Shared lesbian motherhood: a challenge of established concepts and frameworks

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In this issue, Spanish IVF-clinicians (Marina et al., 2010) report the first experiences of their institution with a novel procedure allowing lesbian couples to share biological motherhood. Technically, this involves one of the partners providing the oocytes for in vitro fertilization (IVF) using donor sperm, whereas the other partner provides the uterus and bears the child. The authors refer to this as ROPA (reception of oocytes from partner). For the couples involved, this procedure, although more challenging and costly than having a child through donor insemination (DI), would have the psychosocial advantage of allowing them to both participate in the creation of the child. With DI, the procedure that most centres would offer as the treatment of choice for reproductively healthy lesbian couples, they can have a child of which inevitably one partner is ‘only’ a social mother. With ROPA, however, they can have a child of which both partners are biological mothers, although in different ways.

The idea that IVF might make it possible for lesbian couples to share biological motherhood is far from new, but has until now mainly been discussed as an interesting hypothetical concept (Chan et al., 1993; Robertson, 1994; Dondorp, 2004; Woodward and Norton, 2006). Although there have been incidental media stories about lesbian couples seeking this type of reproductive treatment (De Telegraaf, 2000; BBC News, 2005) and although it was known that some couples had succeeded in thus creating ‘egg mommy, womb mommy families’ (Ehrensaft, 2008), the practice has not received much attention. Recently, a sociological study of partner dynamics between lesbian co-mothers included 10 couples who used IVF as a means to share biological motherhood (Pelka, 2009). This issue’s article by Marina et al. is, to our knowledge, the first clinical report of this procedure in a medical scientific journal. There is no doubt that this will give new impetus to the debate about how this application of IVF technology may challenge established views about parenting, the family and the aims of assisted reproductive treatment (ART). As the authors stress, it is this wider dimension that makes their publication remarkable, rather than the technical aspects, which are not different from regular procedures of IVF using donor oocytes.

In their article, Marina et al. refer to general principles of medical ethics: beneficence, non-maleficence and respect for patient autonomy (Beauchamp and Childress, 2009). They conclude that the practice of offering ROPA meets all the requirements of these principles. First, as ROPA leads to the fulfilment of an important desire of the couple, it would be an instance of ‘doing good’. Second, given the positive outcome of studies of the development of children in ‘lesbian-first families’, no one would be harmed. Finally, as the procedure is carried out on the request of a well-informed couple, it would be in accord with the principle of autonomy. However, this analysis leaves room for further considerations of medical ethics that we briefly address as a contribution to further debate.

‘A bizarre reproductive scheme’

For a start, it is interesting to contrast the conclusions of Marina et al. with the position taken by the Roman-Catholic theologian and ethicist McCormick. More than 15 years ago, he was one of the participants in a debate in the American journal Ethics & Behavior about a then still hypothetical case of ROPA: lesbians wanting to share biological motherhood through IVF (Chan et al., 1993). In his contribution, McCormick argued that although IVF could be ‘legitimate therapy’, it should not be used for ‘bizarre reproductive schemes’ that have nothing to do with the purpose of medicine. McCormick’s view fits in with the traditional understanding of the principle of beneficence, according to which the notion of doctors being called to ‘do good’ is not unqualified, but tightly connected to their professional orientation to fight disease and help the sick. From this perspective, the question is not whether ROPA can indeed be seen as a matter of fulfilling the wishes of the women involved. Even if it does, the question to be answered is whether providing IVF to a couple of reproductively healthy women should be regarded as good medical practice. Whereas Marina et al. refer to this under the separate heading of ‘medical acceptability’, we regard it as a core ethical issue raised by their publication.
This is not to say that we endorse McCormick’s rejection of ROPA. The difficulty with his appeal to the limits of the profession is not so much that in reality the practice of medicine comprises many activities that would then also have to be questioned, including sterilization, abortion, cosmetic surgery and, indeed, DI for reproductively healthy single women and lesbian couples. More fundamentally, the concepts of ‘health’ and ‘disease’ are not as clear-cut and objective as his argument suggests. This is obviously the case in the context of reproductive medicine, certain applications of which are better understood as a treatment for involuntary childlessness than as an intervention aimed to redress a biological defect. IVF for idiopathic infertility in couples of which the female partner approaches the end of her reproductive life-span (currently one of the most frequent applications of the technology) is a clear example. Re-fertilization procedures to allow newly established couples to have children together in addition to those they may have from previous relationships, is another. What these examples show is that how we look at good and ill-health is not only informed by biological facts, but as much a matter of social conventions and justifications (Bateman Novaes, 1998; Richman, 2004). In the domain of assisted reproduction, this bears on shared social understandings of the meaning and value that having children may bring to human lives and relationships. The question then becomes why ROPA could not also be seen as enhancing the reproductive health of a couple in this wider sense.

**ROPA or DI?**

But there is a further issue to be considered. In cases where the couple requesting ROPA could also have a child through DI, one would still need a justification for applying the more burdensome, risky and less cost-effective method of IVF. In focusing on these cases, we leave aside that ROPA may also be chosen when, due to an infertility problem of the woman wanting to become pregnant, IVF is already the treatment of choice. In such a case, ROPA may serve as an alternative either to IVF using the own oocytes of the woman wanting to become pregnant, or (in cases where this woman has a compromised ovarian function), as an alternative to IVF using donor oocytes (Woodward and Norton, 2006). The fact that in these situations, the choice between DI or IVF is made on medical grounds, independently of the couple’s preference for ROPA, makes them ethically less controversial than cases where ROPA implies choosing IVF in advance of DI. Some may argue that for a couple consisting of two women of reproductive age, there can be no indication for IVF as long as at least one of them is reproductively healthy, regardless of the couple’s decision about who will (now) try to become pregnant. This is not in line with current practice in most centres offering assisted reproduction to lesbian couples, nor is it what we mean when saying that ‘the couple could also have a child through DI’. We accept that IVF is indicated for a lesbian couple depending on the fertility status of the woman who wants to become pregnant. However, when this woman is reproductively healthy, it might be asked how to justify ROPA, as obviously there is no medical indication for IVF.

Precisely this was the argument of Dutch clinicians referred to in a newspaper story about a lesbian couple whose request for ROPA was turned down at different IVF centres. (De Telegraaf, 2000). The rejected couple was quoted as saying that they considered going to Belgium, where doctors would be willing ‘to make their dream come true’. Contributing to the ensuing discussion, a Dutch fertility specialist stated that since the couple could have a child through DI, there was ‘no sound medical reason for exposing the women to the risks of IVF treatment, not even at their own request’ (Braat, 2000). There may be several reasons why Dutch clinicians took so strict a view, including the fact that their centres would otherwise risk losing the government licence without which IVF cannot be performed in the Netherlands. But looking at it from the perspective of medical ethics, should one not say that their position was perfectly right? Isn’t this indeed what the principle of non-maleficence (‘first do no harm’) would require? If so, should we conclude that there is no justification for offering ROPA in advance of DI?

A possible rejoinder to this is that if any additional burdens and risks are willingly accepted by well-informed and competent subjects, the choice between ROPA and DI should be a matter of patient autonomy. As Marina et al. stress in their paper, the women’s ‘right to decide for themselves in something as important as having a child [should be] respected’. Although in general the appeal to patient autonomy should not be taken to exempt doctors from their professional responsibility, it can be argued that the burdens and risks of IVF, though not negligible, are readily accepted in many other applications of ART. Against this background, paternalist arguments for not allowing the couple to choose ROPA over DI do not sound very convincing.

But there may be other (non-paternalist) arguments for not allowing this choice. The lower cost-effectiveness of IVF would be such an argument in cases where (part of) the procedure is being paid for from collective means. And what about the fact that as a form of IVF and unlike DI, ROPA entails the creation of surplus embryos? Those who think that human embryos have a certain moral value are committed to the view that they may only be instrumentally used for an important purpose. Helping a couple to have a child may be such a purpose, but can this still be maintained when the couple could also have a child through a less embryo-consuming procedure?

**A more promising route to have a child**

This brings us to the core of the matter: to what extent can DI indeed be regarded as an alternative means to the same end of helping the couple to have a child? Indeed, this is precisely what couples requesting ROPA deny. They do not just want to be helped to have a child, but they want to have a child of which both partners are biological mothers: one through her genes and the other by gestating the child. As one such couple was quoted in the British press, they wanted a child this way so that it ‘truly came from both of them’ (BBC News, 2005). Looking back at the arguments given by Dutch clinicians for not acceding to requests for ROPA, it is remarkable that this crucial aspect (at least from the couple’s perspective) was not even considered. Apparently, the motive behind their request was regarded as an idiosyncratic preference that would not change the conclusion.
A powerful argument for reconsidering this was made by gynaecologist Fox in her contribution to the debate in Ethics & Behavior already referred to (Chan et al., 1993). In an interesting comparison, she pointed to the then new technology of intracytoplasmic sperm injection (ICSI, a variant of IVF) that was in the process of being introduced for heterosexual couples afflicted by severe male infertility. This allowed couples who previously could only reproduce through donor insemination to have a child of whom both partners would be genetic parents, instead of a child with a sperm donor as the genetic father. As in the case of ROPA, this preferred outcome (a child from both partners) is achieved at the price of submitting a genetically healthy woman to IVF where the couple could also have their child wish fulfilled through a much simpler DI-procedure.

In the case of ICSI, as Fox remarks, ‘few physicians struggle over offering such couples this chance for creating a child together. Are [lesbian couples] not entitled to the same opportunity?’ (Chan et al., 1993).

In answer to this, one might perhaps reason that in the case of ICSI, the couple’s reproductive health is affected by a biological problem (low sperm count) that is more fully solved through ICSI than through DI. In the case of lesbian couples asking for ROPA, there is no biological problem. But in what sense does ICSI provide a more complete solution here than DI? Is it that biologically, a child of which both partners are the genetic parents is the normal outcome of human reproduction? True as that may be, this does not answer why an ICSI-child would be a better or more complete outcome than a DI-child. Any convincing answer to this question will have to refer, not to the male partner’s oligospermia, but to the meaning, for human couples, of having a child from both partners. The difference between the two outcomes must be sought in the psychosocial dimension of the parent role. This includes elements such as the contribution of both partners in the creation of the child, the confirmation this entails for their relationship, and the foundation of a shared responsibility for the well-being of the child. The importance of this dimension for understanding the meaning that different reproductive arrangements may have for those involved is increasingly acknowledged (Janssens, 2009). But then, indeed, the question is why similar considerations should not also be taken into account when lesbian couples ask for ROPA.

Of course, very little is yet known about how the choice between ROPA and DI may affect family dynamics in lesbian-first families. The American study by Pelka is only the first to address this issue (Pelka, 2009). This study found that knowing to be either the genetic or the birth mother ‘appears to ameliorate emotional insecurities’ in dual-mother households, both externally (in response to challenges to maternal legitimacy) and internally (when confronted with infant preference for the other parent). More research is certainly needed. Centres openly offering ROPA (such as those of Marina et al.) may provide a suitable setting for this. Moreover, an obvious difference with ICSI remains that lesbian couples still need a third-party contribution in order to be able to ‘create a child together’. This, however, should not detract from the claimed additional value of having a child through ROPA. The main question to be answered is whether the possible psychosocial advantage that ROPA may provide indeed outbalances the disadvantages of the procedure for women who are prepared to accept them in view of what they regard as a more promising route to having a child.

### Justice

In their brief discussion of ethical principles, Marina et al. do not explicitly consider the principle of justice. However, they rightly stress that the debate about assisted reproduction for lesbian couples should be understood against the background of increasing societal acceptance of homosexual relations, which in several countries has led to legalized marriages for homosexual couples (Marina et al., 2010). Equal treatment is a matter of formal justice. Whether this principle can also be invoked with regard to requests for ROPA in advance of DI is a different matter. This will depend on how convincing the (admittedly imperfect) analogy with ICSI is thought to be. A final issue is distributive justice, referring to the just distribution of scarce public or collective means. Marina et al. make clear that they treated only privately paying patients. Currently, ROPA is indeed only conceivably in a private setting, also in countries where assisted reproduction is (partly) covered within a publicly funded health-care system. However, the analogy with ICSI may also lead to debate about whether it is indeed fair to exclude ROPA from coverage. The upshot of our analysis is that the familiar appeal to ‘medical necessity’ will be at best of limited help when having to answer this question (Dondorp, 2004). This is not to say that ROPA should be covered, but that we urgently need a better normative framework for determining what reproductive treatments are eligible for public funding and why.

### References


Brat DDM. ‘Een kind tot (w)elke prijs?’ [In Dutch]. Working group Psychosomatic Obstetrics & Gynaecology (WPOG), Abstracts symposium Dutch Society for Obstetrics & Gynaecology (NVOG), Groningen, 10 November 2000.


Janssens PMW. Colouring the different phases in gamete and embryo donation. Hum Reprod 2009;24:502–504.


