ORIGINAL ARTICLE

Disparities in parenting criteria: an exploration of the issues, focusing on adoption and embryo donation

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This paper examines the consistency of parent selection procedures, focusing on adoption and embryo donation. It outlines the current methods of selection and their disparities, and considers reasons for these disparities; namely, the intentionality of the parents, the gestational experience, and the technological imperative. This discussion is followed by an analysis of the ethical validity of these reasons, in terms of their consistency and how well they meet standards of equity and justice. The paper concludes that current approaches to parent selection are unsystematic and inadequate, and discusses the implications of this assessment.

When considering the parental criteria between different methods of family creation—"natural" conception, adoption, and new reproductive technologies (NRTs)—the differences are striking. These marked disparities are rarely investigated, however, and a comprehensive approach has not been taken towards the issue. This paper explores this diversity in parenting criteria and examines reasons which could be given for these differences. It concludes by assessing the ethical validity of the proffered reasons in terms of justice and equity, and discusses the implications of these conclusions. The focus of the paper is on the parenting criteria employed in adoption and embryo donation (strictly defined as "treatment using donated embryos") because there are obvious similarities in the family unit created by these methods. Fundamentally, children born as a result of embryo donation, like adopted children, are not genetically related to their parents.¹

THE SELECTION PROCESS FOR WOULD-BE PARENTS IN ADOPTION AND EMBRYO DONATION

The primary difference when considering parenting criteria is that in adoption the selection process is lengthy and detailed, and focuses on social and emotional factors, whereas, in embryo donation, the process is less involved and focuses on medical criteria.

The selection process for adoption is concerned with two types of information: factual information (such as age, marital status, ethnic origin, and occupation); and descriptive information, compiled by a social worker, who records observations of household members, made over several visits and spanning a period of months. Emphasis is placed on the personalities of the individuals and the nature and quality of their relationships. Issues ranging from family background to self image are explicitly considered, as is the future upbringing of the child; for example, support networks are discussed and the would-be parents' attitudes to childlessness and parenting are assessed. This in-depth assessment procedure is time-consuming and intrusive but is seen as essential to protect the best interests of the child; anything less is considered irresponsible and negligent. This view is endorsed by adoptive parents in an ongoing study, one of whom said: "You don't

want to just adopt just for you, the most important thing really is the children . . . it's the interest for [sic] the children, that's paramount. It's the good you're doing; they [the children] come first before your feelings".²

In contrast, the primary factor of parent selection in embryo donation is medical. The emphasis is on whether the mother is "medically suitable", not on whether the couple are socially and emotionally suitable to be parents. As the decision is seen as medical, it is taken by a medical practitioner, not by someone trained to consider the social factors.

The only national social criterion which embryo donation parents are expected to meet is found in the Human Fertilisation and Embryology Act, (HFEA) which states that a woman "shall not be provided with treatment services unless account has been taken of the welfare of any child born as a result of the treatments (including the need of that child for a father)".³ This is expanded in the HFEA code of practice:

In deciding whether or not to offer treatment, centres should take account both of the wishes and needs of the people seeking treatment and of the needs too of any children who may be involved. Neither consideration is paramount above the other, and the subject should be approached with great care and sensitivity.⁴

The instruction to consider the welfare of the child adds a moral and social dimension to the decision making process. By acknowledging that the welfare of the child is important, clinics and doctors are recognising that the decision is not just a medical one. They have some responsibility to consider the child's future wellbeing, yet importantly, and unlike adoption, they must give equal weight to the parents' wishes.

The method suggested for determining parenting criteria by the HFEA is to take a medical and family history, and to assess the couple both separately and together. The clinic is also expected to contact the patients' general practitioner (GP) to see if there is any reason why the couple might not be suitable parents. If any of the information causes concern about the future welfare of the child, the clinic is advised to approach the relevant agency or authority for further information. An approach can only be made, however, with the consent of the

patient—rendering this measure of screening less effective. Hence, the social and emotional components of the selection process are superficial, especially when compared to those in adoption: “selection for adoption is concerned with whether an applicant will be a fit parent and every effort is made to discover this, for medically assisted reproduction the effort is fairly minimal and is designed only to exclude those who might seem grossly unfit”.⁵ In effect, only couples who are regarded as being at risk of physically harming their future children are likely to be refused for social reasons. Those who are medically unfit are more likely to be refused treatment, especially given clinics’ (particularly National Health Service clinics’) need to increase the take-home baby rate.

REASONS FOR THE DISPARITY

Having outlined the two selection procedures we will now consider the reasons for these differences. Three solutions present themselves as possible; intentionality of the parents, the gestational experience, and the technological imperative. These reasons will be explored in turn.

Parent intentionality

Intentionality is an increasingly important factor when considering the ethical issues involved in NRTs. For example, if we consider surrogacy, what makes it possible for the commissioning couple to be considered the “real parents” (especially in cases where the “surrogate” mother is the genetic as well as the gestational mother) is their intent. The parents’ intent is causal: it caused the child to come into being and without it there would not have been a pregnancy.⁶ Such reasoning has supported some of the landmark judgments in the field. For example, in the famous *Johnson and Clavert* ruling in California, the court judged that the genetic parents, not the surrogate mother, were the “natural, biological, and legal parents”.⁷ In the UK, while parent intentionality is less important (the birth mother is always the legal mother), this reasoning still has a place. For example, with gamete donors it is their intention to provide gametes for the use of other people that ensures that they are not legally or morally responsible for their genetic offspring. Following this, the intentionality of the adoptive and embryo donation parents differs: the child born through embryo donation comes into being because of the wishes of the parents (without this intent the child would not exist); the adoptive child exists regardless of the intention of the eventual parents. Thus, it could be argued that although the would-be adoptive parents have become such by acting upon their desire to parent, their desire has not caused the child to come into existence. Hence, the argument is that intentionality is a “causal” difference between embryo donation and adoption.

The gestational relationship

The second reason which is cited as a justification for the different parenting criteria applied in adoption and embryo donation is that in embryo donation there is a biological link to one parent, through gestation. This is said to be important for a number of reasons: legal, emotional, social, and practical.

First, the legal difference between the status of embryo donation and adoptive mothers is clear. The embryo donation mother (and her husband if she is married) is the legal parent of the child, whereas in adoption parental rights and responsibilities have to be transferred after birth.

Second, emotionally, the gestational link is important as it allows the woman to feel that the child is “hers”. Indeed, when considering parenthood the gestational link is often felt to be as important as the genetic link, and research shows that “for some, the inability to gestate and give birth represents a greater loss than the inability to have a child whose genetic complement comprises 50% of their own genes”.⁸ Therefore,

the experience of gestation confers on the mother the perception of self as mother. As one mother in the ongoing comparison study, who had two children conceived via embryo donation put it: “that’s what is so nice about [embryo donation] because you actually go through the pregnancy and give birth, it’s your child. I mean, I’m sure people who adopt children feel the same eventually . . . but when you actually give birth, I’m sure there is a stronger initial bond”.² The argument here is that “unlike adoption, the child born through pre-embryo donation also benefits from the additional bond of being gestated in its future mother’s womb, with the support of its future father”.⁹

Socially, gestation enables the couple to experience pregnancy, birth, and child-rearing as if they were a “normal” couple who had conceived “naturally”. Unless the couple chooses to tell family and friends (and indeed the child) of their assisted conception, no one will know. The fact that the mother carries the child makes it possible to keep the non-genetic relationship to the child secret; something which is not possible in adoption. For example, in the ongoing study, the husband of one couple with children conceived using donated embryos regarded the gestational relationship as a reason for not disclosing: “Because at the end of the day it’s us that’s gone through it all, M’s gone through the pregnancy, M’s given birth to them, we’ve bought them up, you know, so it’s not an issue that’s important really”.² In comparison, adoptive parents as a rule disclose the child’s genetic background and discuss it with the child, for example, by keeping “life-story books” containing photos and information about the adoption.

Fourth, the gestation process means that embryo donation parents do not have the same practical obstacles to overcome. Adoptive parents must meet not selection criteria in general, but selection criteria specific to the needs of an individual child. Also, the relinquishment of the adopted child by its birth parents must be taken into account. When selecting parents for adoption the question is not whether the couple are fit to be parents in general, but whether they are suitable, indeed the best parents available, for the particular child—a child with an individual personality, a specific history and with specific needs deriving from that history. As Campion notes, it is: “not just a matter of finding people who would be fit to look after children, but fit to look after the particular children available”.¹⁰ Thus, in adoption it is the child’s needs that determine parent selection and not the parents’ wishes. In embryo donation, although the future welfare of a potential child must be taken into account, the child has no specific needs at the point of parent selection.

The second practical issue is that the adopted child is said to have a “history of rejection” to resolve, with respect to being separated from their birth parents. The assumption is that adopted children have been disadvantaged as a result of their adoption and thus are entitled to the best possible parenting: “adoptive parents need to be not just ordinary parents, but extraordinary parents—with an emphasis on the ‘extra’”.¹¹ It has been argued that there are parallels to this “history of rejection” in embryo donation. For example, Bernstein argues that “children created by embryo adoption may see themselves as ‘spare’ or ‘surplus’ goods and may indeed have the same need for information—for access to their story—as other adoptees, even though they have not been abandoned at birth”.¹² Such a comparison seems extreme—placing a child for adoption does not equate to donating an embryo.

Thus, the gestational relationship of the mother to the child makes embryo donation significantly different from adoption: legally, emotionally, socially, and practically.

The technological imperative

The third reason, the technological imperative, is concerned not with relational aspects but with structural differences. The

technological imperative arises from the assumption that scientific progress is good in itself and should be pursued.

Adoption has been used as a means of creating families throughout human history. It is a social practice which arose primarily out of the need to provide parents for abandoned and orphaned children (a secondary function of adoption was to provide heirs for childless couples). Gradually the process has been regulated, and formal criteria for adoptive parents have been set. By contrast, embryo donation is a relatively new procedure (first reported in 1983¹³) which has become possible by combining technologies of other NRTs, namely in vitro fertilisation (IVF) and gamete donation.¹⁴ Thus, embryo donation has arisen as a medical procedure, from other medical procedures, and thus, like them, is thought of as a treatment for infertility. (Embryo donation, like gamete donation, does not “treat” infertility, but rather offers a solution to childlessness.)

In the origin and the nature of the procedure differences are revealed. Adoption arose as a social practice in response to a social problem, whereas embryo donation arose as one medical procedure among others. As a result, the two procedures have been conceived of in different ways—one is social and subject to social analysis and criteria, and the other “medical” and thus legitimised in a manner similar to other medical procedures. Embryo donation has been driven by medical advances—as the technology has become available it has been implemented. From this perspective, then, the technological imperative is the crucial difference between embryo donation and adoption, as in this scientific context social factors are not considered.

ANALYSIS

Having outlined the major reasons for the disparity in parenting criteria we are now in the position to assess their ethical validity, based on the assumption that parenting selection should be consistent and equitable.

First, parent intentionality. The argument for intentionality being decisive is that intentionality is causal. However, although the intentionality of the adoptive parents is not “causal” in the physical sense, in that it does not bring a child that would otherwise not have existed into being, it does cause them to become parents. Thus, the underlying intention of both sets of parents is the same—to be parents—and it is the means used to achieve this goal which is different. If the intention is similar then the power of the intentionality argument in justifying the disparities in parenting criteria is weakened.

Second, the third reason, the technological imperative. As discussed above, adoption arose as a social phenomenon and embryo donation as a medical procedure, thus, the technological imperative is historically explanatory, in that it accounts for how current parenting criteria came about, but is not justificatory, as it does not offer normative reasons for maintaining the current selection procedures.

Third, the second reason, the gestational relationship. Here, more fundamental differences are found; in particular, legal and practical reasons. The emotional reason is less compelling, for while the importance of gestation is irrefutable, it does not by itself guarantee bonding between mother and child. Even in “natural” conceptions there are occasions when the mother fails to bond immediately with the child. Thus, while gestation may give the embryo donation mother an initial advantage, it does not follow that adoptive mothers cannot bond as effectively, or that this will have a long term effect on the parent/child relationship. Likewise the social reason that embryo donation allows the appearance of a “normal family” is of questionable validity. It rests on the assumption that appearing as a normal family and keeping the genetic origins of the child secret is desirable. Whether this is so is a matter of considerable debate in the field.¹⁵

The legal reason remains significant, although it could be argued that it is a difference in means rather than ends. Once the legal adoption procedure is completed, parental responsibility is no different from that of the embryo donation parent. The final reason, the practical difference, is irreducible. Clearly this difference is pronounced (both practically and theoretically) and provides strong justification for not equating embryo donation and adoption. This said, however, it does not mean that it is a justification for maintaining the scale of the current disparity.

Taken together, the reasons given are inadequate to support the status quo. The differences between the two procedures are, however, marked, and should be reflected in the selection procedure: the parenting criteria should not be the same.

CONCLUSION

In sum, while there are significant reasons for applying different parental criteria to adoption and embryo donation, these reasons do not justify the magnitude of the current disparity. If social criteria are primary in vetting would-be parents in adoption, then social criteria must also have a place in embryo donation. The Human Fertilisation and Embryology Act explicitly states, in its stipulation regarding the welfare of the child, that social factors should be taken into consideration. Indeed, sometimes judgments about access to NRTs are made according to specifically social standards. For example, in *R v Ethical Committee of St Mary's Hospital*,¹⁶ IVF treatment was refused to a woman on the grounds that she had a criminal record involving prostitution and had previously been turned down as an adoptive or foster parent (the decision was upheld). Yet these social criteria are not enforced in any systematic way, and professionals who are trained in making social judgments are not involved. As a result, and despite the Human Fertilisation and Embryology Act's intentions, the two means of parental selection are almost entirely dissimilar. As the previous discussion has shown, while there should be differences in the selection processes, these should be proportional and representative.

Such a conclusion about the selection processes of adoption and embryo donation has implications for other forms of family creation; namely, that if social criteria are to be applied to embryo donation then they should be applied (again in a proportional form) to other NRTs. The remaining question, and criticism, of this conclusion is that if one is applying social criteria to both NRTs and adoption then if one is to be consistent one should also apply social criteria to all would-be parents, including parents who conceive “naturally”.¹⁷ This argument is two-fold. First, if parenting criteria are to be applied to NRTs they should be applied across the board; and second, applying social criteria at all is impractical, as parenting skills cannot be judged in advance, but only by considering treatment of existing children: “we already have the only reliable method of protecting children from inadequate parenting. We remove children from the custody of parents who have palpably ill treated or placed their children in danger”.¹⁷

There does at first glance appear to be a consistency in this argument, however, this objection can be countered.

First, as we have argued that there should be various levels of parenting criteria that are proportional to the similarities between procedures, it is not incoherent to state that adoption may have more stringent standards than NRTs, and that natural conception may require no social screening at all.

Second, the contention that parenting skills cannot be judged in advance is of course on one level true. Approximations and educated guesses can, however, be made. These will not be absolute but pragmatic, and mistakes will no doubt occur. It does not follow, however, that because perfect judgments cannot be made, no judgments should be attempted.

Furthermore, in both adoption and embryo donation we have shown that social criteria are thought important in order to safeguard the welfare of the child. This responsibility stems from the necessity of third party involvement in these methods of family creation. The involvement of third parties marks a fundamental difference between natural conception on the one hand and NRTs and adoption on the other. It could be argued that third parties are involved in the care of parents who conceive naturally—for example, advice from GPs¹⁷ and so criteria should be applied in these cases also if consistency is to be maintained. This argument is unconvincing as there is a difference between caring for women who conceive naturally and those who become parents by virtue of, and as a direct result of, the practitioners' actions. Without the practitioners' (clinicians or social workers) intervention, the parents would not be caring for a child. This instrumental role in family creation makes third parties (and society, insofar as these practitioners are society's representatives) responsible for the child's welfare in way that they are not responsible in natural conception.

In conclusion, the present parenting criteria lack coherence and the reasons for the disparity are not sufficient to validate the status quo. Consequently, the criteria for parenting need to be reassessed in a transparent manner to achieve consistency and proportionality in order to meet the requirements of justice and equity.

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