Proposal of the abovetopic seems inopportune following the recent public furore when fetal ovarieswere suggested as a source of ova for clinical usage. Yet, viewed through alonger perspective, recent events are but a symptom of the need to address requirementsof a rapidly emergent area of medicine which can no longer be ignored. Over thelast two decades research has led to increasing knowledge of the fetus. Addedto this are the many intrauterine procedures introduced to diagnose and treatfetal disorders or abnormalities. Intentionally or unintentionally this focushas attributed to the fetus the presage to be considered as an individual inits own right. It demands that parents and doctors should address its disorderswith due care and, where possible, consider treatment to save fetal life orprevent further harm. First trimester progenitor fetal liver haemopoietic cellsare theoretically an ideal source of material for transplantation to treathaemoglobinopathy (Flake et al. 1986; Crombleholme et al. 1991). Before 14weeks, but especially before the 12th week, the fetal immunological system isnot mature, hence haemopoietic cells from this stage of pregnancy are lesslikely to mount a graft against host reaction (Hayward 1981; Crombleholme etal. 1991). Neither ectopic pregnancies nor miscarriages are a useful source ofprogenitor cells (Byrne et al. 1993), because in these situations fetal deathhas usually occurred some days, if not weeks, before and autolysis invalidatesattempts at cell separation. The most useful supply of progenitor haemopoieticcells is from therapeutic abortions, in effect, a fetus donating organs for thesake of another fetus. The Swedish experience indicated that women seekingabortions are willing to help this course (Westgren et al. 1994). Attempts totreat haemoglobinopathies is but one facet of this debate. Following animalexperimentation, the French and Swedes have already forged ahead with clinicalapplication (Touraine 1991 ; T. H. Bui, personal communication). Successfultreatment has been reported for severe combined immuno-deficiency disorders(Touraine 1983). Inheritable metabolic disorders is another group of diseaseswhere stem cell transplantation can possibly benefit. In the United Kingdomprogrammes are underway to extract progenitor cells from cord blood to treatleukaemia. Fetal hepatic progenitor cells may prove a better source of materialsince there is less risk of graft against host disease. These would not beaffected by recent changes in legislation which refer to the fetal ovary only.Research with use of fetal tissue for treatment of medical disorders drawsattention to the need to process and store the tissue to ensure its safety foruse and that it is in ready supply when required (Cohen & Jonsen 1993). Toaccomplish this, a fetal tissue bank is mandatory. Cohen and Jonsen (1993)argued cogently for federal funding of such a bank in the United States becausethis will allow the advantage of largescale research on processing abortedfetal tissue, control of its distribution on a nonprofit basis, and will ensurestrict standards of quality. They foresee the likelihood of a rapid increase infetal tissue transplantation as a potent argument for directing attention tothe need for such a bank. In Nottingham it has taken us over two years toassemble a team to look at the question of a progenitor (stem) haemopoieticcell bank to anticipate clinical application. This programme complements andsupports that of our colleagues at the Karolinska Institute, Stockholm, Sweden.Their programme has the ethical approval of the

Karolinska Institute, theSwedish Medical Research Council and their National Council for Medical Ethics.They have already made their first clinical steps towards therapeutic trialswith thalassaemia A and B affected fetuses. A stem cell bank programme requiresthe collaboration of a multidisciplinary team which includes immunologists,haematologists, specialists in sexually transmitted diseases, neonatologistsand, not least, a perinatologist involved in prenatal diagnosis and fetaltherapy. Partial funding for our programme has come from local charity, privateconcerns and support from the Trent Region. Recent discussion concerning thevalue of the fetus as a potential donor should be viewed in its properperspective as an urgent need to draw attention to this emergent area ofscience. There is mounting international consensus to indicate that there ismuch to be gained and little lost by being involved. Fetal tissue banking (andresearch to support it) is a pre-eminent issue with far reaching medicalconsequences. We have negotiated local ethical approval for our venture. In thelight of the above discussion it is timely to consider formation of a NationalEthics Committee to adjudicate and provide guidance in this field of research.The cost and complexity of programmes for fetal tissue banking of necessityrequire the consideration and support of national and major funding bodies. Weare trying to ensure we do not stand on the sidelines in this area of newmedicine. We, however, cannot do this without encouragement and proper funding.

FETAL TISSUE BANKING—THE RIGHT TIME IS NOW