationships.(45)

A person's genetic origin is also not universally deemed to be the source of his status or social class. For example, in polyandrous societies ie where one woman has several husbands simultaneously it is difficult to determine exactly which of her husbands is the father of her child. Nor is a serious attempt made to do so. 'Fatherhood' is arbitrarily assigned by casting lots or by the decision of the mother. The child born of her and arbitrarily assigned to a 'father' is accepted with love and dignity by him as though it were his very own child.(46)

It is thus submitted that in order to achieve legitimate status for the children born by these methods that section 39 of the Draft Child Care Bill(47) should be extended to cover situations involving donated oocytes as well. If such an amended bill were to become law it would, it is submitted, firmly establish the mutual responsibilities of the husband, wife and child to each other, both in regard to the duty of support and the right to inherit.

Should no legislation be forthcoming the onus of ameliorating the legal position of the AID and ET child will rest with the courts. It is submitted that they can create a stable, legitimate relationship for the child on the following basis:

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(45) E Glowienka 'A Brighter Side of the New Genetics' (1975) 25 Bio-Science 94 at 95.

(46) Ibid.

(47) (28 Oct 1981) Government Gazette No 7864.

(i) The courts should recognise the fact that the parent-child relationship is built on the informed consent given by both the mother and her husband to the child's conception. Their conscious act of consent should thus bar them from being permitted to subsequently bastardise the child. Their consent should be interpreted as rendering the pater est quem nuptiae demonstrant presumption irrebuttable.(48)

(ii) The courts should designate the mother's husband as being the child's lawful father, regardless of the fact that there are no biological links between them.(49)

(iii) The fact that the 'lawful' father has given an informed consent to the child's conception should render him liable for all the duties, responsibilities and privileges of parenthood.(50)

Alternatively spouses intending to have an AID child should be advised by their doctor or lawyer to adopt the child after it is born. This would render the child legitimate for all practical pruposes.(51)

5. AID, ET and the Marriage Relationship

It is submitted that in only a very small proportion of AID cases has the marriage not been consummated.(52) Where the marriage has been consummated there is naturally no question of it being annulled at the suit of one of the

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(48) I D Schäfer 'Human Artificial Insemination and the Law : Some Legal Implications' (1978) 2 Natal University Law Review 228 at 235; Pauw (1980) TSAR 192 at 196.

(49) Pauw op cit 197.

(50) Ibid.

(51) Strauss Doctor, Patient and the Law (1980) 150.

(52) Oakley (1974) 8 Family Law Q 385 at 395.

parties.(53) Where the husband is impotent it is impossible to consummate the marriage, but if both spouses give an informed consent to AID and a child is subsequently born it is submitted that the spouses' consent should serve as a bar to proceedings by either of them to nullify the marriage on the ground of impotence.(54) The effect of their consent should be interpreted as being a confirmation of the fact that they wish to found a family on a lasting basis and that they appreciate the duties and responsibilities which are involved. They should thus be estopped from raising the very weakness which led them to resort to radical methods to cure.(55)

The Royal Commission on Marriage and Divorce(56) also recommended that consent to AID by the spouses should be a bar to a claim for nullity of the marriage on the ground of impotence:

> 'We consider that if the parties have gone to the length of artificial insemination of the wife, whether by the seed of her husband or by the seed of a donor, it is undesirable that either the husband or the wife should afterwards be allowed to claim that nevertheless the marriage should be annulled on the ground of the impotence of one or other of them. Consent to an act which is likely to produce a child of the wife is in our view so fundamental a step that it must be taken to mean that the parties acquiesce in the marriage. Accordingly, we recommend that the fact that the parties to a marriage have consented to the artificial insemination of the wife, with the seed of either the husband or a donor, should be a bar to proceedings by either spouse for nullity of marriage on the ground of impotence.'

A wife is not only impotent but also sterile. Consequently the spouses agree to have a child by means of fertilising a donated oocyte with the semen of the husband. The blastocyst is either carried by the wife or by a hostess mother. It is submitted that the situation in regard to the annulment of the marriage is analogous to that of the AID situation supra, viz that where the spouses have consented to, and initiated the birth of the child, they should be barred from being allowed to claim an annulment of the marriage on the basis of the wife's impotence.(57)

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(53) W v H 1965 (3) SA 740 (O).

(54) Feversham Report 33.

(55) Pauw (1980) TSAR 192 at 196.

(56) Cmnd 9678 paragraph 287.

(57) Robertson Encyclopedia of Bioethics (1978) 1468.

It is submitted that if one of the spouses had resorted to the use of either AID or ET to conceive a child without the consent of the other spouse it would constitute a breach of faith sufficiently grave to warrant a claim for divorce on the ground of irretrievable breakdown of the marriage.(58)

The custody and maintenance issues which are inevitably involved in a divorce action could, it is submitted, be solved by the normal legal principles applicable to these issues if the AID and ET child was declared by legislation to be the legitimate child of the spouses whose consent was instrumental in its birth.(59)

6. AID, ET and Consent

The giving and receiving of the necessary informed consent is vital to the legal position of all the parties involved in AID and ET.(60) It will inevitably rest upon the shoulders of the physician, by virtue of his position as the co-ordinator of the therapy to acquire the various consents.(61) It is submitted that this is a vital task which should be executed with meticulous attention to detail to ensure that all the parties involved are aware of exactly what they are letting themselves into.(62) The necessity for acquiring consent, its validity, and the consequences of proceeding without the necessary consent are discussed in detail in chapter three.(63) Draft forms setting out the suggested wording to ensure that an informed consent has been elicited from the various parties has also been included.(64)

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(58) Section 4(1) of Act No 70 of 1979.

(59) See supra at pages 310-313.

(60) Kamlet (1975) 24 Cleveland State LR 341 at 354; Robertson Encyclopedia of Bioethics (1978) 1466; K Lebacqz & R J Levine Encyclopedia of Bioethics (1978) 755-761.

(61) See supra at pages 81-99.

(62) Strauss Doctor, Patient and the Law (1980) 3-9.

(63) See supra at pages 81-99.

(64) See supra at pages 86, 87; 90.

7. AID, ET and the Criminal Law

It is submitted that neither AID nor ET, in which the oocyte removed from a particular woman was reimplanted in her, constitutes a crime per se. Whether these therapies infringe certain statutes or common law crimes is discussed in Chapter 5.(65)

8. AID, ET and the Physician's liability

AID requires very little if any medical skill, but IVF and ET, on the other hand, require a degree of skill beyond that of the average specialist gynaecologist.(66) This is reflected by the fact that at present there are a limited number of gynaecologists world wide who have acquired the necessary skill to conceive a child in vitro and successfully implant the blastocyst into the uterus of the mother.(67) Even these experts only achieve a success rate of 1 in 5 at present, although continued research should improve this average in the future.(68) It is therefore obvious that gynaecologists who do not have the necessary skill and training would be negligent if they attempted to conceive a child by this method.(69)

A gynaecologist is not involved in any way with the actual act of conception in the normal pregnancy, whereas a conception by IVF and ET is altogether in the hands of the gynaecologist.(70) Because of his involvement in this vital step in the pregnancy there is an additional responsibility - resting on him to conduct the more careful and detailed tests on the foetus to ensure that it is developing normally.(71) Because the IVF and ET technique has not yet been

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(65) See supra at pages 170-188.

(66) See supra at pages 131-135.

(67) Ibid

(68) Steptoe, Springbok Radio 'Top Level' 10 Octover 1982 at 19h15.

(69) See supra at pages 147-155.

(70) Grobstein (1979) 240 Scientific American 33-40.

(71) Holder Legal Issues in Pediatrics and Adolescent Medicine (1977) 31-46; Milunsky Encyclopedia of Bioethics (1978) 1332-1335.

perfected and there is a distinct possibility that the blastocyst might not develop normally, regular and thorough monitoring of the developing foetus must be done. Failure to carry out such tests would, it is submitted, constitute negligence on the part of the gynaecologist and render him liable to a claim for damages should the child be born defective.(72)

It is further submitted that it is not necessary to extend the nasciturus fiction in order to provide a basis for an action by a child born with defects which are the result of the physician's negligence because the right to claim for damages arises at the moment the child is in fact born defective.(73)

9. Public Reaction to so-called test-tube reproduction

The recent revelations of Steptoe and Edwards' alleged 'experimentation' with human embryos has raised an outcry from a number of sources who claim that this type of research is unethical and should be banned.(74) In discussing the issue of science and society Daniel Callahan, a director of the Institute for Society, Ethics and Life Sciences at Hastings-on-Hudson NY, stated that public reaction to scientific experiments, for or against, has made little difference to the attitude of scientists or their determination to pursue their chosen course of research.(75)

It is submitted that in regard to IVF and ET the general public should be educated in order to get human 'test-tube' reproduction into perspective.(76) The term test-tube procreation is a misnomer to start with as in fact no more than six days of the foetus's life are spent outside the womb, the remaining 260 days are spent within.(77) As far as the allegation that IVF and ET

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(72) See supra at pages 149-169.

(73) See supra at pages 148-149.

(74) 'Daily News' 6 October 1982; 'Natal Mercury' 6 October 1982; 'Natal Witness' 6 October 1982.

(75) 'Test Tube Babies ' Reaction sets in' (27 July 1974) 106 Science News 52, 53.

(76) Oakley (1974) 8 Family LQ 385 at 399.

(77) (27 July 1974) 106 Science News 53.

'dehumanises' procreation it is submitted that the test-tube technique, as it is currently practised, is no more disruptive than AID and probably even less so, since the woman has the option of having her egg fertilised by her husband's sperm, and not that of a donor.(78)

Will test-tube procreation threaten natural procreation? It is submitted that this is most unlikely because it will remain restricted to women who cannot reproduce becasue of blocked oviducts. This is reflected in the words of Dr Andre Hellegers, Director of the Kennedy Institute for Bioethics and Human Reproduction at Georgetown University:

> 'I don't see that a woman would prefer to have her ovum taken out of her and fertilised in vitro, then see a doctor again and have it reinjected if she can reproduce by intercourse. I don't think that test-tube reproduction will endanger the family because I don't think there is going to be a big market for it.'(79)

(78) Grobstein (1979) 240 Scientific American 38-39; Reilly Genetics and the Law (1975) 366.

(79) (27 July 1974) 106 Science News 53.

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