The welfare of the child

An emerging issue in the regulation of assisted conception

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The regulation of assisted conception has been a contentious issue for many years and the debate shows no sign of approaching a conclusion. New reproductive technologies are being developed so rapidly that they are outstripping the provisions of the few legal frameworks that have been devised to regulate them (Ohl et al., 1996). Legislators have raised doubts as to whether any ‘single piece of primary legislation will ever be sufficient of itself to deal with such a complex area and with such fast-moving technology’ (Jowell, 1996).

Year on year, fresh issues arise and are featured prominently in the media and academic journals. Lurid headlines follow reports of women being implanted with the ‘wrong’ embryo (Rogers, 1994), the misappropriation of embryos (Goodwin, 1995), women psychologically damaged by being reduced to baby making machines (Hunt, 1996) and lesbian women having ‘do-it-yourself’ babies (Rayner, 1997).

Fresh controversy has been aroused by reports of the posthumous retrieval of gametes. In the UK, successful posthumous gamete retrieval has been accompanied by sceptical reporting (Ahuja et al., 1997a) and in the US, the absence of clear legal or ethical frameworks has been noted (Ohl et al., 1996). In sharp contrast to countries where assisted conception services are not subject to formal legislation and regulation, the UK position is clearly set out in Schedule 3 of the Human Fertilisation and Embryology Act 1990 (hereafter called the Act).

The Act came into force after wide public consultation and a government appointed Committee of Inquiry into Human Fertilisation and Embryology. After due consideration, the Report of the Committee expressed ‘grave misgivings’ about the posthumous use of gametes because this ‘may give rise to profound psychological problems for the child and the mother’ (Warnock, 1984, p. 18). However the report made no recommendation for action, stating instead that ‘posthumous use of gametes is a practice which we feel should be actively discouraged’ (Warnock, 1984, p. 55). Accordingly, the Act did not prohibit the retrieval and storage of such gametes, it added a proviso: the effective consent of the originator was required before storage could be lawfully carried out. Posthumous use of gametes stored with effective consent is therefore lawful – and acceptable. A large proportion of UK licensed treatment centres would consider their use (Corrigan et al., 1996).

Despite the clear-cut position in the UK, the case of Diane Blood generated a torrent of public sympathy when the Human Fertilisation and Embryology Authority (HFEA), which regulates the provision of assisted conception, refused Diane Blood treatment using the spermatozoa of her deceased husband Stephen. The Bloods had been married for 5 years, wanted children and had ‘discussed at great length how they would be prepared to have a child if they discovered they had trouble conceiving’. They agreed they would go to any artificial lengths if Mrs Blood was unable to conceive from her husbands spermatozoa. They saw no objections to the posthumous use of Mr Blood’s spermatozoa (Ashton, 1996). Early in 1996 Stephen Blood became unwell with meningitis and within 4 days he was dead.

Whilst his life was maintained mechanically and he was unable to give consent of any kind, two sperm samples were retrieved at the request of Diane Blood, although their subsequent storage was a clear contravention of the Act.

Diane Blood found herself in a position where viable spermatozoa from her husband were in storage, but the HFEA refused her permission to use them because they had been unlawfully stored, without effective consent. Before consent can be considered effective, it must be made in writing and after the provision of ‘such relevant information as is proper and a suitable opportunity to receive counselling’ (the Act, Schedule 3). These are considered necessary safeguards, in keeping with best medical practice. However, the recent controversies surrounding the destruction of cryopreserved embryos and payment to gamete donors has vividly illustrated the point that consent may continue to be problematic. These controversies generated a worldwide response, ranging from hard academic argument to poetry (e.g. Bergues and Sele, 1997; Edwards and Beard, 1997; Johnson, 1997; Pennings, 1997).

In the case of cryopreserved embryos, the Act requires written consent from both biological parents for the maintenance of embryos for longer than 5 years. Embryos produced using donor spermatozoa faced destruction, if for any reason the donor’s consent could not be obtained or was denied. In effect, women who had obtained embryos using donated gametes could not prevent the destruction of their ‘own’ embryos (Edwards and Beard, 1997). A second, apparently equally fundamental prerequisite was added by HFEA in the case of gamete donation – fully informed consent should be free from any inducement and pressure (Johnson, 1997). This demonstrates a developmental approach to the definition of consent, reflecting the practical demands of specific situations.

In defence of the more absolutist position adopted in the
UK licensed treatment centres to take into account ‘the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth’. This is not a new idea, laws including the notion of taking account of the best interests of the child had preceded both the Act and the Code of Practice (for example, The Children Act 1989, Section 1[3]).

The inclusion of the welfare of the child provision was adopted as a focus of attention for participants, both in this and subsequent debates in the House of Commons. However the debates did not critically examine this provision, rather they assumed the value of the provision and set it against other considerations. The mood of the House of Lords was exemplified by the comment of Lord Clyde; the inclusion of a welfare of the child proviso meant his mind had been ‘substantially set at rest’ (Clyde, 1996).

Other compelling issues began to be marginalized. The first of these was the primary and central issue, what should constitute effective consent. Commenting on the Diane Blood case, Ahuja et al. (1997a) note that ‘the doctrine of explicit consent, a fundamental requirement of medical care, somehow did not appear to be germane to the case of this unfortunate widow’. The government were, however, to launch a review of the consent provisions in the Act (McLean, 1997). This re-focused consideration on the issue of consent and sought representations from interested parties.

A further issue, largely unconsidered, was that of service provision. Although parliament discussed the appositeness of treatment, it was concurrently assumed that treatment would be readily available and would follow from retrieval. Under current UK legislation, no person has the absolute right to ‘have’ a child; even if Stephen Blood’s spermatozoa had been legally obtained and stored, Diane Blood would have no automatic right to assisted conception services using his spermatozoa, or indeed that of any other donor. National Health Service funded treatment may be difficult to obtain as funding is often targeted at establishing a primary family unit, a two parent heterosexual family.

Whether an applicant can obtain public funding or provide their own funding for treatment, decisions about the provision of treatment services rest within individual licensed treatment centres, guided by the HFEA Code of Practice (HFEA, 1995), which sets out guidance about the appropriateness of providing treatment. Consequently, the retrieval of gametes may be a necessary but is never a determining part of a process which may or may not culminate in the provision of treatment.

Lord Winston’s Bill was to be withdrawn, as it did not attract government support and so was most unlikely to become law. The HFEA remained emphatic, Diane Blood could not lawfully be inseminated with her husband’s spermatozoa in the UK. However, an alternative emerged; it is within the remit of the HFEA to permit the export of spermatozoa to another country, where such treatment could be lawfully provided. Following the judgement of the Court of Appeal (6 February, 1997) Diane Blood succeeded in her appeal to export her husband’s spermatozoa to Belgium, where she could lawfully be inseminated with Stephen Blood’s spermatozoa. The Court of Appeal gave great weight to European Union
legislation (Treaty of Rome, Article 59) that permits citizens freedom to seek medical treatment in any country in the European Union of their choice. The HFEA considered the significance accorded to this legislation, rather than to UK legislation, to be ‘unusually strong’ (HFEA, 1997).

The HFEA imposed conditions; export being allowed provided that account was taken of ‘the welfare of any child who may be born, including the need of that child for a father’ (HFEA, 1997). This simply imposed the assessment upon a clinician who would have the additional disadvantage of working primarily in a country other than the one in which the child may be born and raised.

The inclusion of a ‘welfare of the child’ provision in Lord Winston’s Bill appears to have been valued sufficiently highly to mitigate against other arguments put forward at the time. Simultaneously, it is possible to identify from within parliamentary debate the genesis of a set of illusory beliefs about the value of current welfare of the child provisions.

The first of these is that the welfare of the child has been ascribed some priority. When Baroness Warnock spoke in support of Lord Winston’s Bill, she asserted along with others that ‘the good of the potential child should be paramount’ (emphasis added – Warnock, 1996). It was further asserted ‘there were no two ways about it: we said that their interests are paramount’ (emphasis added – Knight, 1996). However, the Act clearly fails to make any such provision (Blyth, 1996).

The second illusory belief is that current provisions have a proven value. Although enshrined in the Act and the HFEA Code of Practice, both intended to govern the provision of assisted conception treatments and specify measures to ensure the welfare of the child, recent research has shown the welfare of the child to be a slippery concept. The welfare of the child test lies within the remit of each individual licensed treatment centre, who draw up their own individual protocols regarding the welfare of the child. Clinicians managing licensed treatment centres have pressing concerns about their ability to gather the information required to reach an equitable judgement of ‘risk’ (Lieberman et al., 1994, and private communications). Baroness Warnock noted recently that regulation may rest on ‘guessing about the good of the child’ (Warnock, 1996). This lack of a collective approach and a common standard detracts from the effectiveness of the welfare of the child test.

The test is intended to ensure that treatment services are withheld where there is thought to be risk of harm to the child, for example when potential recipients have been convicted of offences against children. However, it has been noted that where regulation is considered necessary, emphasis is placed upon establishing a legal provision acceptable to all concerned parties, rather than making provisions which are readily translatable into practical activities with achievable outcomes (King, 1997). In practice, provisions made for the welfare of the child may be ineffective and permit less legitimate and discriminatory activities, such as the exclusion of certain social groups or the prohibition of particular treatments which are legitimized in UK law (Douglas, 1992; Lieberman et al., 1994).

Nevertheless, Blyth (1996) concluded that licensed centres ‘may be less ready than previously thought to use the welfare of the child as a convenient, if thinly disguised, rationale for refusing to provide certain services or treat certain people’. This discord seems likely to continue.

The welfare of the child test may be in danger of becoming so central to any argument about treatment services that the overall message appears to be ‘so long as the welfare of the child is considered all will be well’. However, whilst issues surrounding the welfare of the child test remain unresolved it cannot be considered as mitigation against other contentious issues. Doing so only serves to complicate already complex and unresolved issues, such as those of individual rights and informed consent highlighted in cases of posthumous gamete retrieval in general, and the Blood case in particular.

The views expressed in the parliamentary debate surrounding Lord Winston’s Bill showed a growing confidence in the welfare of the child provisions, further reflected in the recent Department of Health consultation documents covering consent for the posthumous retrieval of gametes (McLean, 1997) and surrogacy (Brazier et al., 1997). Both assume the value of current welfare of the child provisions.

What has been spotlighted here is a worrying tendency – a ‘better the devil you know’ stance – towards a contentious issue in assisted conception. Issues such as whose rights should prevail and in whose interests medical interventions may be made are matters on which there are many divergent opinions. In contrast, the value of the welfare of the child test would appear to be becoming widely accepted, despite evidence to show that whilst the idea of taking account of the welfare of the child is worthy, in practice it may be fraught with difficulty. It is certainly no mitigation against the unresolved difficulties of other issues or a panacea for our ethical ills. We must do more to resist the urge to embrace ‘the devil we know’ until we know enough about it to make an informed choice.

References
New families, old values: considerations regarding the welfare of the child

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In spite of the changes that have taken place to the structure of the family in the latter part of this century, it remains the case that a family headed by two heterosexual married parents who are genetically related to their children represents the ideal, and that deviations from this pattern are commonly assumed to result in negative outcomes for the child. Families created by assisted reproduction depart from the norm in two important ways. Firstly, the children may be genetically unrelated to the father (when conceived by donor insemination), to the mother (when conceived by egg donation), or to both parents (when conceived using a donated embryo). In the case of surrogacy, whereby one woman hosts a pregnancy for another woman, the child may be genetically related to neither, one or both parents depending on the use of a donated egg and/or spermatozoa. Secondly, a growing number of single heterosexual women and lesbian women are opting for assisted reproduction, particularly donor insemination, to allow them to conceive a child without the involvement of a male partner. Children in these families grow up in the absence of a father from the outset, and many children in lesbian families are raised by two mothers.

In the UK, the Human Fertilisation and Embryology Act (1990) requires the welfare of the child to be considered, including the need of that child for a father, in the decision of whether or not to offer assisted reproduction, although there are no specific criteria for acceptance or rejection of prospective parents. In the article by Blyth and Cameron (1998), it was argued that the welfare of the child test is problematic in a number of ways including the use of different criteria by different licensed centres, lack of knowledge about what factors are likely to place the child at risk and of how to obtain the necessary information to make a fair judgement of risk, and the potential for this test to be used as a means to exclude certain social groups from treatment. The aim of the present paper is to add to this debate by considering what aspects of parenting matter most for children’s optimal psychological development, whether conception by assisted reproduction is likely to place children at risk, and what can be learned from empirical studies of the development of children conceived in this way.

Parenting: what really counts?

From a psychological perspective, the quality of children’s relationships with their parents, and particularly how securely attached they are to their parents, is considered to be central to their emotional well-being throughout childhood and into adult life (Bowlby, 1969, 1973; Ainsworth et al., 1978; Main et al., 1985; Rutter, 1995). Attachments form when an infant is ~6 months old. It is at this age that they begin to show distress when separated from a parent, and at the same time begin to show wariness of strangers – or even outright protest when left with someone they do not know. Except in severe cases of social deprivation, all children become attached to their parents. It is the nature of their attachments that can vary; some attachment relationships are secure whereas others are insecure, and the child may be securely attached to one parent while insecurely attached to the other. Securely attached children use their parents as a base from which to explore the world and can obtain comfort from them when distressed. In contrast, insecurely attached children cannot depend on their parents to be emotionally available when they need them. Infants and young children who are securely attached to their parents (or to at least one parent) have been shown to fare somewhat better than insecurely attached children in many..
aspects of psychological development; they have higher self-esteem, they are more popular, and they are more co-operative at school (e.g. Suess et al., 1992; Youngblade and Belsky, 1992; Belsky and Cassidy, 1994). It has even been shown that they are more likely to have securely attached children themselves (Fonagy et al., 1991).

Studies of differences in children’s attachments have shown that the involvement of a person (usually but not necessarily a parent) who is warm and responsive to the child, and who is sensitive to the child’s needs, is associated with the development of a secure attachment relationship, although characteristics of the child, such as how irritable or sociable he or she is, may influence that person’s behaviour towards the child. Thus, from the perspective of attachment theory, it is parental responsiveness, rather than biological relatedness, that is considered to be important for the development of secure attachment relationships (Grossmann et al., 1985; Isabella et al., 1989).

Further evidence for the relatively greater importance of parental responsiveness comes from the lack of difference between adopted and non-adopted infants in the proportion classified as securely attached to their mother (Singer et al., 1985). Bowlby (1969, 1973) argued that it is through their experiences with attachment figures that children develop self-esteem; children whose parents are sensitive and responsive are likely to view themselves as loveable and have a positive sense of self whereas children whose parents are emotionally unavailable or rejecting are more likely to develop a lack of self-worth.

Aspects of parent-child relationships other than security of attachment have also been shown to shape children’s development, the most widely studied of which is parental style. Baumrind (1989) has demonstrated that an authoritative style of parenting, i.e. a combination of warmth and discipline (as opposed to an extremely authoritarian or an extremely free-and-easy parenting style) has the most positive outcomes for children’s psychological development, with children of authoritative parents the most likely to be self-reliant, socially responsible and co-operative. It is important to remember, however, that parental style may, to some extent at least, be a product of the child’s personality. After all, it is a much easier undertaking to adopt an authoritative style with a co-operative child than with a child who tends to be aggressive or defiant. In addition, factors other than parental style such as shared feelings and connectedness of communication are thought to be important aspects of children’s relationships with their parents (Dunn, 1993).

It is not just the quality of parents’ relationships with their children but also the quality of their relationship with each other that influences children’s psychological well-being. Recent research has pointed to a link between marital conflict and the development of psychological problems in children, most commonly the development of antisocial behaviour and conduct problems particularly among boys (Emery, 1988; Grych and Fincham, 1990; Cummings and Davies, 1994). Although the mechanisms through which parental conflict results in psychological difficulties for children are not fully understood, there are thought to be both direct effects resulting from the child’s repeated exposure to hostility between the parents (Cummings and Cummings, 1988; Harold and Conger, 1997) and indirect effects resulting from the poorer quality of parenting of mothers and fathers who are locked in conflict with each other (Fauber and Long, 1991).

An association also exists between parents’ psychological well-being and the psychological well-being of their children such that children whose parents have psychological problems are more at risk for psychological problems themselves. For example, there is growing evidence that a mother’s depression produces an increased risk of difficulties for her child with recent research pointing to a link between post-natal depression, the mother’s lack of responsiveness to her infant, and the infant’s insecure attachment to the mother (Murray, 1992).

**Parenting children conceived by assisted reproduction**

From the above discussion it appears that several aspects of parenting are related to children’s psychological well-being; sensitive responding, emotional availability, and a combination of warmth and control are associated with positive outcomes whereas marital conflict and parental psychiatric disorder can have a negative effect. Although it is impossible to predict just which children will experience difficulties, not least because some children show remarkable resilience in the face of multiple adversities (Rutter, 1985; Zimmerman and Arunkumar, 1994), there is substantial empirical evidence that these factors play a part in influencing the course of children’s social, emotional and identity development. In considering the welfare of a child born through assisted reproduction we may therefore examine whether these families deviate from the ideal family unit in ways that are likely to have a negative impact upon the aspects of parenting that matter most for children’s psychological well-being. In so far as such parents do not differ with respect to quality of parenting, difficulties would not necessarily be expected for the child.

**Absence of a genetic link**

A major concern regarding the potential negative consequences of the absence of a genetic link between the child and one or both parents is that the practice of keeping information about genetic origins secret from the child may have an adverse effect on the quality of parent–child relationships and consequently on the child (Daniels and Taylor, 1993; Schaffer and Diamond, 1993). As few children are told that a donated spermatozoa or egg had been used in their conception, the large majority grow up not knowing that their father or their mother is genetically unrelated to them.

Findings suggestive of an association between secrecy about genetic parentage and negative outcomes for children have come from two major sources: research on adoption and the family therapy literature. It has been demonstrated that adopted children benefit from knowledge about their biological parents, and that children who are not given such information may become confused about their identity and at risk for emotional problems (Sants, 1964; Triseliotis, 1973; Hoopes, 1990; Schechter and Bertocci, 1990). In the field of assisted reproduction, parallels have been drawn with the adoptive situation and it has been suggested that lack of knowledge of, or information
about, the donor may be harmful for the child (Snowden et al., 1983; Clamar, 1989; Snowden, 1990).

From a family therapy perspective, secrets are believed to be detrimental to family functioning because they create boundaries between those who know and those who do not, and cause anxiety when topics related to the secret are discussed (Karpel, 1980). In examining the particular case of parents keeping secrets from their children, Papp (1993) argued that children can sense when information is being withheld due to the taboo that surrounds the discussion of certain topics, and that they may become confused and anxious, or even develop symptoms of psychological disorder, as a result. Experimental studies provide some support for this suggestion by demonstrating that people who are deliberately trying not to disclose information often give themselves away by their tone of voice, body posture or by saying less than they normally would in a similar situation (De Paulo, 1992).

A further concern raised by the use of gamete donation is that parents may feel or behave less positively toward a non-genetic than a genetic child. It has been argued that the child may not be fully accepted as part of the family, and that the absence of a genetic tie to one or both parents may have an undermining effect on the child’s sense of identity (Burns, 1987). Studies of adopted children who are aware of their origins (Brodzinsky et al., 1995), and of children in stepfamilies (Hetherington and Clingempeel, 1992; Hetherington, 1993), have shown that the lack of genetic relatedness between a child and one, or both, parents can be associated with alienation and hostility between the parents and the child. However, adopted children have to face that they were given up by their biological mother, and children in stepfamilies not only have to cope with their new stepparent alongside the loss of a biological parent with whom they had shared their daily lives but often acquire step brothers and sisters as well. Children born through egg or sperm donation do not experience the loss of an existing parent. Nor do they need to negotiate relationships with new family members. Thus genetic unre-relatedness has a different meaning for children conceived by gamete donation than for children in adoptive families or in stepfamilies. It is also important to remember that the large majority of children who are adopted in infancy, the situation that most closely resembles conception by egg or sperm donation, do not experience psychological difficulties as they grow up (Brodzinsky and Schechter, 1990).

In spite of the expectations that children conceived by gamete donation may be at risk for psychological problems, research on children conceived by egg or sperm donation shows not only that these children are functioning well, but also that they have better relationships with their parents than children who have been naturally conceived (Cook et al., 1995; Golombek et al., 1995, 1996, 1998). This suggests that a strong desire for parenthood seems to be more important that genetic relatedness for fostering positive family relationships, and that conception by gamete donation does not appear to have an adverse effect on the socio–emotional development of the child. Nevertheless, it is important to point out that the average age of children studied was 6 years. In addition, not one of the 111 donor insemination parents interviewed, and only one of the 21 egg donation parents, had told their child about his genetic origins.

**Single heterosexual mothers**

On average, children in single parent families do less well than those in two-parent households in terms of both psychological adjustment and academic achievement (Ferri, 1976; McLanahan and Sandefur, 1994). They are also less likely to go on to higher education and more likely to leave home and become parents themselves at an early age. But it is not simply being raised by a single parent that leads to these outcomes. Children in single parent families are more likely to suffer economic hardship, and many will have been exposed to the conflict, distress and family disruption that is commonly associated with their parents’ separation or divorce. Experiencing their parents’ separation or divorce can be extremely upsetting for children, and for 2 years afterwards they are more likely to develop psychological problems than children in intact families (Amato and Keith, 1991; Hetherington, 1988, 1989; Hetherington et al., 1982, 1985). Boys, in particular, can become aggressive and difficult to manage both at home and at school. Various explanations have been given for the rise in children’s emotional and behavioural difficulties at this time including reduced family income and the mother’s distress which may reduce her ability to look after her children. But the single most important factor leading to problems for children appears to be hostility between the parents before, and around the time of, the divorce (Amato, 1993). It is these factors that accompany single parenthood, rather than single parenthood itself, that are largely responsible for the disadvantages experienced by children in one-parent homes.

One question that is often posed regarding single mother families is whether the negative consequences for children result from the absence of a father in particular or the absence of a second parent from the home. This is a difficult question to answer as the two go hand-in-hand making it difficult to conclude whether it is one, or the other, or both that make the difference for the child. Factors such as parental conflict and financial hardship are clearly linked to the father but we cannot say whether it is the lack or loss of a parent in general, or of a male parent in particular, that is associated with the difficulties faced by children in single mother homes.

Studies of two-parent families show that fathers spend much less time with their children than mothers, but it seems that this matters less than what they do when they are with them. The more that fathers are actively involved in parenting, the better the outcome for children’s social and emotional development, and fathers appear to be particularly valued by their children as playmates (Parke, 1996; Lamb, 1997). However, it does not seem to be their maleness that matters. If their gender was important we would expect children without fathers, and children with highly involved fathers, to differ in terms of their masculinity and femininity from children in traditional two-parent families. There is no evidence that this is the case. Girls in such families are no less feminine, and boys no less masculine, in their identity and behaviour than children who grow up in more traditional homes, and children of highly involved fathers hold less conventional attitudes.
about male and female roles (Stevenson and Black, 1988; Radin, 1994). Instead, it seems that fathers have a positive effect on their children’s development in the same way as mothers do. Fathers who are affectionate to their children, who are sensitive to their needs, and who respond appropriately to their emotions, are more likely than distant fathers to have well-adjusted children (Lamb, 1997). So it appears that it is their role as an additional parent, not as a male parent, that is beneficial to the child.

Children born to single mothers following donor insemination differ in important ways from children who find themselves in a one-parent family following divorce in which they are raised by a single mother right from the start and have not experienced their parents’ divorce and the departure of their father from the family home. Although little is known about children conceived by single women through donor insemination, studies of children raised in fatherless families from the outset (sometimes described as ‘solo’ mother families) are now beginning to appear. Whether or not these children do less well than those from two-parent homes seems to depend on their financial situation and the extent to which their mother has an active network of family and friends to offer social support (Weinraub and Gringlas, 1995; Golombok et al., 1997). From the evidence that exists so far, family circumstances, rather than single parenthood per se, appears to be the best predictor of outcomes for children in solo mother homes.

**Lesbian mothers**

Lesbian mothers are similar to families headed by a single heterosexual mother in that the children are being raised by women without the presence of a father, but differ in the sexual orientation of the mother. There are two common assumptions about children in lesbian families. The first is that they will be teased and ostracized at school, and will develop psychological problems as a result. The second is that the boys will be less masculine, and the girls less feminine, than their peers from heterosexual homes, and also that they will grow up to be lesbian or gay themselves, an outcome that is often considered undesirable by courts of law and policy-making bodies. The early investigations of lesbian families focused on women who had become mothers in the context of a heterosexual marriage before adopting a lesbian identity, and thus the children studied had lived with their father during their early years (Kirkpatrick et al., 1981; Hoeffer, 1981; Golombok et al., 1983; Green et al., 1986; Huggins, 1989; for reviews, see Patterson, 1992; Golombok and Tasker, 1994). No differences between children of lesbian and single heterosexual mothers have been identified for emotional well-being, quality of friendships or self-esteem. It has also been shown that the sons and daughters of lesbian mothers are no different from the sons and daughters of heterosexual mothers in terms of their masculinity or femininity. Regarding the parenting ability of the mothers themselves, it has been demonstrated that lesbian mothers are just as child-oriented (Pagelow, 1980; Miller et al., 1981; Kirkpatrick, 1987), just as warm and responsive to their children (Golombok et al., 1983) and just as nurturing and confident (Mucklow and Phelan, 1979) as heterosexual mothers. A longitudinal study of adults who had been raised as children in lesbian families has found these young men and women to continue to function well in adult life and to maintain positive relationships with both their mother and her partner, and contrary to popular assumptions, the large majority identify as heterosexual (Tasker and Golombok, 1995, 1997; Golombok and Tasker, 1996).

Perhaps surprisingly, rather more is known about children born through assisted reproduction to lesbian mothers than through assisted reproduction to single heterosexual mothers as controlled studies of lesbian couples who conceived their child through donor insemination have recently been reported. In the UK, 30 lesbian mother families were compared with 41 two-parent heterosexual families using standardized interview and questionnaire measures of the quality of parenting and the socio–emotional development of the child (Golombok et al., 1997). Similarly, Brewaeys et al. (1997) studied 30 lesbian mother families in comparison with 68 heterosexual two-parent families in Belgium. In the US, Flaks et al. (1995) compared 15 lesbian families with 15 heterosexual families, and Patterson et al. (1998) studied 55 families headed by lesbian and 25 families headed by heterosexual parents. Unlike lesbian women who had their children while married, these mothers planned their family together after coming out as lesbian. The studies are of particular interest because they allow an investigation of the influence of the mothers’ sexual orientation on children who are raised in lesbian families with no father present right from the start.

Although the children investigated in the above studies are still quite young (around 5–6 years on average), taking the findings together, the evidence so far suggests that they do not differ from their peers in two-parent heterosexual families in terms of gender development. It seems, therefore, that the presence of a father is not necessary for the development of sex-typed behaviour for either boys or girls, and that the mother’s lesbian identity, in itself, does not have a direct effect on the gender role behaviour of her daughters or sons. The children were not cut off from men, however, and many had a close relationship with one or more of the mothers’ male friends. In terms of socio–emotional development, the children appear to be functioning well; there is no evidence of raised levels of emotional or behavioural problems among the children raised in a lesbian mother family. It is possible of relevance that, unlike the majority of children in studies of father absence, almost all of those investigated lived in an intact two-parent family with a good relationship between the parents, and had not experienced family disruption as a result of parental separation or divorce. The most significant finding to emerge so far from the studies of lesbian families with a child conceived by donor insemination is that co-mothers in two-parent lesbian families are more involved with their children than are fathers in two-parent heterosexual families.

**Conclusions**

Studying families created by assisted reproduction allows us to address questions about the relative importance of family structure on one hand, and the quality of family relationships on the other, for children’s’ psychological adjustment, as well
as interactions between them. What existing findings appear to suggest is that aspects of family structure such as genetic relatedness, number of parents and the mother’s sexual orientation, may matter less for children’s psychological adjustment than warm and supportive relationships with parents, and a positive family environment. New families, it seems, flourish on old values.

Nevertheless, research on the consequences for children of growing up in these new family forms is in its infancy and many questions remain unanswered. For example, although keeping the method of conception secret from young children conceived by egg or sperm donation does not appear to have a negative impact upon family relationships or on children’s psychological development, it remains to be seen whether non-disclosure leads to difficulties as these children grow up. It could be expected that problems are most likely to arise in adolescence, the time at which issues of identity, and difficulties in relationships with parents, become more salient. Certainly, it is the case that adopted children show a greater increase in behavioural and emotional problems at adolescence than non-adopted children (Maughan and Pickles, 1990), alongside an increased interest in their biological parents (Hoopes, 1990).

A further issue relates to the controversy about the provision of assisted reproduction for single heterosexual women to enable them to have a child without the involvement of a male partner (Englert, 1994; Shenfield, 1994). A small, uncontrolled investigation of 10 single women requesting donor insemination (cited by Fidell and Marik, 1989) found that an important reason for opting for this procedure was to avoid using a man to produce a child without his knowledge of consent. Donor insemination also meant that they did not have to share the rights and responsibilities for the child with a man to whom they were not emotionally committed. Although rare, women who have never experienced a sexual relationship with either sex have also been given access to donor insemination (Jennings, 1991). Children born to single mothers as a result of assisted reproduction for single heterosexual women to enable them to have a child without the involvement of a male partner are not systematically studied to establish what actually happens to children and their parents in these new family forms.

References


The welfare of the child


How to care for the children? The need for large scale follow-up studies

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As a psychologist active in the field of reproductive medicine, I have had the opportunity to listen to a wide variety of couples requesting fertility treatment in order to fulfill their wish for a child. Like all professionals in this domain I have been confronted with the sometimes extreme distress experienced
by those who appeared to be infertile. Consequently, in the early years of reproductive medicine, the major focus of clinicians was directed to the well-being of the infertile couple and the development of successful treatments was their first priority. It was only in the course of the 1980s that more questions were raised about the long-term effects on the well-being of the children born as a result of such treatments. In the same period a plea for social regulation of assisted conception was becoming heard in all Western countries. Politicians were pressured into drafting bills to ensure the responsible use of these techniques and the rights of the future child became a major point of concern.

In my view the paramount importance attached to the welfare of the child must be regarded as a positive evolution. From the perspective that in whatever decision with regard to assisted conception, the child’s position is the most vulnerable one, this priority appears to be a correct principle. Theories about family development have underlined that every child is born into an existential asymmetric relationship with the parents. The child, as a descendant, had no voice in its parents’ decision to procreate and its welfare is directly dependent on the quality of the parental care. Moreover, its own developmental history will again influence further generations (Bozormeny Nagy, 1986). This inequality between parents and children implies an ethical obligation for whatever adult party involved (parents, donors, clinicians, society) to look carefully at the possible impact of the decision on the future development of the child.

Precisely the priority given to ‘the welfare of the child’ is the major topic in the article by Blyth and Cameron. They argue that the priority given to welfare principle appears to be contentious. First of all, it would mitigate against other important considerations. For example, the authors express the fear that a major issue in the regulation of reproductive medicine, such as the importance of consent to treatment, would lose its impact as a result of the priority given to the welfare of the child. I do not share these worries because to me it is undoubtedly clear that the welfare of the child depends greatly upon the quality of the arrangements made between the adult parties involved. The psychological health of the child is not an isolated variable. Its well-being is directly related to the quality of the family relationships and to certain socio-economic features of the family environment. The assumption that there might be a discrepancy between the interests of the child and those of the other parties involved, overlooks their interdependency.

From a practical point of view, however, the provision of the welfare of the child gives rise to a number of severe problems. The authors correctly emphasize that we are talking about ‘a slippery concept with a lack of proven value’. Although developmental psychology has undoubtedly provided a body of knowledge about features enhancing a healthy child development, there is a great lack of information about the specific development of children born after fertility treatments. Large scale follow-up studies are only starting to emerge and many questions about the development of these children remain unanswered.

The committees charged with the task to ensure responsible use of these techniques were confronted with many problems. As there was no experience based evidence to support their decisions, their views were merely inspired by subjective personal and cultural assumptions. This has led to a diversity of opinions reflected in the laws of several Western European countries. An illustrative example of such conflicting views can be found in the national regulations concerning the use of donor spermatozoa. While a number of countries impose the use of identifiable donors (Sweden, a number of Australian states), others, such as Belgium and Norway, made the use of anonymous donors compulsory. The Human Fertilisation and Embryology Authority (HFEA) on the other hand, ordered the setting up of a central registry of non-identifying information. Apparently, opinions about the welfare of the child, had led to opposite conclusions among policy makers. What is then the value of such a provision? Individual patients are forced into one choice imposed by a central authority, a choice for which there exists no empirical evidence. This restrains them the freedom to decide for themselves which donor type would fit in their particular family concept. Several authors have correctly emphasized that the political decisions frequently occur over the heads of the patients involved (Shenfield, 1996; Jansen, 1997; Pennings, 1997).

Perhaps as a consequence of this lack of objective knowledge, the concept of ‘the best interest of the child’ has remained extremely vague in most official regulations. For example, the HFEA provides that: ‘A woman shall be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth’. This single sentence has the risk of becoming meaningless when taking into account the number of questions which were not addressed in the provision. What does it precisely mean to say that ‘account has been taken’ of the future child’s welfare? Which criteria must be used to prove the woman’s parental fitness? Who will take that account? What if there is disagreement between the parties involved about the best interest of the child?

In this extremely short provision, however, one point has been made very clear: ‘a child’s need for a father’. As Morgan and Lee have clearly pointed out in their comments on the HFEA, this provision was made in the context of a proffamilist ideology. It was ‘the opinion of the members involved’ that a child should be born into a stable heterosexual relationship and that the creation of a child for a woman who is not a partner in such a relationship would be morally wrong’. (Warnock Report paragraph 2.11 in Morgan and Lee 1991, p144).

I now come to the point where I would like to refer to the case of Diane Blood. In their article, Blyth and Cameron use the controversy surrounding the Blood case and Lord Winston’s proposed amendment to the HFEA to illustrate how the ‘welfare of the child’ provision appears to have the power to mitigate against other considerations. I believe that the Blood case leads to confusion when we want to discuss the consequences of this welfare provision. The major problem is that there appears to be a contradiction in Lord Winston’s proposal.
The idea is that, in the case of Mrs Blood, the provision of the welfare of the child would be an argument to overcome other constraints such as the absence of a written consent. The logic of this argument remains, however, a mystery. Despite the vagueness of this whole-child provision (see above), one criterion has been made very clear: ‘a child needs a father’. This is precisely what the potential child of Mrs Blood will not have. I therefore cannot imagine which positive outcome could have been expected from the argument of Lord Winston.

On the other hand, the case of Mrs Blood illustrates another worrying tendency. Like several other authors, I believe that the current attempts to regulate responsible use of reproductive medicine have led to a number of premature rules and prohibitions (Edwards and Beard, 1997; Jansen, 1997; Pennings, 1997). The urge to establish social regulations in reproductive medicine was not accompanied with a similar urge to check the empirical value of the assumptions on which these regulations were based. Moreover, little effort was made to establish in each fertility centre a group of independent and well trained counsellors who could guarantee a respectful approach of each individual request. The problems encountered by Mrs Blood highlight the inflexibility of such regulations. The existing social and legal prohibitions restrained the possibility of considering the personal request of Mrs Blood within a multidisciplinary professional context. The HFEA forced Mrs Blood to the high court to gain access to her husband’s spermatozoa. Furthermore, as a result of the public attention with regard to this case, the pros and the cons of such a complex request were extensively discussed in the press, leading to a polarisation of opinions. A serene and human approach, in which it would be the task of professional counsellors to consider all aspects of this particular demand, became therefore virtually impossible. The final solution, in which Mrs Blood was allowed to export her husband’s spermatozoa to Belgium, therefore illustrates the inadequacy of the current system.

In conclusion, I would like to underline that the priority given to the welfare of the child in whatever decision in reproductive medicine, is theoretically correct. Practically, however, the concept appears to be contentious. Objective statements about the best interest of the child are hard to make, due to the lack of empirical knowledge about the long-term physical and psychological development of the children involved. As there is no consensus about the best policy, it is an illusory believe that legislation alone could adequately regulate the use of these techniques. From this perspective, the implementation of long-term follow-up studies on the one hand and of professional counselling services on the other, should become the first priority.

References


Access to assisted conception: a framework of regulation

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Society’s attempts to regulate assisted conception are frequently challenged. New technological possibilities prompt the need for new legislation. Well-established principles are tested to their limits in novel and compelling cases. But some of the most difficult questions in this area are not new; how should we balance the interests of prospective parents and of children-to-be; the views of gamete donors and the views of medical staff? What sorts of families should we encourage and assist in beginning? And under which circumstances is it appropriate to deny someone access to assisted conception?

Existing constraints on access to assisted conception are the result of a complex mixture of political, economic, ethical and legal factors. Parliament, through the Human Fertilisation and Embryology Act 1990, has imposed a number of specific restrictions on access to in-vitro fertilization (IVF) and donor insemination provided by medical practitioners. These include the requirement to obtain informed consent from all adult participants and the obligation to take account of the welfare of any child who may be born as the result of such treatment. The ethical views of medical staff (and gamete donors) may also lead to access being denied: those on whom treatment programmes depend may wish to limit the circumstances in which they are prepared to assist in conception. Of course, the most significant restriction of access stems from the policy decisions of many health authorities not to purchase treatments such as IVF and donor insemination. Where there is limited provision, demand far exceeds supply and rationing decisions need to be made in determining how to allocate the limited resources.

This consideration of the welfare of the child-to-be is particularly interesting, for it is more than just a statutory requirement. It is also the basis of ethical and conscientious opposition of some medical staff to the provision of treatment to certain groups of people. And it is used to justify certain rationing decisions. Blyth and Cameron (1998) have addressed some of the shortcomings of this emphasis on the welfare of the child. This article responds to a number of the points raised by them, taking a systematic look at the way in which
access is presently regulated and appraising the validity of the policies in question.

Restrictions imposed by law

The need for informed consent

Public sympathy for Diane Blood, after being denied access to insemination using her deceased husband’s spermatozoa, is understandable. Nevertheless, there are important issues beyond the emotionally compelling situation of the bereaved woman (Hull, 1996). From a legal point of view, the principles on which the denial was based are of fundamental importance (R v HFEA ex parte Blood, 1997). The Human Fertilisation and Embryology Act takes appropriate care to ensure that participants in assisted conception give free and informed consent and are offered the opportunity to receive counselling before doing so (McLean, 1997). For men, this is the case whether they are requesting artificial insemination together with a partner or are offering to act as sperm donors. Written consent is an important formality, attesting to the provision of information and discussion that has gone before.

Did Stephen Blood give consent to the retrieval of semen and subsequent insemination of his wife? We know from Diane Blood that he wanted to be a father. We are less clear that he wanted to be one via artificial insemination and a fortiori that he wanted this to take place after his death. Diane Blood was sure that her husband would have agreed with her plan. If she is right, then the law acted to deny both of them their chance to try to reproduce. If, on his death bed or before, Stephen Blood had given informed consideration and consented to the subsequent retrieval of semen and insemination, then the matter of written consent might well appear a legalistic formality; English common law recognises the validity of ‘advance directives’ under certain circumstances (Re C, 1994; Airedale NHS Trust v Bland, 1993). It is possible to argue that the Human Fertilisation and Embryology Act might be amended so as to allow some sort of judicial consideration of cases in which there was clear prior verbal consent. But whether Diane Blood would have succeeded given such an amendment is far from clear.

However, this does not end the discussion, for posthumous insemination does not simply raise questions about the protection of the rights of adults. Even if Stephen Blood had given full legal consent, some might have sought to deny his wife the chance to bear their child. A study conducted in 1995 indicated that more than a third of centres licensed to store spermatozoa or embryos were opposed to posthumous treatment (Corrigan et al., 1996). Their refusal to provide such treatment is generally on the grounds that they do not wish to assist in the conception of a child who will not know his or her father. To what extent is this a valid exercise of their discretion?

The requirement to consider the ‘welfare of the child’

The Human Fertilisation and Embryology Act (1990) states in section 13(5) that ‘A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father)’.

The welfare of the child: historical basis in family law

The notion of the ‘welfare of the child’ underpins much of modern family law. The idea was first put into statutory form in the Guardianship of Infants Act (1886) as a ‘relevant consideration’ to be regarded along with the conduct and wishes of the parents. By 1925, the Guardianship of Infants Act (1925) had made the welfare of the child the ‘first and paramount consideration’. The paramountcy principle has been upheld in the Children Act (1989). When a court deals with a family matter, no other consideration can overrule that of the welfare of the child. However, it is not all-pervasive in family law. In the Adoption Act (1976), for example, the child’s welfare is described as the ‘first’ but not the ‘paramount’ consideration. This means that in some circumstances, the rights of others, for example of birth parents to raise their own children, may be determinative.

The welfare of the child under the Human Fertilisation and Embryology Act (1990)

Section 13(5), which requires account to be taken of the welfare of the prospective child, did not appear in the original Bill and arose as the result of a lengthy debate. The Warnock Committee had been unwilling to recommend conclusively either that treatment should be restricted to married couples or that posthumous insemination should be forbidden (Warnock, 1984). However, the Committee did state, ‘We believe that as a general rule it is better for children to be born into a two-parent family, with both father and mother’ and they added that posthumous insemination should be ‘actively discouraged’. In the Consultation Paper preceding legislation, the government solicited views on whether prospective parents ‘should, be subject by law to a formal procedure designed to assess their suitability as parents’ (DHSS, 1986).

Members of both Houses of Parliament attempted to restrict access to assisted conception to certain groups of people. In the House of Lords, Lady Saltoun lost by only one vote an amendment that these services be limited to married couples (House of Lords Debates, 1990a). Lord Ashbourne proposed that services should only be aded where there was evidence that there would be a father involved in raising the child. (House of Lords Debates, 1990b). This amendment was withdrawn following government agreement to take action on the matter. The result was section 13(5). Hence, the welfare of the child was, from the beginning, linked with the question of family structure.

Other European countries make this link even more explicit. Several, e.g. Austria, France, Norway, Sweden and the Swiss cantons which allow IVF, restrict access to assisted conception to married couples or to heterosexual couples in a stable relationship. In other countries, where there is no legislation yet, professional regulations act to the same effect. There are, however, exceptions. Spain, for example, allows the treatment of any woman, whether married or not (Gunning and English, 1993). The Council of Europe Report on Human Artificial Procreation (Council of Europe, 1989) states that, ‘the techniques of artificial human procreation may...be used for the
benefit of a heterosexual couple when appropriate conditions exist for ensuring the well-being of the future child’. The Report also prohibits posthumous insemination.

The HFEA Code of Practice
The Human Fertilisation and Embryology Authority (HFEA), Code of Practice (HFEA, 1995) established in accordance with section 25 of the Human Fertilisation and Embryology Act widened the scope of the welfare clause. The first explanatory memorandum (HFEA, 1991), suggested that the main focus in considering the welfare of the child was the attempt to prevent children from being born into situations in which they might suffer serious harm.

The HFEA Code of Practice sets out a list of factors which centres should ‘bear in mind’ when deciding whether or not to offer treatment. These include the commitment and stability of parents-to-be, their ages and medical histories, their likely future abilities to look after a child and any risk of harm to the child through neglect, abuse, or the transmission of inherited disorders. In cases where there is to be no legal father, centres are expected to consider the mother’s ability to meet the child’s needs and to investigate whether there is anyone else willing to share her responsibilities in doing so.

How are centres to weigh up these factors? The HFEA Code states that the Human Fertilisation and Embryology Act ‘does not exclude any category of women from being considered for treatment’. Centres ‘should take account both of the wishes and needs of the people seeking treatment and of the needs of any children who may be involved. Neither consideration is paramount over the other’. People are entitled to a ‘fair and unprejudiced assessment of their situation and their needs’ which should be conducted with ‘skill and sensitivity’. Centres ‘should have a clear written procedure to follow for assessing the welfare of the potential child’, but they ‘should avoid adopting any policy which may appear arbitrary and discriminatory’.

These statements appear to be inconsistent. The statute requires some sort of discrimination to be made between situations that will benefit the welfare of the child-to-be and those which will not – and yet this is not to appear to be ‘discriminatory’. The HFEA Code expects a ‘clear written procedure’, but this may not be ‘arbitrary’.

However, as far as the weight to be given to the welfare of the child, the HFEA Code of Practice is clear. The child’s welfare is not paramount, and is only one consideration to be weighed with others. Interestingly, this is the same formula as that used in the Guardianship of Infants Act (1883), when notions of child welfare were in their infancy and the law’s support of parental (and especially paternal) rights was still very strong. When viewed in the light of other areas of modern family law, a requirement merely to take account of the welfare of the child would appear to offer only weak protection to children. But the meaning of the welfare test and the appropriate balance between parents and children may be different where there is as yet no child and the decision is whether one should come into being.

The welfare of the child


determination of who shall be offered treatment. In the case of R v Ethical Committee of St. Mary’s Hospital (Manchester), ex parte Harriott (1988) the court considered the rejection of a woman on grounds of her lifestyle (specifically, her convictions for prostitution-related offences). The court in that case quoted from the Warnock Report, referring to the ‘heavy burden of responsibility’ of the individual consultant who must make social judgments that go beyond the purely medical’. The decision of the ethics committee was upheld; the court ruled that as long as a decision could not be described as one which ‘no reasonable ethics committee’ could make, it would be acceptable.

The role of the ‘conscience clause’ in the HFE Act
Section 47 of the Human Fertilisation and Embryology Act makes specific reference to the conscientious objections of medical staff. This provides doctors, and indeed all staff, with one of the few situations in medical practice in which they are free to choose not to participate in activities to which they are opposed. Other similar cases involve the provision of contraceptives and the termination of pregnancy. Although there is no case law on the question of conscientious objection to providing assisted conception, the judgment in R v Ethical Committee of St Mary’s Hospital (Manchester) ex parte Harriott (1988) suggests that the conscience clause may be interpreted not only to mean choosing not to become involved in all or specified types of assisted conception, but also choosing on moral grounds not to provide services to certain people. National or community health service providers may be obliged to suggest alternative means of obtaining a treatment which they have declined to provide, but independent services would probably have no such obligation, except to avoid illegal discrimination, for example on the grounds of race.

Methods of assessment and selection by treatment centres
Established policy – or case by case consideration?
Broadly speaking, centres select those whom they will treat in two ways. The first is to establish and publicise guidelines on selection criteria, e.g. that the centre will only treat couples in a stable heterosexual relationship or that it will not carry out posthumous insemination. Generally, these criteria are concerned with the lifestyle of the prospective parents or their family structure. The advantage of such a policy is its clarity. It appears to comply with the requirements of the 1995 HFEA Code of Practice. The disadvantage is that it may be inflexible. Section 13(5) requires the consideration of whether the child...
needs a father, but a decision that all children need fathers may infringe the requirement in the HFEA Code of Practice to avoid policies that may seem arbitrary and discriminatory.

Other centres try to avoid this dilemma by relying, in whole or in part, on a ‘case-by-case’ system of assessment. Many request a reference from the patient’s general practitioner. ‘Difficult’ cases may be reviewed by an ethics committee or decided by the consultant alone. This case-by-case system allows flexibility. Its disadvantage is that patients and general practitioners are given no indication in advance as to the criteria that may be used to decide between patients, although it may, over time, become known whether or not a centre is generally willing to treat certain groups of patients, (e.g. widows, single women or lesbians). The potential for arbitrary or discriminatory practice still exists. It is simply not as transparent and thus not as open to comment and change. Whichever approach is taken, Patel and Johnson (1998) strongly support the development of reliable protocols for undertaking an assessment of the welfare of the child, in keeping with the requirement in the HFEA Code of Practice for ‘clear written procedures’.

The role of gamete donors
Sometimes, centres choose to delegate certain difficult decisions to gamete donors. It may be the practice to ask sperm donors whether or not they are willing to allow their spermatozoa to be used by lesbian women; other donors may make specific stipulations about the use of their gametes. If the donor may determine to some extent the family structure in which ‘his’ or ‘her’ child will be raised, this belies the policy otherwise embodied in the Human Fertilisation and Embryology Act of minimizing the significance of the biological relationship between donor and child. In the case of blood and bone marrow donors, it is not the usual practice to ask or allow conditions to be set. Does the gamete donor have a stake in the future of the child he or she has helped to exist? Is this merely a practical matter which should be left to centres when recruiting donors, or should society limit donation to those who are able to give unconditional consent?

The possibility of latent means of selection
Anecdotal evidence suggests that in practice, few people are actually turned away by licensed centres. Further investigation is needed to determine whether this is because of lack of interest on the part of those who might be deemed unsuitable, or some other factor. General practitioners may play a ‘filter’ role in discouraging those who they know are unlikely to be accepted. Individuals who place advertisements for sperm donors in newspapers and magazines may feel driven to do so because they know they are likely to be turned down, or may simply be happier removing the process of donor insemination and reproduction from the medical context.

Restrictions based on resource allocation

Standard models of rationing health care
It is clear that many centres which provide assistance in conception cannot assist all those who might seek their help. In most cases, public funding is either non-existent or very limited; in others, there may be a shortage of gamete donors.

The allocation of scarce resources in this area often follows policies which are also used in rationing decisions in other areas of medical treatment. For example, if a health authority has provided funding for its own region, whether in local centres or through extra-contractual referrals, then only people living in that region may be eligible. Centres frequently exclude those who already have children living with them, or who have more than one child. This could be seen as providing services to those whose need is greatest. It is also common for publicly funded centres to accept only women below a certain age for IVF. This is consistent with a widely-held policy in resource allocation of providing treatment first where it has the highest likelihood of success.

Of course, these are not the only ways in which resources might be allocated. There are other possible approaches, such as providing an equivalent amount or value of treatment irrespective of the chance of success. It has been suggested that the general public seems to prefer equal opportunity to selective efficacy (Ubel et al., 1996). And there may be personally satisfying benefits of treatment other than simply births (Ryan and Donaldson, 1996). In the case of R v Sheffield Health Authority, ex parte Seale (1994) the court was asked to rule on the legality of a centre’s decision to reject women over the age of 36 from IVF treatment on the grounds of shortage of resources. As in most other cases of judicial review based on questions of resources, the court ruled that rationing decisions were a necessary feature of the provision of medical care and that this was a reasonable exercise of discretion.

Rationing based on ethical criteria

A further means of distributing limited resources makes a selection of whom to treat on ethical grounds: for example, limiting treatment to those who have a positive recommendation from their general practitioner, to those who are married or who are in stable heterosexual partnerships. In other areas of medical treatment, this sort of selection based on perceived merit might be seen as contentious. However, in many areas of assisted conception, such as the provision of donor insemination to women without male partners, the medical treatment model sits somewhat uneasily with the reality of providing a service to a healthy woman. If one is rationing a social service rather than a medical treatment, and if the question of the welfare of the child still looms in the background, then this may be seen as an appropriate model. The allocation of limited resources based on perceived merit certainly follows the example of adoption practice; there are few legal bars to adoption, but in practice the limited number of small healthy babies are allocated to those whom adoption agencies see as the ‘best’ prospective parents.

Discussion

How useful are notions of the ‘welfare of the child’ in matters relating to assisted conception?

Even in standard family law cases, a frequent criticism of the ‘welfare test’ is that it is susceptible to very wide interpretation. It is ‘vague and general, enabling decision makers, whether
judges magistrates or social workers to ‘write in’ their own subjective values’ (King, 1987). Even if one attempts an objective assessment of welfare, it is difficult for anyone to say with justified confidence which of a number of choices is in a child’s best interests (Parker, 1994). There are additional problems in deciding what the measure of ‘best’ is to be. Mnookin (1975) states that this ‘poses a question no less ultimate than the purposes and values of life itself’. Despite this, the welfare test is still felt to have an important symbolic and moral value, reminding us that children must be protected from harm and given every opportunity to become healthy, well-developed adults (King, 1987; Cretney and Masson, 1997).

When a court uses the welfare test, it is usually in the context of a choice – between one parent or another, between parental care and state intervention. What role, what interpretation of the test is appropriate in the context of assisted conception? The first unusual feature is that here, unlike in other family law situations, there is no child yet. The question is whether or not assistance should be given to bring one into being. This has prompted some to argue that the appropriate test is simply better, for the potential child, existence would appear to be preferable to non-existence (Lockwood, 1985; Dickens, 1987). However, it is suggested that this cannot have been the intention of Parliament. English courts have consistently refused to entertain any notion that it might be worse to be alive than never to have been born (McKay v Essex, 1982). Given that position, a welfare test that relied on this sort of reasoning would be of no use at all. If it is always better to be alive than not alive, then all assisted conceptions would have to be allowed. But even if this unhelpful interpretation is rejected, the meaning of the welfare test in the context of a prospective child is still extremely vague. What is ordinarily a child-centred test becomes necessarily centred entirely on the merits of the parents-to-be.

**Considering the ‘welfare of the child’ when there is no child yet**

The European Convention on Human Rights states that, ‘Men and women of marriageable age have the right to marry and to found a family’. However, this has generally been interpreted in the context of a negative right – a right not to be interfered with. English courts too have upheld this right, in the context of the sterilization of mentally handicapped girls and women (Re D, 1976; Re B, 1987, Re F, 1989), calling the right to procreate a ‘fundamental’ one. Clearly, we do not feel it appropriate to interfere in the process of natural procreation, save in the most extreme cases (e.g. in laws prohibiting incest or sexual relations with mentally handicapped persons). Perhaps this is simply because interference is virtually impossible.

And yet, if the right to ‘found a family’ includes more than simply giving birth, the state does interfere with the interests of parents in raising their own children, setting a minimum standard beneath which parents must not fall if they are to retain the care of their own children. While we oblige courts to take the welfare of children as their paramount consideration, the minimum standard for parent’s own behaviour is lower.

However, section 31 (2) of the Children Act 1989 states that a child may be taken away from parents (through a care order) if the child is suffering or is likely to suffer significant harm.

In the context of adoption, there is considerable state and professional involvement in deciding who will become a parent. But assisted conception does not fit either model perfectly. The child may well be the genetic offspring of at least one of the parties who intend to raise it. And yet without professional help, this conception would not be possible. Meulders-Klein (1988) and Mason (1990) both make the point that procreation is never a question merely of individual personal rights. It always requires at least two participants. ‘There can be no ‘right’ to something which necessarily involves a second party who has an equal right to withhold co-operation’. In the case of assisted conception, there may well be three or four parties, once one includes parents, gamete donors and medical staff. But what weight should the claims of the respective parties have, whether acting in their own interests or on behalf of children-to-be?

In family law, any attempt at a precise definition of the welfare of the child, might prevent courts from having the flexibility they need to deal with individual circumstances. The Warnock Committee took the same view in the context of assisted conception: ‘We decided it was not possible to draw up comprehensive criteria that would be sensitive to circumstances in every case’ (Warnock, 1984). The HFEA Code of Practice stipulates factors which are to be borne in mind. These serve the same function as the ‘welfare checklist’ in section 1 of the Children Act (1989); they provide at least some indication of the areas which should be investigated in determining the welfare of the child. However, in cases of assisted conception, the questions of what is meant by welfare and how much importance it is to be accorded are less clearly defined, and medical staff are being asked to serve as judges. It is not surprising that there is residual unease amongst doctors as to how their duties are to be fulfilled (Lieberman et al., 1994; Patel and Johnson, 1998).

**Should we strengthen the obligation to consider the welfare of the child?**

Should Parliament or the HFEA give clearer instructions as to how the welfare of children ought to be safeguarded in assisted conception cases, perhaps identifying specific cases in which treatment should be withheld? Jansen (1997) warns against excessive restriction in the absence of ‘evidence-based’ ethical justifications. Glover (1989) suggests that, ‘Only the likelihood of a fairly serious disadvantage supports guidelines ruling out help for parents’. This would be consistent with the test in the Children Act (1989) which allows children to be removed from their parents if they are at risk of ‘significant harm’. Others would go further. Snowden (1983) writes, ‘We should not be introducing complications into an already complicated situation...There is no justification for setting up conditions of risk’. However, even if we restrict ourselves to the cases of potentially significant harm, there are probably some near-absolute contra-indications to assisted conception: the existence of criminal convictions for child abuse, for example, or having other children on the ‘at risk’ register or perhaps the presence
of serious mental illness. It is the intention of the HFEA to consider the matter of potentially life-threatening physical illness [e.g. human immunodeficiency virus (HIV) infection or autoimmune deficiency syndrome (AIDS)] in the forthcoming third revision of the Code of Practice (HFEA, 1996). If it is concluded that any of the cases described above present a significant risk of serious harm, then perhaps it should be clearly indicated that there is at least a presumption against treatment in these situations.

Parliament or the HFEA might also provide more guidance about the procedures through which threats to child welfare are to be identified. Studies by Blyth (1995) and Douglas (1993) indicate that centres generally rely on the information provided by prospective patients themselves, or on letters of reference from general practitioners (who may not know much about the non-medical backgrounds of their patients). Sometimes, counsellors are left in the invidious position of assessing patients while purporting to counsel them. Much can probably be gleaned about a couple by astute staff in the course of several meetings, and most of those requesting assisted conception are probably very satisfactory potential parents. Nevertheless, it might buttress the present legal requirements and the ability of centres to comply with them if there were some more standardized means of identifying problem cases. One possible method might be the introduction of assessment procedure, along the lines of that used in adoption, but with the presumption in favour of allowing the treatment to go ahead as long as there was no evidence of anything on the list of contra-indications.

**Should we limit the exercise of discretion in considering the welfare of the child?**

A number of writers have criticized the fact that medical staff rely on their own ethical views in assessing the suitability of prospective parents and determining what will be in the interests of the children who may result (Millns, 1995; Steinberg, 1987). It is alleged that the exercise of discretion in this area leads to the promotion of traditional families and the denial of the rights of certain patient groups such as single women and lesbians. The prospective creation of a non-traditional family may not be an absolute contra-indication to assistance in conception. For example, the courts have recently held that there is no public policy against adoption by a homosexual [Re W (Adoption: Homosexual Adopter), 1997]. However, is it acceptable for some centres to decide that being a widow, or a woman of 60 or a lesbian is a relative contra-indication of sufficient strength as to merit withholding assistance. This approach is still seen in other areas of family law. For example, in the case of *C versus C* (1991), Lord Justice Balcombe held that, ‘The judge can only start with the approach that in our society it is still the norm that children are brought up in a home with father and mother...and, other things being equal, such an upbringing is most likely to be conducive to their welfare’. There is as yet little empirical work demonstrating the effects on older children and adults of having been raised in standard versus non-standard families. Tasker and Golombok (1991) point out the limitations of their own oft-cited study of lesbian mothers. It is difficult to say whether, if we set out to create an environment which is likely to be conducive to successful adult life, it would include or exclude any given family structure. Glover (1989) concludes, ‘Until the disadvantage hypothesis is overwhelmingly supported or refuted empirically, those who have to decide about helping will divide in their views...It seems right for doctors and others to follow their consciences’.

**Conclusions**

As a society, we do not have clear views on what we consider a ‘good’ family; nor of how ‘good’ a family needs to be before it can be given the blessing of assistance in conception. However, where there are minimum standards of child protection on which we can achieve some measure of consensus, these should be stated clearly and enforced appropriately; otherwise, the legislative direction to consider the welfare of the child may well be seen as hollow. Beyond this, there may be little alternative to the system which exists at present, a system in which each centre is left some latitude in setting its own rules of access, supported by rules which allow the exercise of discretion on the grounds of conscience and oblige the exercise of discretion in testimony to society’s belief that the welfare of the prospective child is an important consideration for all who work in this area.

**References**

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