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Licensing Parents

Regulating assisted reproduction¹

Adrienne Asch

Introduction

In 1980, Hugh LaFollette published a compelling argument for the licensing of all parents. Recognizing the significance and responsibilities of parent-child relationships, he contended that a decent society should pay as much attention to protecting children from those who were manifestly unfit parents as it did to protecting patrons of barbershops from incompetent barbers. As LaFollette himself acknowledged, any parental licensing scheme would encounter both practical hurdles and fierce ideological opposition. He also conceded that any interference with creating and sustaining parent-child relationships would need to avoid enshrining a narrow set of cultural values and biases. It also had to recognize the limitations of the data on what makes for 'good-enough' parenting, and to honour the fact that children can survive and thrive in circumstances that outsiders might think difficult and distressing. Nevertheless, LaFollette made a powerful case for rethinking the connection between biological procreation and social parenthood.

Such rethinking takes on new significance in light of developments in assisted reproduction technology (ART) over the past thirty years that have effected a practical separation of procreation and parenthood. In the context of assisted reproduction, I will claim that whether or not an individual or couple has a right to parent the child they create biologically, they have no right to the assistance of third parties in creating a child for them to parent. Further, although it may be appropriate for the state or private clinics to set fitness conditions for providing reproductive assistance, such standards have often been mistakenly conditioned on factors with no relevance to effective parenting, such as marital status and sexual orientation. Instead, reproductive assistance should be conditioned on a kind of parental fitness specific to collaborative reproduction: a willingness to modify the ideal of the self-contained nuclear family to accommodate the more complex relationships created by third-party involvement. In particular, reproductive assistance should be conditioned on the willingness of prospective parents to disclose to the child the manner of his

creation, and to enable the child to learn about and establish contact with the people who contributed to his existence. This is a weaker claim than LaFollette's, since it calls for the imposition of conditions on a positive right to reproductive assistance, not a negative right to 'keep' the child one has produced.

I will also consider another important aspect of parental fitness for assisted parenthood – an openness about the traits of the child to be created; a willingness to accept a wide variety of children as one's own. As well as urging that clinics modulate, if not eliminate, their own selectivity, I will conclude that openness and flexibility on the part of prospective parents is best achieved by sensitive counselling and education.

Licensing parents and assisted reproduction

In 2007, Richard Storrow extended LaFollette's ideas to the ART context, reviewing practices in the United States and laws and practices in several other countries that have developed systematic approaches to determining which persons should and should not receive ART services. Storrow opposed denials of ART services unless there was reason to believe that the prospective parent or parents would cause significant harm to children or would be determined unfit using standards analogous to those used in cases of termination of parental rights. In the decades between LaFollette's proposal for reproduction in general and Storrow's formulation for assisted reproduction, scholars, standard-setting bodies, and law commissions in many countries have taken different approaches to oversight of ART services. Those that view assisted reproduction as analogous to unassisted reproduction generally oppose any legal or professional gate-keeping. By contrast, those who compare family-building through assisted reproduction with child placement in adoption tend to support or accept more review.

Supporters of professional or legal gate-keeping generally contend that although society cannot institute parental licenses and protect children from physical, psychological, or social harms if they are born through sexual reproduction, that same society should protect as-yet-unconceived children from foreseeable adverse consequences by refusing to aid the adults who might be responsible for negative outcomes. Cohen (1996) and Coleman (2002) argue that providers of ART services should not aid in the births of children likely to experience serious impairments. Nations with a protectionist view towards psychological and social harms include the Czech Republic, Taiwan, Korea, and Japan, which restrict services to married heterosexual couples (reviewed in Jones and Cohen 2001)².

Prospective parents are rejected in both the un-regulated and the regulated nations of the world. Exclusions may be both categorical (no single people, same-sex couples, people over fifty years old, with histories of substance

abuse or psychiatric diagnosis) (Gurmankin *et al.* 2005); or they may follow an individualized determination of unsuitability (too narcissistic, depressed, or controlling) (Center for Surrogate Parenting 2003). As Jones and Cohen (2001) and Storrow (2007) discuss in their reviews of the worldwide ART situation, some countries are more permissive than others in accepting reproductive services without regard to marital status or sexual orientation. Ease of travel and the popularity of what some refer to as 'reproductive tourism' enable people who don't like the laws in their home country to go elsewhere for help. Although laws in many nations restrict ARTs to heterosexual couples, Belgium, South Africa, Spain, most Australian states, and the Netherlands have no such limitation (Jones and Cohen 2001). Prospective parents from Sweden who don't want adult children to have contact with the providers of eggs or sperm need only obtain gametes from Denmark, where providers are permitted to remain anonymous.

In the United States, no state or federal laws govern access to ARTs save to prohibit discrimination against groups protected under state and federal civil rights statutes³. Decisions about eligibility rest with private fertility clinics and individual practitioners. As the American Society for Reproductive Medicine explains in statements discussing requests for service by people who are HIV-positive (2002), postmenopausal (2004b), of uncertain child-rearing ability (2004c), or gay, lesbian, or single (2006), practitioners typically balance respect for the procreative liberty of adults with concern for the wellbeing of future children, and with sensitivity to differing views of professional integrity and responsibility. Practitioners report that they would use their professional judgment in assessing whether particular ART candidates should receive services (Stern *et al.* 2001; Gurmankin *et al.* 2005).

Yet despite findings from the aforementioned surveys that clinic directors felt they had the right and responsibility to reject would-be parents for medical, psychological, or social reasons, most centres operated without written policies about whom to treat; program directors who reported that they would be extremely likely to turn away people based on certain characteristics did not always collect information about those characteristics. For example, 11 per cent of directors claimed they would be slightly, and 71 per cent said they would be very, likely to refuse a couple if the man had been abusive to his existing children, but not all programs actually inquired about relationships with existing children or about the children's physical or mental wellbeing (Gurmankin *et al.* 2005). Whether or not programs are learning about sexual orientation, marital status, substance abuse, or financial stability of those who seek them out, respondents to the most recent survey of US practitioners reported that only 4 per cent of all applicants were denied services in the year preceding the survey (Gurmankin *et al.* 2005). Only 1 per cent of denials were for what the clinic directors or the researchers called 'social' reasons⁴.

By contrast to instances where practitioners rejected ART applicants for social factors that they believed would influence the children negatively,

there are documented instances in which non-conforming adults who received ART services caused dismay in the media, the public, and the scholarly community. A transgender man with a functioning uterus reported that after many practitioners refused to treat him and his wife, he became pregnant with a baby created from his wife's egg and anonymous sperm (Beatie 2008). Claudia Martinez received artificial insemination notwithstanding being a single, unemployed woman with developmental disabilities (McClain 2001). After learning of the services to Martinez, bioethicist Arthur Caplan commented 'as this case proves, there are no guidelines, no rules or regulations governing who becomes pregnant with this technology, and there should be... No one has to make sure the woman is capable of caring for a child. No one has to consider if she will be a fit parent' (McClain 2001: A1). The practitioner who treated Ms. Martinez counters that it is not his business to decide who will be a fit parent but instead to provide medical services and treat health problems like diabetes and hypertension that prevented Martinez from maintaining her first pregnancy. Robertson (2009) noted that similar calls for increased oversight and regulation occurred after a woman who already had six children using assisted reproduction then gave birth to eight more. But he also quotes practitioners who insist that if people using coital reproduction can decide to have large families, so can people using ARTs.

Responding to requests for services from individuals and couples who don't fit the original profile of the heterosexual married couple seeking IVF after unsuccessful attempts to have their own genetic child, the Ethics Committee of the US ASRM developed guidelines on treating postmenopausal women, same-sex couples and single people, and those whom some suspected would be poor parents (Ethics Committee of the ASRM 2004b, 2006, 2004c respectively). These guidelines make room for practitioner diversity: they condone those who deny services based on concerns about how children will fare, and also support practitioners who refuse to deny services based on such concerns when the vast majority of the population can become parents without review of their child-rearing potential. Steinbock (2005) cogently defends this pluralist stance that tolerates practitioners whose principles compel them to decline some applicants, as well as practitioners prepared to treat those who make other professionals and segments of the general public decidedly uneasy. (A distinct issue is presented by practitioners morally committed to a different policy than those of the organizations for whom they work.)

Procreative liberty vs. the right to parent

The principal arguments against any form of gate-keeping flow from beliefs about the procreative liberty of adults (Robertson 1986, 1994, 2004), and convictions that outside monitoring of families-in-making or families

once-created undermines the intimacy and privacy that distinguish familial relationships from all others (Brighouse and Swift 2006). I will contend that the first argument is of only limited relevance to those seeking reproductive assistance: it defends the liberty of individuals seeking to provide assistance to make their products or services available, but not the liberty of recipients to use those products or services in creating a child over whom they will have parental authority. The second argument makes the unwarranted assumption that screening prospective parents for eligibility will interfere with the intimacy or privacy of the family relationships established by those found eligible.

Robertson's defence of procreative liberty, for people refraining from and engaging in coital or assisted reproduction, rests on his commitment to adults' freedom to make decisions about their own bodies and lives. That defence bears more on the freedom of gamete providers and gestators to use their reproductive capacities and materials than on the reproductive opportunities of the recipient prospective parents. Procreative liberty cannot be invoked in opposition to professional or legal scrutiny and limit-setting for recipients. Couched in the language of 'passing on one's genes' or 'deciding how to use one's body', Robertson's arguments help gamete providers and gestators; they do not help the people typically understood as the ART patients (or perhaps consumers) – those who want to become social, rearing parents. If procreative rights are grounded in control over one's own body, the privacy of sexual relationships between consenting adults and, per Robertson, the desire to ensure one's genetic continuity, those values do not entitle people to assume the grave responsibility of raising a child. If providers have a right to give or sell their reproductive products and services, then prospective parents may have a right to receive or purchase those services. But that would not give them the right to become the social parent of any child resulting from the transaction.

The second argument, about intimacy, rests on a concern that access restrictions on ART will interfere with the family relationships of those granted as well as those denied access (Robertson 1994; Steinbock 2005). The claim is that the intimacy that should characterize parent-child relationships cannot flourish if outsiders control the terms of that relationship. But this claim seems unwarranted, or at least unsupported. As long as the parents deemed eligible to receive reproductive assistance enjoy the same parental rights as those who reproduce without such assistance, there is no reason to believe that the initial screening will cramp or chill the relationships they establish with their children.

More broadly, it is difficult to argue for a right to become a parent, as opposed to a right to be free from interference or coercion in matters of reproduction. The right of biological parents to parent any child they produce, though called into question by LaFollette (1997, 2010), arguably can be seen as a right of the latter sort – a negative right to be free from having one's biological child taken away. Prospective parents who require reproductive assistance, in contrast, would have to claim a positive right to that assistance – a harder claim to establish.

Moreover, whether or not individuals have a right to state support in acquiring a child to parent, it is not clear why they would have a right to parent a child with whom they have some kind of biological connection. Even if the desire for a biological connection is reasonable and defensible, it need not be given the same weight as the more general desire to parent a child or form a family.

People may believe that prospective parents are likely to be more loving, devoted, or generally fit if they had some biological connection to the child rather than none. It is here that LaFollette's arguments against a presumption of fitness apply *a fortiori*: if we cannot presume parental fitness on the basis of full or standard biological connections, we can hardly do so on the basis of the partial ones made possible by ARTs. The ability to use one's genetic material and reproductive capacities to bring a child into being has nothing to do with the skills needed to protect, support, value, guide, socialize, love, respect, and respond to the individuality of children once they are born. Scholars and societies have rarely had to justify the presumption that biological relationships would create the desire and capacity to rear (but see Gheaus 2011 for such an attempt); instead, they have relied on this presumption and made it hard to overcome. Perhaps the assumption springs from the conviction that genetic connectedness, the notion that a child was 'flesh of my flesh', would create the psychological and social identification with children Bartlett (1988) described as an essential part of parental responsibility (see Richards 2010). But there is no research to support that conviction, and much to support the view that parents can be equally effective when the child they raise has no biological connection to them (Golombok 2000). The strength of the link between biological capacity and parental fitness is certainly called into question by the number of children who are abused or neglected by their biological parents, as well as by the psychological, social, and academic difficulties of children unwanted by the biological parents who raised them (David *et al.* 1988). Genetic relatedness by itself cannot yield the prerequisites for adequate parenting.

It is certainly understandable that many prospective parents seek such a connection. No matter how much they recognize that most of parenting is social and consists in the many daily acts that support, teach, and inculcate values and interests in a child after its birth, many people look forward to seeing themselves, their partner, and other relatives in the new child. Families have seemingly endless conversations about whom the child resembles. Many women and their partners often view a wanted pregnancy as the beginning of their parental experience. Low- and high-tech means of giving the infertile couple a genetically-related child that the woman carries to term are often costly in dollars, time, and psychological resources. Undoubtedly the researchers and clinicians who pioneered the means for infertile heterosexual couples to achieve biological parenthood have both responded to and strengthened the desire for these expected biological ties to children. But the desire for a parental role and a meaningful relationship with a biologically connected child cannot

be seen as a social or political right⁵. The person who cannot or does not wish to engage in sexual intercourse that could lead to reproduction may well have the qualities of responsiveness, empathy, and demandingness to help a child become an exemplary family member, worker, and citizen, but she is not entitled to acquire gametes with which to make an embryo she can then gestate.

Parental responsibility and assisted reproduction

The previous section suggested that it is better to approach access to reproductive assistance in terms of the responsibilities of parenting, and the welfare of the future child, than to invoke an indefensible right to become a parent. In this section, I will argue that such a focus on parental responsibility and child welfare may favour more open access to ARTs, based on the willingness and capacity of prospective parents to take on a demanding, difficult, but intensely rewarding task.

Scholars, practitioners, and policy-makers who maintain a primarily rights-based, adult-centred view of parenthood understandably fear proposals that would limit access to family-creation services. Elsewhere I and others have contended that procreative liberty may not be the best banner under which to raise claims to the goods of parenting (Bartlett 1988; Asch 1995; Murray 1996; Ryan 2001; O'Neill 2002; Cutas and Bortolotti 2010). Onora O'Neill (2002: 66) wryly points out that 'limiting childbearing may promote individual autonomy, but having children generally curtails it'. If we moved from an adult autonomy, rights-based to a relationship- and responsibility-based view of parenthood, we might better serve the welfare of future children. I believe that professionals and prospective parents should embark upon a family-building enterprise focused on the needs of the children they seek to raise. Paramount among those needs is the potential for a secure, reliable, tie to someone who will combine acceptance of a child's individuality with the expectation of cooperation in joining the community of a family and the larger society (Darling 2007). As Katharine Bartlett writes, 'responsibility describes a certain type of connection that persons may experience in their relationships with one another. That connection is one of identification. Identification ... must be positive and affirming; it seeks what is good for the other person' (1988: 299). Bartlett's description of what it means to be a responsible person captures something at the heart of the parental project, a project that ideally should motivate those seeking to become parents:

Responsibility ... is a self-enlarging, open-ended commitment on behalf of another ... We want a society in which parent-child relationships are strong, secure, and nurturing... [O]ur ... concern is how the interests of both parent and child link together in relationships. Responsibility is a critical dimension of these relationships. Parents being responsible for children ... fits the best picture we have of ourselves. (Bartlett 1988: 299–300)

Accepting this responsibility- and relationship-based understanding of parenting should lead professionals not so much to refuse access to ARTs or to adoption but rather to challenge the adults who seek their aid to ask themselves hard questions about whether they are up to the task of identifying with and responding to the needs of the child they are bringing into their lives.

This concern with parental responsibility and child welfare, however, is not reflected in prevailing educational and medical social practices. If US society wished to ensure minimal welfare of all its future children, it might make learning about parenthood part of its public education; develop safe and effective male and female reversible vaccines to prevent unintended procreation (Battin 1996); and develop methods of assessing the capacities of adults to be responsive and demanding. People who understand what their society expects of them, and want the responsibilities and relationship that come with parenting, have at least the knowledge and motivation to care for and about their children.

Without a serious commitment to child welfare, US society accepts biological connection as the appropriate prelude to social parenthood. This assumption influences thinking about how children should be raised when biology does not lead to parental destiny. Fearing that adults without a genetic identification with children might not fulfil parental responsibilities, adoption professionals have instituted a form of licensure by the complex screening process that evaluates prospective adoptive parents through in-depth interviews, reference checks, and a home study. Yet despite the ubiquitousness of such assessments, standards of acceptance vary widely from agency to agency and have reflected many of the cultural biases discussed above in the world of ARTs. Moreover, according to conversation with adoption professionals at a major centre for adoption research and policy, the standards used to assess prospective adopters have never been correlated with child outcomes (Georgia Deoudes 2000, personal communication); I have found no subsequent research on the efficacy of the adoption assessment process.

In the case of parents who employ ART, there has been some outcome research. That research has found that the experience raising genetically connected children is similar to but *more* positive than that of raising genetically related children conceived without assistance (Brewaeys *et al.* 1997; Golombok *et al.* 2002). The similarities between the IVF or ICSI-created parent-child constellation and the families created without assistance should make us especially wary of practitioners who want to act as gate-keepers for the people seeking their assistance to create biologically related offspring from their own gametes.

To urge that child rearing be seen in terms of responsibility and relationships is not to endorse standard psychosocial screening criteria. Clinicians who would deny a woman the opportunity to parent based on her being postmenopausal, or being single, in a lesbian relationship, or having a cancer history, must demonstrate why she does not have the requisites for child-rearing.

The extensive research conducted by and reviewed by Golombok (2000) indicates that typical demographic characteristics such as parental age, marital status, sexual orientation, and genetic relatedness to a child are not the factors that predict effective parenting. Rather, the factors that do predict success are the capacities to foster a child's secure attachment and to respond to the needs of the individual child.

Given the cultural biases and questionable assessment methods that have plagued adoption, there is good reason not to incorporate its version of parental screening into the process of assisted reproduction. At the same time, however, the roles of third parties in some forms of ART create additional responsibilities for the prospective parents who employ their services. They must consider what relationship, if any, these people will have with the family they have helped create.

Clinicians who started out by providing ARTs for the heterosexual infertile couple increasingly find that they are being asked to create children who won't be raised by some or any of the people to whom the children owe their biological existence. When same-sex couples, single people, or heterosexual couples seek to create children using others' gametes or gestational services, they have moved away from the parenthood through biological assistance to a family that blends biologic and adoptive parenting. Unlike the two parents in ordinary reproduction and in most IVF- and ICSI-reproduction, collaborative arrangements can give a child three biologic contributors and additional social parents. Genetic and gestational contributors may be known by or unknown to the intended rearing parents, but in many cases the commissioning parent or parents don't plan to tell the child how she was created, or that certain gametes were requested in hopes of giving her particular physical, cognitive, or personality attributes.

Examples abound:

- A heterosexual married couple in their thirties selects sperm from a sperm bank's profiles and plan to keep the method of conception a secret from their families and their child.
- A twenty-something couple finds out that the woman's uterus can't hold a baby and creates an embryo to be gestated by an anonymous woman who will not meet them and whose role will never be known to the child.
- Less common, but not a hypothetical case, is that of a postmenopausal woman who wants to carry and raise a child created from her daughter's egg fertilized with the sperm of the mother's current husband, the daughter's stepfather.
- Single women request help in forming families using sperm of known or unknown others.

- In order for both members of a lesbian couple to share a biological connection to a child, one woman will provide the egg to be fertilized with the sperm of her partner's brother, and then the embryo will be implanted in and gestated by the first woman's partner.
- An infertile Pakistani couple asks for an embryo made up of gametes from Caucasians so that the child they bear and raise will escape the ethnic prejudice that has plagued their lives in Great Britain (Van Dijck 1994).

These situations illustrate some of the complexities of third-party or collaborative reproduction. There are different numbers of contributors and widely varying relationships between them and the parents who relied on their assistance. Gamete provision and gestational services may indeed produce children with a genetic connection to someone who will raise them. But the children will also be affected throughout their lives, though to an unknown extent, by their genetic or gestational connection to someone outside of their parent or parents. The professionals are creating children who could not have come about without these technologies and social arrangements. These complexities create special responsibilities for parents, and one goal of education and screening for third-party ART services must be to ensure that prospective parents understand these responsibilities and are willing and able to fulfil them.

Selectivity, secrecy, and the parent-child relationship

I conclude by articulating my vision of how parents and practitioners can best discharge their responsibilities to the children they create and raise. The circumstances of parental selectivity in gamete providers and in gestators, along with the fact of having created a child with discontinuities in his biologic and social parentage (whether or not the child knows these facts), give rearing parents unique responsibilities and give clinicians a significant counselling and gate-keeping role. First, parents who employ ART should limit their selectivity among possible providers and display a willingness to accept a wide variety of kinds of children. Second, those parents must be willing to disclose their child's origin to her in age appropriate ways, and to give her any information they have about the identity and medical history of the (other) biological contributors to her existence. Their parenting responsibilities will include helping the child understand his origins, a responsibility that distinguishes the job of the ART parent from the job of biological parents raising a child. Gate-keeping should focus on ensuring that prospective parents are ready for that responsibility.

Choosing collaborators

As soon as ARTs involve genetic material and gestational services outside of the intended rearing parent or parents, the people who will raise the child must choose the others to participate in the child's creation. Sometimes the intended parents choose a gamete provider or gestator based on a previous friendship or familial connection and look forward to involving the person in their child's life. More commonly the commissioning parent or parents do not select the reproductive collaborators based on past or future relationship but on information they glean from photographs, essays, sometimes an in-person or telephone interview, and the knowledge that professionals approved them for their role. People often base their selections on the hope that some or all of the attractive physical and personality characteristics will be transmitted to the child genetically or will assure a safe intrauterine environment. Gamete providers and gestators are not selected for anything but the particular attributes recipient parents seek. Unlike mate selection, with which this version of reproduction is erroneously compared, people do not select a partner for a child-rearing project knowing that everyone will have both desirable and less attractive qualities. Moreover, the typical collaborator has had and will have no other relationship, role, or responsibility in the life of the adult; when partners decide to become parents together with or without assistance, the parenting is only one important part of a multi-faceted relationship. To the extent that people select partners based on what they think the partner will be like as a parent, they are selecting for many reasons; for a complex relationship, and for a partner in parenting; they are not selecting someone to raise a child with, and make a life with, solely based on height, complexion, or intelligence.

As I've argued, it is hard to claim that access to ART services and the resulting parent-child relationship is any kind of right, since no one has a right to anyone else's genetic material or reproductive services, and no one has a right to a child with particular genetically-transmitted characteristics. In other work, I've also argued against parental selectivity, whether they were screening for or against particular traits (Asch and Wasserman 2005). Using third-party collaborators raises concerns similar to and different from those I've described previously. Intense efforts at genetic and gestational selectivity expose a tension within ART that should trouble practitioners and challenge prevailing practices. ART is promoted as a means of permitting individuals and couples to come as close to unassisted reproduction as their biological or social circumstances permit. Practitioners treating an infertile heterosexual couple using their own gametes and gestation are helping to replicate the randomness of ordinary reproduction. The couple's genetic endowment is taken as a given; the partners have not selected each other primarily on the basis of the traits they hope to pass on to their offspring (extreme claims about assortative mating notwithstanding). In contrast, practitioners helping anyone select particular gametes and gestators

are working to minimize the chance qualities of reproduction and trying to give prospective parents greater control over their future child than they would have exercised had they been able to procreate without assistance.

The Pakistani couple described previously (Van Dijck 1994) are seeking to create a child whose phenotypic characteristics deliberately differ from their own. They are being selective in trying to create a child with particular attributes that they themselves could not replicate with biologic reproduction. The practitioner is not merely helping an infertile couple create a child, but a very particular kind of child, with features they could not have obtained from their own genes. In doing so, the practitioner and parents come closer to making a child to order. It is particularly problematic in a case like this, where their selectivity is, in Margaret Little's (1998: 163) phrase, complicit with 'suspect norms of appearance' concerning skin colour and ethnicity that help to perpetuate racism.

Practitioners who do not wish to become involved in these forms of selection could refuse services to everyone who wanted to select eggs, sperm, embryos, or gestators. In order to avoid unjustified and unjustifiable discrimination based on marital or partner status, age, or sexual orientation, these practitioners would have to refuse to serve both the heterosexual and homosexual couple and single women or men who needed outside biological contributions. These practitioners could still help people who needed gametes or gestational services if the prospective parent or parents brought in collaborators with whom they had relationships.

My own opposition to selectivity is more comprehensive; it stems from my conviction that responsive and responsible parenting entails the capacity for welcoming exactly the mystery that new human beings have always been and will continue to be, regardless of attempts to shape and control them before and after birth. I'm aware that I'm offering a norm for ideal parenting that many will not share and for which I may fail to make a compelling argument. But this norm receives support from studies of parenting styles for children born with and without reproductive assistance, which find that among the most important correlates of positive child outcomes are the qualities of the parent-child relationship, in particular, parental responsiveness to the child's individuality (Golombok 2000; Ehrensaft 2005; Darling 2007).

The willingness to accept a wide variety of children as one's own reflects an attractive ideal of parenthood. It is, however, more difficult and less appropriate to require of prospective parents than a willingness to disclose the child's origins. It is more difficult to require because selectivity pervades the culture and practice of contemporary reproductive medicine. It is less appropriate to require because fertility clinics themselves aggressively promote selectivity and screen donors for various inherited conditions.

Clinics do not have to reject selectivity altogether to modulate it both in their own practices and in their clients' decision-making. The current emphasis

on selectivity fuels the false beliefs in the power of genetics and fails to prepare parents for the child who defies what the gametes might have predicted. Practitioners could place less emphasis on the ‘quality’ of the genetic material they provided and offer clients less information about the ‘credentials’ of their providers, and they could encourage their clients to broaden their range of acceptable gamete providers and gestators.

Let me be very clear that I’m not interested in preventing those who need gametes or gestation from reproducing. I’m arguing that fertility specialists should be wary of helping people meet very particular standards for who is an acceptable collaborator or child. Prospective parents do not have the right to demand biological contributors with as long a list of paper qualifications as an elite college may use in selecting its entering class. But it may be difficult for clinics to discourage parents from being too finicky when they do so much to promote selectivity, from screening providers on the basis of family history to advertising their elite providers.

More needs to be said about how a society generally prepared to accept ‘designer families’ should guide or regulate their creation. I favour a policy that discourages screening out but that emphasizes the promotion of flexibility and openness in the people who will become parents with third-party assistance. At the same time, I recognize that people who are searching for help from a stranger for this intimate activity of creating a new human being want to establish a sense of confidence in and appreciation for any collaborator participating in this project. But clinic staff willing to meet these demands should be reminding everyone who seeks eggs from a woman who played chess and the cello that the genetic son of the chess-playing cellist may have no aptitude for or interest in either pastime.

Learning about collaborators

The parental selectivity issues for practitioners, parents, and ultimately the children, are rivalled in complexity by issues of the child’s knowledge of and relationship with collaborators. Any counselling of service recipients should incorporate discussion of dreams, hopes, expectations, and fears about family life after the long-sought child goes home. The conversation should include the much-debated topic of whether and how to tell children about where they came from. My proposals extend the US Ethics Committee ASRM (2004a) guidelines on disclosure to offspring about their conception; they go further than the ASRM in calling for practitioners to acknowledge the problems but support greater parental openness. In doing so, I draw on insights from the limited social science data available on families formed through collaborative reproduction (consonant with Scheib and Hastings’ discussion in this volume). But I am also advancing my own normative views about parenthood. Explaining to a child that the people raising her took these steps

to become parents can support the secure attachment all children are thought to need (Golombok 2000).

By contrast, secrecy about how the child came to exist can perpetuate the fundamental tension or ambivalence about biological origins inherent in the use of third-party ART. When Nachtigall *et al.* (1998) report that non-disclosing parents consider the information confidential within the couple and not necessary for the child, the parents are denying the very concerns that led them to choose this method of family creation (see Scheib and Hastings, this volume). Why don't these parents consider that their concerns could matter to the child? In a world ever more convinced of the power of genes and gestation to exert lifelong influence, non-disclosing parents are telling themselves that the child won't care about these biological facts. Exactly how can the parents hold such a view at the same time that they worked to obtain help from others who had particular desired characteristics?

Although non-disclosing parents may have additional reasons for secrecy I'll discuss shortly, the claim of irrelevance is one practitioners should challenge. Genes and gestation don't predict everything about any future person, but they certainly influence appearance, health, and perhaps facets of cognitive and behavioural functioning. It is hard to make sense of the claim that only rearing counts, and that biology isn't important, in the face of parental efforts at giving the child a certain biology. If ART users didn't believe that genetics was significant for their child's future, and if genetic origins would have relatively little effect on their experience of parenthood, these users might first try to adopt an existing child from their own country or abroad. I am not suggesting that adoption is morally preferable to the use of ART, but rather trying to underscore the claim that because the child's biologic origins matter to the people who ultimately raise it, the parent or parents shouldn't suppose these origins will not matter to the child.

So far, the data available on family lives created through collaborative reproduction don't provide decisive conclusions about the effects of disclosure versus openness or collaborator anonymity versus known collaborators. Single parents and same-sex couples cannot keep secret the fact that others played a genetic or gestational role in the child's creation; instructive for majority heterosexual families and ART practitioners is the evidence that even if these children do not know who their genetic fathers are, they appear comfortable and able to function well both within their rearing families and with peers and adults at school and in the larger community. In one study of ten-year-olds in lesbian homes in the US, Gartrell *et al.* (2005) report that children who knew their genetic fathers generally enjoyed relationships with them, but the ones whose fathers remained anonymous did not evidence much concern about this state of affairs. Extensive research on children created by artificial insemination and raised by single women or lesbian couples consistently indicates that children fare at least as well on measures of social

and academic development and on relations with their families as those living in heterosexual families (Golombok 2000; Perrin 2002; Gartrell *et al.* 2005; Paige 2005; Scheib and Hastings, this volume).

Writing about lesbian social, non-biological mothers in a 1997 report on European artificial insemination families, Brewaeys *et al.* articulate the apprehensions that many heterosexual, as well as gay and lesbian parents, have about their role when there is a reproductive collaborator: 'the social mothers, the biological mothers' partners, opted significantly more often for an anonymous donor than the biological mothers. These results suggest that the parent who lacks a genetic relationship with the child may experience the donor as more threatening to his/her position in the family than does the biological parent, regardless of the parent's gender' (1997: 1595). The parents in heterosexual couples who opt for secrecy about their use of a collaborator could fear that if the child learns that the person she thinks of as her mother or father has not contributed the typical genes or gestation, the child may discount or reject the non-biological parent. For these parents, secrecy about how their family differs from typical families appears to safeguard family stability and the child's attachment to both parents (Cook *et al.* 1995; Nachtigall *et al.* 1998; Golombok *et al.* 2002).

Families of egg provision and gestational collaboration are being studied, but most available research focuses on two-parent heterosexual ART families who have used artificial insemination. Fearful that secrecy in ART would lead to the negative consequences attributed to the 'lethal secrets' described by Baran and Pannor in their (1989) study of the children of donor insemination in the US, and aware that adopted children benefited from learning about their birth parents, some in the ART world insist on both openness and the availability of identity information (Donor Conception Support Group 1997; Daniels 2004). Others who focus on the dissimilarities between ART and adoption argue that the stance for disclosure or identity information is misguided, contrary to the strong preferences for secrecy in large numbers of ART parents surveyed in many countries, and premature in the absence of data on problematic outcomes (Cook *et al.* 1995; Brewaeys *et al.* 1997; Nachtigall *et al.* 1998; Golombok *et al.* 2002). Research from many studies in the US, Europe, and Australia cited in the Ethics Committee of the US ASRM's (2004a) disclosure guidelines, suggests no indications that planned disclosure before a child's adolescence is harmful; by contrast, accidental disclosure in adolescence or adulthood appears to produce negative consequences.

I have found no reports in any studies of planned parental disclosure suggesting adverse effects for parents or children, and conversely, some indications of parental relief and apparently positive effects on children's relations with genetic and non-genetic parents (Scheib *et al.* 2003; Lycett *et al.* 2005; Lalos *et al.* 2007). The ART families with school-aged and early-adolescent children didn't differ from one another in parent-child

relationships or children's outcomes based on whether or not parents had explained the child's biologic origins (Golombok *et al.* 2002), and all families appeared to be faring as well as or better than children of unassisted reproduction, adoption, or IVF without collaboration (Brewaeys *et al.* 1997; Golombok *et al.* 2002). Being raised in families with both biological and non-biological parents, whether or not children know about the arrangements that brought them about, does not appear to have any adverse effects on children. As previously cited work has shown, what goes on between parent and child, not the number of parents, their genetic relatedness, or their sexual orientation, best predicts children's development (Golombok 2000; Ehrensaft 2005).

That most ART families are doing well does not argue that secrecy is morally preferable; the data merely indicate that most families are good enough. Findings that families with secrets are doing all right up to the child's adolescence don't invalidate the reports that adolescent and adult children of ARTs (mainly donor insemination) have been distressed to learn of their origins when these revelations were accidental or occurred in moments of family disruption by death or divorce. The available data on these late-adolescent and adult discoveries of donor insemination origins don't permit sorting out whether the distress resulted from the content of what was revealed, the fact that a secret had been kept, or the manner and circumstances of revelation. Nonetheless, psychologists who have studied family secrets in many contexts observe that 'secrecy about one's beginnings is particularly difficult to justify, as it places a lie at the center of the most basic of relationships – the one between parent and child' (Schaffer and Diamond 1993). I appreciate those clinicians and bioethicists who caution against replacing the previous adamancy for secrecy and anonymity with an uncritical demand for openness and available identity-information (Klock 1997; Shenfield and Steele 1997; Ehrensaft 2005). Nonetheless, I am persuaded by practical, psychological, and moral arguments for at least openness about the fact of third-party assistance, and preferably the possibilities for identity-release and contact with, all the people who played a role in a child's biological existence.

Furthermore, I believe that professionals who counsel collaborators and rearing parents towards openness can underscore the value and priority of the non-biological components of parent-child relationships and family life. A parent quoted by researchers studying collaborative reproduction in Sweden puts my point well: 'The staff should be rooting for the child. They should be aware that what they are doing is more than giving medical treatment. It is about creating a life for someone who will grow up to be an individual with rights and possibilities' (Lalos *et al.* 2007).

As a practical matter, the child may want or need medical information that can best be provided through genetic analysis. With increasingly common and useful DNA testing, rearing parents may find it impossible to withhold the

facts from their children for fear that their children will be deprived of health-promoting or life-saving information. But medical information is hardly the only reason children may want knowledge of or contact with the people who contributed to their existence. Long before a child or young adult needs to learn that his unknown genetic mother's family has a history of adult-onset diabetes, he needs to know that he can rely upon and trust what his parents tell him about themselves, about himself, and about the world.

As a psychological matter, the child's life with the people who care for and about him is what counts. It is hard to understand why that sense of 'mother' and 'father' will not survive a simple, matter-of-fact explanation that he doesn't look like his mother because she didn't contribute her genes. She has been contributing to his life ever since she was pregnant with him or began nurturing him. The rearing parents who fear that they will lose a child's love if the child finds out that she grew in someone else's belly forget all the other things that have gone on in their interactions with their child. They can teach an immensely valuable life lesson to their child by explaining that although her father couldn't give her his genes, he gives her time and attention. No parent can do everything for a child that they might like or that a child might want; but children can live with an honest explanation of what couldn't happen and can value what they receive.

The practitioners who link commissioning parents with collaborators should help parents imagine how they can explain a child's conception and birth in ways that do not minimize the biological significance of origins, the planning that gave rise to the collaboration, and the shared life they now lead. There is every reason for parents to be at least comfortable with, if not proud of what they have done to fulfil their goal of child-rearing. Although they may think they can avoid helping a child deal with any sense of shame or embarrassment by keeping origins secret, they are expending immense energy in guarding a simple biological fact that is of material significance to the child. The literature about others who try to conceal what they think of as stigma, and who try to pass as something they are not, suggests that concealment and pretence drain psychic resources from living life (Goffman 1963).

When a child created with ART starts asking about her birth, as all children seem to do, her parents should introduce the idea that they wanted her, and got help from someone who provided the egg, sperm, or womb they needed to bring her into the world. As the child gets older, but probably before adolescence, they can explain how the 'someone' was selected and can tell the child something about that person. If parents don't explain about collaborators, they're actually beginning a chain of falsehoods.

Often discussions about disclosure versus secrecy are tied to debates about the pros and cons of collaborator anonymity, but the topics can be considered separately. In order for parents to possess relevant medical history, practitioners must obtain and provide at least non-identifying information of

the sort the parents examined when they selected collaborators initially. Ideally, collaborators would consent to having their identities made available to the children when they became legal adults, so that those children could establish contact if they, like their parents, regarded biological origins as important. Practitioners should encourage parents to disclose the fact that there was a collaborator regardless of how much information they can give the child about who the person is.

The ART professionals should recognize that they are providing more than medical treatment and should include serious conversation and counselling in their expected work with people who seek them out. They should be developing parent-to-parent networks, offering parents material they can use to explain the facts to the children, and working to change the parents' language from 'disclosure' and 'secret' to explaining one fact of a child's and family's life. Professionals should enable all those who contribute to a child's life to acknowledge their part in that life. They should present parents with clear information about why they think the secrecy can damage the child psychologically, and how it can be detrimental to their child's relationship with them. Practitioners can explain why they think candour will ultimately be better and much less stressful for everyone involved. They can also provide parents with resources to guide them and tools they can use with their child. If practitioners believe that would-be parents cannot envision telling a child that they selected someone to help create her, perhaps practitioners should advise them to rethink the enterprise. They should hesitate to start a parental project feeling that it would be damaged or compromised unless its origins remain secret from the person it helped create.

Practitioners and future ART parents could learn a lot about creating their families from the gay and lesbian families successfully raising children who know about, and often know personally, the people who helped their parents create them (Gartrell 2005; Mundy 2007). Research shows that children can clearly distinguish rearing parents from biological collaborators, even when they know about the existence of those collaborators, and even when the collaborators go on to participate in the child's life. The facts are likely to be much easier to deal with than they fear, and they can distinguish themselves as parents from biological contributors, just as they distinguish themselves from uncles, grandparents, neighbours, baby-sitters, and family friends who participate in their child's life.

Conclusion

In my own personal utopia, prospective parents wouldn't be so enthusiastic about where their child's genes came from, and if two people couldn't provide the genes or gestation, they might randomly pick gametes or might adopt a

child who needed a family. Whether or not they selected gestators or gamete providers from relatives, friends, or profiles, they would tell their child what happened and make room for the child to put them into her life if she wished. Absent anything like my ideal, I'm urging clinicians not to license, but to counsel and converse, to give new entrants into the ART world the benefits of their experience with thousands of others already raising children. Elsewhere I have given qualified endorsement of conscience exceptions for professionals who would decline to provide other medical services (Asch 2006), and I thus must acknowledge that some clinicians may wish to avoid creating children for parents they expect will be ill-equipped to care for them. Clinicians who refuse to treat infertile couples for any reason should refer them to practitioners who might have different standards. And ART practitioners should team up with researchers to follow children and parents through childhood and into adulthood to learn whether their practices foster the kind of responsive parenting everyone thinks children need and deserve.

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Notes

- 1 This is a revised version of my paper given at the Ethics of Procreation and Parenthood Conference in Cape Town, South Africa in May 2008.
- 2 Having previously written on the subject of pre-implantation and prenatal diagnosis (Fine and Asch 1982; Asch 1989, 1999, 2000), I will restrict my comments in this essay to other psychological and social harms. In this paper I focus on two of the harms Robertson sees as specific to ARTs: deficient 'child-rearing ability' and 'novel family forms' (2004).
- 3 There is too little US case law to make many conclusions about how courts will respond to exercises of practitioner discretion. Guadalupe Benitez, denied based on sexual orientation, won her case (*Benitez v. North Coast Women's Medical Care Group* 2003). In another case, the clinic convinced the jury that factors other than the patient's blindness prompted them to deny service to Tuana Chambers. Three years after Chambers' denial, she obtained insemination services through another clinic and gave birth to a daughter (Hershey 2003).

- 4 Denials based on clinic opposition to treating people with genetic conditions, or denials stemming from concerns about child-rearing ability of people with disabilities, might have been classified as medical reasons.
- 5 I agree with Pennings (1999) that children do not have a 'right' to parents of a particular age. But I disagree with Boivin and Pennings' (2005) claim that parenthood as such is a right.

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