

THE BIOETHICS OF PROSPECTIVE PARENTHOOD: IN PURSUIT OF THE PROPER STANDARD FOR GATEKEEPING IN INFERTILITY CLINICS

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INTRODUCTION

In response to concerns that the infertility industry is the “Wild West” of medicine, regulation of the infertility industry is becoming more commonplace around the world. Whether arising in response to the sensational court cases and media reports of the last two decades,¹ as in the United States, or after prolonged periods of national soul-searching, as in Canada² and parts of Europe,³ regulation of consumer access to fertility treatment has been an attempt to balance the procreative autonomy of adults with the welfare of children.⁴ The desired balance finds its current expression in gatekeeping mechanisms imposed by governments and by private clinics.

Legislative gatekeeping—statutory prohibitions of certain reproduction assisting practices or exclusions of certain classes of

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¹ See Andrew H. Malcolm, *Steps to Control Surrogate Births Rekindle Debate*, N.Y. TIMES, June 26, 1988 (reporting on legislative moves to restrict surrogacy in the wake of *In re Baby M*, 537 A.2d 1227 (N.J. 1988)).

² See Timothy Caulfield, *Politics, Prohibitions, and the Lost Public Perspective: A Comment on Bill C-56: The Assisted Human Reproduction Act*, 40 ALBERTA L. REV. 451 (2002); Alison Harvison Young, *Let's Try Again . . . This Time with Feeling: Bill C-6 and New Reproductive Technologies*, 38 U.B.C. L. REV. 123 (2005).

³ See Eric Blyth, *The United Kingdom: Evolution of a Statutory Regulatory Approach*, in THIRD PARTY ASSISTED CONCEPTION ACROSS CULTURES: SOCIAL, LEGAL, AND ETHICAL PERSPECTIVES (Eric Blyth & Ruth Landau eds., 2004).

⁴ See, e.g., The Ethics Committee of the American Society for Reproductive Medicine, *Child-Rearing Ability and the Provision of Fertility Services*, 82 FERTILITY & STERILITY 564 (2004) [hereinafter Ethics Committee].

individuals from treatment⁵—has been the subject of a growing body of scholarship comprising medical, ethical, and socio-legal perspectives.⁶ Clinical gatekeeping consists of screening practices employed by individual clinics to determine the eligibility of applicants for infertility treatment in the first instance. Although some clinics employ very little or no screening, those that do apply evaluative standards familiar to the family lawyer—parental fitness and the best interests of the child. Use of the parental fitness standard is an effort to bar certain individuals from receiving treatment who do not demonstrate the capacity to provide minimally adequate parental care. Use of the best interests standard, an extension of the parental fitness standard, is an effort to bar applicants whose becoming parents would not be in the best interests of their yet-to-be conceived offspring. The application of these standards to applicants for infertility treatment is far from uniform across clinics, and within individual clinics the standards may be applied without appropriate guidance. Available numbers suggest that literally hundreds of applicants are turned away from infertility clinics each year because the clinics believe they should not become parents.

This Article argues that while clinics should be allowed to perform fitness screening on their applicants, they should not be able to perform best-interests screening. Part I examines gatekeeping practices in clinics. Part II discusses potential legal models for clinical gatekeeping. Situating assisted reproduction along a regulatory continuum between unassisted reproduction and adoption, this Part shows how blocking access to assisted reproduction as a general proposition does not violate either general constitutional principles or the most common anti-discrimination laws. This Part then explores family-law uses of fitness and best-interests screening and shows how these interrelated inquiries into child welfare find expression and become contested in present-day

⁵ See, e.g., OKLA. STAT., tit. 10, § 553 (2006); IFFS Surveillance 2004, 81 FERTILITY & STERILITY S19-S20 (2004) [hereinafter IFFS Surveillance 2004]. It is not the purpose of this Article to discuss discrimination claims that might be brought under public accommodations provisions, a topic that has received treatment elsewhere. See, e.g., Nanette R. Elster, *HIV and ART: Reproductive Choices and Challenges*, 19 J. CONTEMP. HEALTH L. & POL'Y 415, 419-22 (2003); Holly J. Harlow, *Paternalism Without Paternity: Discrimination Against Single Women Seeking Artificial Insemination by Donor*, 6 S. CAL. REV. L. & WOMEN'S STUD. 173, 204-13 (1996); Justyn Lezin, *(Mis)Conceptions: Unjust Limitations on Legally Unmarried Women's Access to Reproductive Technology and Their Use of Known Donors*, 14 HASTINGS WOMEN'S L. J. 185, 199-200 (2003).

In *Sheils v. Univ. of Pa. Med. Ctr.*, the plaintiffs alleged a clinic's gatekeeping practices violated statutory prohibitions on disability discrimination. *Sheils v. Univ. of Pa. Med. Ctr.*, 1998 WL 134220, at *1 (E.D. Pa. 1998). Since the plaintiffs had not been denied infertility treatment, their claim was dismissed for failure to state a claim. *Id.* at **2-3.

⁶ See, e.g., Richard F. Storrow, *Rescuing Children from the Marriage Movement*, 39 U.C. DAVIS L. REV. 305 (2006); Richard F. Storrow, *Parenthood by Pure Intention: Assisted Reproduction and the Functional Approach to Parenthood*, 53 HASTINGS L.J. 597 (2002).

clinical gatekeeping practices. Part II also delves into the trust law doctrine of virtual representation to show how the body of law most analogous to clinical gatekeeping does not support best-interests screening in the clinical setting. Part III draws on the insights of Part II in formulating recommendations for clinical gatekeeping. Using a set of family-law guideposts, this Part posits that, because of the unique pre-conception context of access decisions, fitness screening is congruent with the goals of clinical gatekeeping but that best-interests screening is not. This Part recommends that (1) no clinic should be compelled to perform screening on applicants for fertility treatment if it is that clinic's practice to treat persons who need assistance with reproduction the same as persons who do not; (2) clinics should be permitted to perform fitness screening on their applicants but not best-interests screening; and (3) clinics should look to the law governing the termination of parental rights and not the law of child custody when making parental-fitness determinations.⁷ It is hoped that by looking to well established legal principles, clinics will succeed in investing their gatekeeping practices with greater integrity, uniformity and consistency.

I. CLINICAL GATEKEEPING

Clinical gatekeeping refers to the decision of an infertility clinic to admit or not to admit a patient for treatment. Motivation for clinical screening may be based on the fear of litigation,⁸ anxiety about success

⁷ It is not the purpose of the present study to discuss prenatal post-conception harm or the moral or legal status of pre-implantation embryos, both of which have received extensive treatment elsewhere. See generally JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 173-94 (1994); John A. Robertson, *Prenatal Duties of Fathers and Mothers to Prevent Harm to Offspring*, 13 POL. LIFE SCI. 259 (1994); BONNIE STEINBOCK, LIFE BEFORE BIRTH: THE MORAL AND LEGAL STATUS OF EMBRYOS AND FETUSES 196, 199, 215-16 (1992) (moral status); JAN CHRISTIAN HELLER, HUMAN GENOME RESEARCH & THE CHALLENGE OF CONTINGENT FUTURE PERSONS 123-30 (1996); MARY WARNOCK, MAKING BABIES: IS THERE A RIGHT TO HAVE CHILDREN? 32-37 (2002) (moral status); ESHRE Task Force on Ethics and Law, *The Moral Status of the Pre-Implantation Embryo*, 16 HUM. REPROD. 1046 (2001); *Davis v. Davis*, 842 S.W.2d 588, 594-97 (Tenn. 1992) (bestowing upon pre-embryos the legal status of quasi-property); Robert Lee, *To Be or Not to Be: Is That the Question? The Claim of Wrongful Life*, in BIRTHRIGHTS: LAW AND ETHICS AT THE BEGINNINGS OF LIFE 172 (Robert Lee & Derek Morgan eds., 1989).

⁸ Compare NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY, *infra* note 12, at 178, with *Huddleston v. Infertility Ctr. of Am.*, 700 A.2d 453, 460-61 (Pa. Super. Ct. 1997) (submitting to jury question whether father foreseeably posed significant risk of serious injury to child born of surrogacy agreement); IFFS Surveillance 2004, *supra* note 5, at S33 (“[D]octors or biologists are implicated in responsibility for an unhealthy child.”); *Ethics Committee*, *supra* note 4, at 565. See STEINBOCK, *supra* note 7, at 92-95.

rates,⁹ or simply a strong feeling of professional obligation to patients and society.¹⁰ Infertility clinics use blood tests, psychological evaluations, and genetic screening to determine whom they will allow to proceed with infertility treatment.¹¹ On average, clinics turn away four percent of applicants each year. Three percent are turned away due to medical concerns that run the gamut from the near futility of treatment to the high risk of transmitting serious genetically based disorders to offspring.¹² One percent are refused treatment due to psychosocial concerns.¹³

In the United States, most aspects of infertility clinics' practice are not governmentally regulated. A majority of clinics oppose governmental regulation but do not resist self-policing by the profession.¹⁴ The American Society of Reproductive Medicine (ASRM) and its affiliate the Society for Assisted Reproductive Technology (SART), the dominant professional societies in this area of medical practice, have developed a voluntary accreditation program that requires clinics to adhere to the program's guidelines and practice standards.¹⁵ These are in the nature of medical practice standards and laboratory guidelines and do not establish any prescribed set of screening protocols or even raise the issue of gatekeeping in any way.¹⁶

⁹ See Weil, *infra* note 27 (noting that patients choose fertility clinics based on success rates). In fertility clinics specifically, physicians are under enormous pressure to achieve and report high rates of success in a very lucrative and highly competitive practice area. See *id.* This may lead physicians to screen for patients who are likely to conceive but not to avoid multiple gestation. See Pennings, *Multiple Pregnancies*, *infra* note 94, at 2468.

¹⁰ F. Shenfield, *The Counsellor, ART, Responsibility, and the Law in Europe*, in PRE-CONGRESS COURSE 2 – JOINT SIG PSYCHOLOGY & COUNSELLING / ETHICS & LAW 14, 16-17 (2005); John A. Robertson, *Procreative Liberty and Harm to Offspring in Assisted Reproduction*, 30 AM. J.L. & MED. 7, 22-23 (2004).

¹¹ See *Sheils v. Univ. of Pa. Med. Ctr.*, 1998 WL 134220, at *2 (E.D. Pa. 1998); Simone Bateman, *When Reproductive Freedom Encounters Medical Responsibility: Changing Conceptions and Reproductive Choice*, in CURRENT PRACTICES AND CONTROVERSIES IN ASSISTED REPRODUCTION 320, 330 (Effy Vayena, Patrick J. Rowe et al. eds., 2002) (“Most physicians do not restrict their evaluation of a medical indication for treatment to the physical symptoms. The choice of the most adequate treatment often takes into consideration a patient’s finances, family surroundings, mental health, etc.”).

¹² See Gurmankin, *infra* note 26, at 63; see also NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY 178-202 (1998) (surveying “the most common screening criteria used in ART programs”) [hereinafter NYS TASK FORCE].

¹³ See Gurmankin, *infra* note 26, at 63.

¹⁴ See William R. Keye, Jr. et al., *A Survey of the Practices and Opinions of the Domestic Members of the American Society for Reproductive Medicine*, 82 FERTILITY & STERILITY 536 (2004).

¹⁵ See David Adamson, *Regulation of Assisted Reproductive Technologies*, in REPRODUCTIVE TECHNOLOGIES: A READER 1, 9 (Thomas A. Shannon ed., 2004).

¹⁶ See Practice Committee of the American Society for Reproductive Medicine, *Revised Minimum Standards for Practices Offering Assisted Reproductive Technologies*, 80 FERTILITY & STERILITY 1556 (2003).

Apart from its practice guidelines, ASRM has issued a body of ethical pronouncements intended to advise clinics.¹⁷ As a part of this ethics initiative, the ASRM has issued a guidance on how child-rearing ability should be taken into account in the provision of fertility services.¹⁸ The guidance addresses the dilemma of clinics asked to treat patients who exhibit “large deviations from normal health and social situations”¹⁹ that, as an empirical matter, signal “seriously deficient child-rearers”²⁰ and a “substantial risk of harm to offspring.”²¹ It concludes that clinics who object to treating such patients may refuse treatment on moral grounds as long as they do not violate statutory prohibitions against discrimination.²² Clinics should feel free to treat such patients, however, “except when significant harm to future children is likely.”²³

Although it is thought that “most practitioners follow [ASRM’s ethical] guidelines,” the guidelines themselves are in the nature of standards for self-regulation only.²⁴ This lack of downward pressure on clinics from either the legal system or professional associations means that many clinics have no written policy on access to services.²⁵ As such, screening protocols vary widely across clinics.²⁶ This variation probably accounts for the near non-existence of litigation arising from screening.²⁷ As a practical matter, when refused treatment at one clinic,

¹⁷ See Adamson, *supra* note 15, at 8 (describing the ASRM’s ethical pronouncements as “creat[ing] standards for self-regulation”).

¹⁸ See Ethics Committee, *supra* note 4. A task force within the Ethics and Law special-interest group of The European Society of Human Reproduction and Embryology (ESHRE) is currently discussing a similar protocol. See Task Force 12: The Welfare of the Child in Medically Assisted Reproduction (2006), <http://www.eshre.com/emc.asp?pageId=350>.

¹⁹ Ethics Committee, *supra* note 4, at 566.

²⁰ *Id.* at 566-67.

²¹ *Id.* at 566.

²² *Id.* at 567.

²³ *Id.* at 565, 567.

²⁴ Adamson, *supra* note 15 at 8. Eighty-three percent of respondents to a survey of ASRM members reported following ASRM Ethics Committee opinions. See Key, *supra* note 14, at 537.

²⁵ See Stern, *infra* note 30, at 596-97.

²⁶ Andrea D. Gurmankin, Arthur L. Caplan, & Andrea M. Braverman, *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 66 (opining that the lack of national or professional guidelines in the United States may account for variation in screening practices).

²⁷ The most recent case is *North Coast Women’s Care Med. Group, Inc. v. Superior Court*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006), *cert. granted*, 46 Cal. Rptr. 3d. 605 (Cal. 2006). In *Sheils v. Univ. of Pa. Med. Ctr.*, 1998 WL 134220, at *2 (E.D. Pa. 1998), plaintiffs’ suit was dismissed for failing to state a claim under the Americans with Disabilities Act and for failing to raise a case or controversy under the Fourteenth Amendment. In Minnesota, a court has granted summary judgment to a clinic accused of refusing to artificially inseminate a lesbian because of her sexual orientation. See Harlow, *supra* note 5, at 207-12. In Massachusetts, the parties settled a similar lawsuit before trial. *Id.* at 212-13. For mention of other cases, see NYS TASK FORCE, *supra* note 12, at 185-86; Elizabeth Weil, *Breeder Reaction*, MOTHER JONES, Jul. 2006, available at http://www.motherjones.com/news/feature/2006/07/breeder_reaction.html (last visited Feb. 1,

applicants merely proceed to another.²⁸

Recent studies about gatekeeping in United States fertility clinics have shed light on this “under-examined” area of clinical practice.²⁹ As a general matter, this research shows that gatekeeping practices vary widely. They may run the gamut from no gatekeeping at all to finely-tuned screening that takes into account a multiplicity of factors.³⁰ In a recent survey, Andrea Gurmankin *et al.* studied how 210 American clinics screen candidates for treatment. The authors’ objective was to determine whether screening takes place, and, if so, on what grounds applicants are denied access to treatment and whether such grounds are problematic from the standpoint of equity.³¹ They posited that restrictions on infertility treatment *per se* raise ethical concerns about (1) reproductive freedom, (2) dual standards for parenthood, (3) inconsistency of treatment across programs, and (4) the fear that efforts to prevent unfit prospective parents from conceiving might—however unintentionally—tend in the direction of denying access to prospective parents who are merely less than ideal. In another study, Judy Stern *et al.* noted the complexity of questions surrounding the ability of a clinician to limit access to infertility services,³² described how such assessments are made internally,³³ and emphasized the right of physicians to refuse treatment.³⁴ In addition, Stern drew parallels

2007); Robertson, *supra* note 10, at 30.

²⁸ See Laura Josephs, *Therapist Anxiety about Motivation for Parenthood*, in *FROZEN DREAMS: PSYCHODYNAMIC ASPECTS OF INFERTILITY AND ASSISTED REPRODUCTION* 33, 37 (Allison Rosen & Jay Rosen eds., 2005). This practice mirrors the movement of “reproductive tourists” from countries with restrictive reproductive laws to countries with fewer or no restrictions. See generally Richard F. Storrow, *Quests for Conception: Fertility Tourists, Globalization and Feminist Legal Theory*, 57 *HASTINGS L.J.* 295 (2005). The term “reproductive tourism” has been criticized as trivializing the distress of couples who must travel outside their own countries for infertility treatment. Roberto Matorras, *Reproductive Exile Versus Reproductive Tourism*, 20 *HUM. REPROD.* 3571, 3571 (2005). Professor Guido Pennings has urged the use of the term “cross-border reproductive care” to describe this phenomenon. *Reply: Reproductive Exile Versus Reproductive Tourism*, 20 *HUM. REPROD.* 3571, 3572 (2005).

²⁹ Gurmankin, *supra* note 26, at 61, 62; see Stern, *infra* note 30, at 3, 13.

³⁰ See Judy E. Stern, Catherine P. Cramer et al., *Access to Services at Assisted Reproductive Technology Clinics: A Survey of Policies and Practices*, 184 *AM. J. OBSTETRICS & GYNECOLOGY* 591, 597 (2001) (“Some clinics are fairly permissive, appearing to place a high value on patient autonomy by providing services to most of the patients listed. Others clinics are more restrictive and provide services in very few of these situations. The vast majority of clinics will fall somewhere in between.”).

³¹ See Gurmankin, *supra* note 26, at 61.

³² See Stern, *supra* note 30, at 596.

³³ See *id.* at 596.

³⁴ See *id.* at 596 (“The right to deny services is framed as a liberty right of providers.”); see also Ethics Committee, *supra* note 4, at 566-67 (describing the scope of a physician’s autonomy). Although a physician generally has no professional responsibility to provide treatment, see *NYS TASK FORCE*, *supra* note 12, at 177, 202, the right of a doctor to refuse treatment based on personal moral objections may come into conflict with professional ethics codes or anti-discrimination laws. See generally Udo Shüklenk, *An Introduction to Bioethics*,

between access-to-services criteria employed by infertility clinics and adoption agencies.³⁵ Like Gurmankin, Stern found substantial variability in screening protocols across programs.³⁶

According to Gurmankin, most clinics engage in screening because they want to “ensur[e] a prospective child’s safety and welfare” and not place the mother’s health at risk.³⁷ Although many clinics will turn away applicants whose profiles raise child-protection concerns, some insignificant number (albeit not over 50%) would also deny access to single men, gay couples and poor couples based merely on notions of the best interests of the child.³⁸ The technique of these programs is to gather information about the psychological and physical attributes of the prospective parents that might compromise their fitness to parent or place the prospective child at risk.³⁹ The overarching concern of these programs is to ensure the prospective child’s safety and welfare.⁴⁰ Attributes for which programs were comfortable turning away candidates ranged from women for whom pregnancy would place their life at risk and parents who had a history of physically abusing their other children to factors such as marital status, sexual orientation, and income.⁴¹ The study noted the lack of conformity between programs

<http://sunsite.wits.ac.za/bio/intro8.htm> (last updated Apr. 2, 2001); Robertson, *supra* note 10, at 23. The medical profession has wrestled recently with whether pharmacists should be able to refuse on moral grounds to fill prescriptions for morning-after-pill contraception. See Elizabeth Fenton & Loren Lomasky, *Dispensing with Liberty: Conscientious Refusal and the “Morning-After Pill”*, 30 J. MED. & PHIL. 579 (2005); cf. John H. Pearn, *Gatekeeping and Assisted Reproductive Technology: The Ethical Rights and Responsibilities of Doctors*, MED. J. AUST., Sept. 15, 1997, at 318 (opining that “[a]ntidiscrimination legislation may pressure doctors to act against their ethical, moral or religious beliefs”). The issue of conscientious objection arises with greater frequency as more state legislatures enact prohibitions on sexual-orientation and marital-status discrimination. See Jack S. Vaitayanonta, *In State Legislatures We Trust?: The “Compelling Interest” Presumption and Religious Free Exercise Challenges to State Civil Rights Laws*, 101 COLUM. L. REV. 886, 888 (2001). Infertility clinics may fall outside the ambit of such legislation, however, if they are not considered places of public accommodation. Courts have reached different conclusions on whether medical clinics are places of public accommodation. Compare *Duffy v. Illinois Dep’t of Human Rights*, 820 N.E.2d 1186 (Ill. App. Ct. 2004) with DISABILITY LAW RESOURCE PROJECT, ADA TITLE III TECHNICAL ASSISTANCE MANUAL III-1.2000(6), <http://www.usdoj.gov/crt/ada/taman3.html>; Ethics Committee, *supra* note 4, at 566. The California Supreme Court will examine the issue as it applies to infertility clinics in deciding *North Coast*, *supra* note 27. See Bob Egelko, *State High Court to Hear Lesbian’s Case: Doctors Denied Her Infertility Treatment on Religious Grounds*, S.F. CHRON., June 15, 2006, at B5.

³⁵ See Stern, *supra* note 30, at 596. Gurmankin, though, found that it is extremely rare for a clinic to conduct a home study, as is obligatory in adoption. Gurmankin, *supra* note 26, at 63. See also Ethics Committee, *supra* note 4, at 565 (noting no necessity for a home study, as “[t]here is no existing child to be placed for adoption”).

³⁶ See Gurmankin, *supra* note 26, at 65, 66; Stern, *supra* note 30, at 597.

³⁷ See Gurmankin, *supra* note 26, at 64-65.

³⁸ *Id.* at 63-64.

³⁹ *Id.* at 65.

⁴⁰ *Id.*

⁴¹ *Id.*

regarding what factors would compromise one's fitness to parent or undermine child welfare.⁴² Gurmankin queried whether the slide from factors triggering risk of harm concerns toward those more appropriately deemed life enhancing or optimizing might signal discriminatory or even eugenic practices creeping into the screening regimen.⁴³ At the very least, the variability of practice among clinics purporting to apply similar criteria suggests a lack of consensus about how such criteria should be employed in the clinical setting.⁴⁴

In Europe, unlike in the United States, access to assisted reproduction is much more so (but not fully) determined by legislation. Where access is restricted to heterosexual couples, as in France,⁴⁵ Italy, the Germanic countries,⁴⁶ Denmark,⁴⁷ and Norway,⁴⁸ paramount are the views that medical assistance to reproduce should address medical as opposed to social infertility and that a child's welfare depends upon his being raised by his biological parents who live together in a stable marital or marriage-like relationship.⁴⁹ Clinical screening efforts are thus reduced to resolving issues of distributive justice among similar infertile couples⁵⁰ and may be guided by child welfare concerns.⁵¹ In other European jurisdictions, the welfare of the child comes directly into play via legislative mandate, most notably in the United Kingdom, where it must be considered in every application of assisted

⁴² See *id.* at 66. The authors noted that some of this might be explained by disparities "in local mores, religious beliefs, and religiosity." *Id.* at 66-67.

⁴³ See *id.* at 62.

⁴⁴ See *id.* at 66 ("Programs do not seem to share beliefs regarding what constitutes a fit parent or an inappropriate risk to a prospective child and thus whom they will assist in the conception of a child.")

⁴⁵ See Jacqueline Pousson-Petit, *Procreation artificielle dans les pays romanistes*, in BIOMEDICINE, THE FAMILY AND HUMAN RIGHTS 515, 532-33 (Marie-Therese Meulders-Klein et al., eds., 2001).

⁴⁶ See Bea Verschraegen, *Artificial Reproductive Technology in the Germanic Countries*, in Meulders-Klein & Deech, *supra* note 45, at 545, 548.

⁴⁷ See Linda Nielsen, *Artificial Procreation in the Nordic Countries*, in BIOMEDICINE, THE FAMILY AND HUMAN RIGHTS, *supra* note 45, at 559, 561-62.

⁴⁸ See *id.* at 563.

⁴⁹ See, e.g., Mission d'Information sur la Famille et les Droits des Enfants, *Rapport* 150, 159-60, 166, 172 (Assemblée Nationale de France Jan. 25, 2006); Pousson-Petit, *supra* note 45, at 533; Verschraegen, *supra* note 46, at 548; Nielsen, *supra* note 47, at 570-71; see also Anita Stuhmcke, *Limiting Access to Assisted Reproduction: JM v QFG*, 16 AUST. J. OF FAM. L. 245, 251-52 (2002) (criticizing the view that only heterosexuals can be medically infertile).

⁵⁰ See Guido Pennings, *Distributive Justice in the Allocation of Donor Oocytes*, 18 J. OF ASSISTED REPRODUCTION & GENETICS 56 (2001) (advocating a "point system" for the allocation of scarce donor gametes); NORTH LINCOLNSHIRE PRIMARY CARE TRUST, GUIDELINES FOR THE PROVISION OF NHS FUNDED FERTILITY SERVICES FOR PEOPLE WHO LIVE WITHIN THE AREA COVERED BY NORTH LINCOLNSHIRE OR ARE REGISTERED WITH A NORTH LINCOLNSHIRE GENERAL PRACTITIONER 2-5 (2005) (describing the factors the Trust will consider in "seeking a fair distribution of resources").

⁵¹ See Verschraegen, *supra* note 46, at 548.

reproduction.⁵² As a result of the child-welfare principle, “[m]any fertility centres do not accept lesbian couples for treatment,”⁵³ and almost two-thirds of clinics in the United Kingdom responding to an informal poll indicated that “they would not inseminate a single wom[a]n under any circumstance.”⁵⁴ This has led to charges of arbitrary and capricious application of the welfare principle and has spurred the British government to circumscribe the discretion of individual clinics to refuse treatment.⁵⁵ On the other end of the spectrum from the countries already mentioned, Spain does not require clinics to assess the child-rearing ability of its applicants, and single women and same-sex couples have full access to assisted reproduction.⁵⁶ Not surprisingly, Spain has become a destination for fertility tourists from other more restrictive European countries.⁵⁷

In a study of gatekeeping in the thirteen in vitro fertilization (IVF) centers in Holland, where licensing requirements strongly imply the need to take into account the future welfare of child,⁵⁸ Professors Hunfeld and Passchier discovered that, although clinical screening practices varied throughout the Netherlands, all were firmly rooted in the harm principle of denying access only to patients exhibiting psychopathology or who would cause the child to suffer severe psychosocial problems.⁵⁹ These practices are congruent with the

⁵² This is likewise the case in Australia and Canada. See IFFS Surveillance 2004, *supra* note 5, at S33-S34; 52-53 Elizabeth II, chap. 2(2). See Julian Savulescu, *Assisted Reproduction for HIV Serodiscordant Couples: The Ethical Issues in Perspective*, AM. J. BIOETHICS, Winter 2003, at 53, 53; Vera Terry, *Artificial Reproductive Technologies in Australia—Legislation for the New Millennium?*, 19 MED. & L. 210, 215 (2000). New Zealand, by contrast, rejects the paramountcy view of the best interests of the child. See Lisa Fong, *Balancing Rights and Interests in Access to Infertility Treatment*, 9 AUCKLAND L. J. 1181, 1194 (2003).

⁵³ Patricia Baetens, *Reproductive Services with Lesbian Couples*, in GUIDELINES FOR COUNSELLING IN INFERTILITY 41, 41 (Jacky Boivin & Heribert Kentenich eds., 2002).

⁵⁴ Jacky Boivin, *Reproductive Services with Single Women Without Partners*, in Boivin, *supra* note 53, at 43, 44.

⁵⁵ For more on this recent development, see *infra* Part III. Despite the governmental crackdown, discriminatory practices continue. See *MPs Challenge Fertility Clinic Ban on Lesbians*, THE GUARDIAN, July 3, 2006, at 7. A similar problem has arisen in Canada, where fertility clinics are specifically disabled from refusing treatment on the basis of sexual orientation. See *Lesbian Couples Say Hospital Denied Them In Vitro Fertilization*, CBC NEWS, Jan. 13, 2005, <http://www.cbc.ca/canada/montreal/story/2005/01/13/mon-lesbian-050113.html>.

⁵⁶ See Pousson-Petit, *supra* note 45, at 534.

⁵⁷ See Giles Tremlett, *Spain Becomes the Destination of Choice for Fertility Tourists from Britain*, THE GUARDIAN, May 12, 2006, at 16.

⁵⁸ See J.A.M. Hunfeld & J. Passchier et al., *Protect the Child from Being Born: Arguments Against IVF from Heads of the 13 Licensed Dutch Fertility Centres*, *Ethical and Legal Perspectives*, 22 J. OF REPRODUCTIVE & INFANT PSYCHOLOGY 279, 280 (2004).

⁵⁹ See *id.* at 287 (“When asked about the possible psychological effects of IVF treatment of special patient groups on the future welfare of the child[,] many physicians mentioned that schizophrenic or chronic[ally] unstable patients could have a negative impact on the future child. In fact[,] they seem to rehearse the psychological risk factors mentioned in the Planningsbesluit (1997) (i.e. a well-documented history of child abuse or neglect, or severe psychological

recommendation of the Ethics Committee of the American Society for Reproductive Medicine described above.⁶⁰ Like Gurmankin, though, the authors of the Dutch study suggested that, for some patient groups, screening practices are sufficiently open-ended as to allow considerations about child protection to stray into the realm of ensuring that the child's best interests are met.⁶¹

Given the multiplicity of approaches to gatekeeping and the lack of direction contained in ethical pronouncements or the legislation of countries where gatekeeping is mandatory,⁶² it is unsurprising to find health care workers experiencing ambivalence about their role as gatekeepers. Clinics on one side of the spectrum express doubt about whether they have the wherewithal or even the right to decide who should become a parent with their assistance.⁶³ Clinics on the other side express satisfaction with their role as gatekeepers, claiming the right and responsibility to perform that role.⁶⁴

Clinical psychologists working in reproductive medicine have done the most soul-searching about gatekeeping. Some take the view that "counselors are morally obliged to obtain a realistic picture of the expected conditions for the offspring and to survey the condition of the children who are born."⁶⁵ Nonetheless, counselors in the gatekeeping

instability) instead of being more specific."). This may result from the fact that, as a practical matter, relatively little screening for psychosocial risk factors, as opposed to medical risk factors, takes place in Dutch clinics. *See id.* at 280.

⁶⁰ *See supra* notes 19-23 and accompanying text. Note in particular the authors' statement that psychosocial arguments against treatment are "not always evidence-based." Hunfeld & Passchier, *supra* note 58, at 288.

⁶¹ *See* Hunfeld & Passchier, *supra* note 58, at 284-85 (suggesting that in cases where the arguments against treatment are purely psychological, paternalism may need to be curbed except in cases where patient autonomy is "clearly lacking").

⁶² *See* Gillian Douglas, *Assisted Reproduction and the Welfare of the Child*, in 2 CURRENT LEGAL PROBLEMS 1993, at 53, 62, 71 (M.D.A. Freeman & B.A. Hepple eds., 1993) (noting diversity of gatekeeping practices among clinics and lack of guidance in governing legislation).

⁶³ *All Things Considered*, (NPR radio broadcast July 29, 2005) (reporting that some clinicians feel comfortable making these gatekeeping decisions where the health of the patient is at stake but not where it is simply a question of who is suitable to become a parent); Gurmankin, *supra* note 26 (stating that some clinics will screen only for medical reasons, claiming they have no expertise in making psychosocial assessments); Ethics Committee, *supra* note 4, at 565; Hunfeld & Passchier, *supra* note 58, at 287 (noting that physicians "mentioned that they are not experts in the psychological field and that psychological problems are difficult to assess"); *see also* Douglas, *supra* note 62, at 70 (describing medical staff as unskilled to make child-welfare assessments without the help of professionals from other disciplines).

⁶⁴ Gurmankin, *supra* note 26, at 61, 64 (revealing that "the majority of ART programs believe that they have the right and responsibility to screen candidates before providing them with ART to conceive a child"); NYS TASK FORCE, *supra* note 12, at 202; M.M. Peterson, *Assisted Reproductive Technologies and Equity of Access Issues*, 31 J. MED. ETHICS 280, 281 (2005) (claiming that "[t]here has been little, if any, open resistance by doctors to [gatekeeping]."); *id.* at 282 (noting that some clinicians purport to use "common sense" to judge what reproduction is "appropriate" and who has adequate parenting ability); *cf.* Stern at 10, 11.

⁶⁵ IFFS Surveillance 2004, *supra* note 5, at S33.

role often experience anxiety.⁶⁶ Their anxiety stems in large measure from the highly speculative nature of their work and the absence of useful guideposts. Perhaps the most important question I have been asked is “where do we draw the line?”⁶⁷ Psychologists are particularly troubled where there is no data to back up subjective viewpoints that children will suffer psychological harm if they are raised by a particular parent.⁶⁸ Another source of anxiety is the narcissism and sense of entitlement underlying the motivation for parenthood in many patients presenting for infertility treatment. Psychologists also query whether the experience of infertility itself—particularly if involving years of failed attempts at conceiving a child—may lead to such feelings of inadequacy and low self-esteem as to compromise the patient’s ability to be a good parent. A related concern is that IVF children are so precious to the couples to whom they are born that they will be stifled in their development by overprotective, smothering parents or, conversely, will be deemed not perfect enough to have warranted such Herculean efforts to procreate. Other therapists ponder whether those same efforts might in fact make the infertile so much better parents that concerns about marital status and sexual orientation are overridden.⁶⁹

Given the complexity of approaches to gatekeeping and the reactions of the gatekeepers themselves, scholarly interest in how notions of child welfare determine access to assisted reproduction has been unsurprisingly brisk.⁷⁰ The issue of clinical gatekeeping has, however, been relatively neglected by the legal academy. The next section, then, will be an examination of the constitutional law, family law, and trust law models found in clinical gatekeeping. These considerations will serve as the basis of the recommendations for

⁶⁶ See generally Josephs, *supra* note 28.

⁶⁷ This question was asked by Jean Benward in response to my talk at the American Society for Reproductive Medicine’s annual meeting in 2005.

⁶⁸ *All Things Considered*, *supra* note 63.

⁶⁹ See Andrea Mechanik Braverman et al., *Characteristics and Attitudes of Parents of Children Born with the Use of Assisted Reproductive Technology*, 70 FERTILITY & STERILITY 860, 863-64 (1998); Josephs, *supra* note 28, at 42.

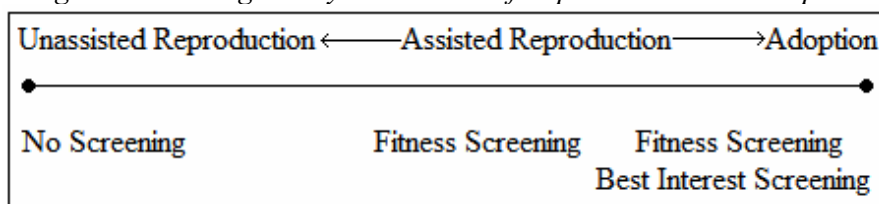
⁷⁰ See, e.g., Françoise Shenfield, *The Welfare of the Child: Whose Responsibility?*, in CONTEMPORARY ETHICAL DILEMMAS IN ASSISTED REPRODUCTION (Shenfield & Sureau eds., 2006); Guido Pennings, *Measuring the Welfare of the Child: In Search of the Appropriate Evaluation Principle*, 15 HUMAN REPROD. 1146 (1999); J. Boivin & G. Pennings, *Parenthood Should Be Regarded as a Right*, 90 ARCH. DIS. CHILD. 784, 785 (2005) (“The most important standard to evaluate the acceptability of procreation is the ‘welfare of the child’ standard.”); Ken R. Daniels et al., *The Best Interests of the Child in Assisted Human Reproduction: The Interplay Between the State, Professionals, and Parents*, 19 POL. & LIFE SCI. 33 (2000); Peterson, *supra* note 64; Douglas, *supra* note 62; Eric Blyth, *The United Kingdom’s Human Fertilisation and Embryology Act 1990 and the Welfare of the Child: A Critique*, 3 INT’L J. CHILD. RTS. 417 (1995); M. Emery, *What Ethical Issues on the Welfare of the Child Need to Be Addressed During Psychological Counselling?*, in PRE-CONGRESS COURSE 2—JOINT SIG PSYCHOLOGY & COUNSELLING / ETHICS & LAW 5.

clinical gatekeeping contained in Part III.

II. LEGAL MODELS IN CLINICAL GATEKEEPING

In examining legal models already at work in clinical screening, we might start with a determination of the degree of scrutiny that prospective parents face from the government or private actors. Figure 1 places the different forms the quest for parenthood assumes along a spectrum with a corresponding qualifier or qualifiers indicating the level of screening that is common to unassisted reproduction and adoption. Extrapolating from unassisted reproduction and adoption, it is then suggested what level of scrutiny we might expect to be applied to applicants for assisted reproduction.

Figure 1: The Regulatory Continuum of Reproduction and Adoption



On one side of the spectrum, the “old-fashioned” unassisted way of becoming a parent is largely unregulated, due in part to constitutional doctrine surrounding sexual privacy and the political and practical obstacles that make a system of parental licensure highly unlikely to emerge.⁷¹ On the other side of the regulatory spectrum is adoption. This is a common way of becoming a parent, but in contrast to the old-fashioned way, adoption is highly regulated. It is reasonable to think that assisted reproduction falls somewhere in the middle of this continuum. First, assisted reproduction is distinct from unassisted reproduction because sexual privacy is not an issue.⁷² In addition, assisted reproduction involves the participation of third-party medical personnel, whose practice is on many levels governmentally controlled and whose profession adheres to a well recognized code of ethics. These distinctions create a reasonable expectation of a greater degree of regulation for assisted reproduction.

Adoption and assisted reproduction are similar in several ways. Both often originate with infertility, offer methods for establishing legal

⁷¹ See Emily Jackson, *Conception and the Irrelevance of the Welfare Principle*, 65 MOD. L. REV. 176, 177 (2002).

⁷² UNIF. PARENTAGE ACT § 102(4) (2002).

parentage outside the context of procreation via sexual intercourse and outside the context of biological relationships, and both invest one's intention to parent with legal significance. Assisted reproduction may involve the presence of third parties in the reproductive process and thus further distance assisted reproduction from unassisted reproduction by raising questions about the importance of genetic and gestational ties to the determination of parentage. But assisted reproduction is also distinct from adoption. Adoption was created by statute to provide a mechanism for the termination of one parent's rights and the recognition of a new parent. The state understandably has a significant interest in regulating this process. Assisted reproduction is distinct because, unlike adoption, it is typically a private matter in which the state is not involved: even where third-party donors contribute to the reproductive process there usually is no need to transfer parental rights from one individual to another. This is because adoption begins after a child or fetus already exists; assisted reproduction, though, is used to start the reproductive process in the first instance.⁷³ From this point of view, assisted reproduction would warrant less regulation than would adoption.

With this regulatory continuum as a backdrop, we now turn to a consideration of whether principles of procreative liberty, child welfare, and trust law assist us in defining more precisely what level of screening is appropriate in assisted reproduction.

A. *Procreative Liberty*

The procreative liberty dimensions of assisted reproduction are a perennial topic in the legal literature.⁷⁴ Commentators have taken any number of positions about how procreative liberty functions in this context, from collaborative reproduction,⁷⁵ to sex selection,⁷⁶ to pre-

⁷³ See *Surrogate Parenting Assocs., Inc. v. Ky.*, 704 S.W.2d 209, 211 (Ky. 1986).

⁷⁴ John Robertson, the most well known proponent of the primacy of procreative liberty, posits a theory of procreative liberty that would encompass even reproductive cloning. ROBERTSON, *CHILDREN OF CHOICE*, *supra* note 7. Robertson is not without his critics. See, e.g., MARY WARNOCK, *MAKING BABIES* 85 (2002) (positing that assisted reproductive technology is not a fundamental right); Maura A. Ryan, *The Argument for Unlimited Procreative Liberty: A Feminist Critique*, HASTINGS CTR. REP., July/Aug. 1990, at 6. Philip G. Peters reasons that procreative liberty is a guarantee permitting individuals to have offspring genetically related to themselves. PHILIP G. PETERS, JR., *HOW SAFE IS SAFE ENOUGH? OBLIGATIONS TO THE CHILDREN OF REPRODUCTIVE TECHNOLOGY* (2004), *reviewed in* Mary B. Mahowald, *Reproductive Technology: Overcoming the Objections*, HASTINGS CTR. REP., Sept./Oct. 2005, at 46 (2005).

⁷⁵ Helen M. Alvaré, *The Case For Regulating Collaborative Reproduction: A Children's Rights Perspective*, 40 HARV. J. ON LEGIS. 1, 33-46.

⁷⁶ See, e.g., Edgar Dahl, *The Presumption in Favour of Liberty: A Comment on the HFEA's*

implantation genetic diagnosis, and reproductive cloning.⁷⁷ Researchers of such practices are uniform in positing that, as a general matter, restrictions on assisted reproduction raise ethical issues of procreative autonomy.⁷⁸ Scholars cannot agree, however, on how procreative liberty principles actually apply here.⁷⁹ The federal courts have made only a very few discrete pronouncements on this matter⁸⁰ and the issue is hardly likely to arise with any frequency in a system where so little regulation exists.⁸¹

This disagreement about whether and how procreative liberty applies to assisted reproduction probably arises from the fact that procreative freedom is not particularly well defined or stable.⁸² Since the time when the United States Supreme Court's landmark procreative-liberty decisions of the 1960s and early 1970s located a penumbra of procreative liberty emanating from the Bill of Rights and the Fourteenth Amendment,⁸³ there has been little clarification of the scope of this right as a substantive matter.

In general, procreative liberty cases are of two stripes: those in which the state or an individual seeks to prevent procreation and those

Public Consultation on Sex Selection, 8 REPROD. BIOMEDICINE ONLINE 266-67 (2004); Edgar Dahl, *Procreative Liberty: The Case for Preconception Sex Selection*, 7 REPROD. BIOMEDICINE ONLINE 380-84 (2003); Claude Sureau, *Gender Selection: A Crime Against Humanity or the Exercise of a Fundamental Right?*, 14 HUM. REPROD. 867 (1999).

⁷⁷ John A. Robertson, *Liberty, Identity, and Human Cloning*, 76 TEX. L. REV. 1371 (1998).

⁷⁸ Gurmankin, *supra* note 26, 61-62.

⁷⁹ Compare Note, *Assessing the Viability of a Substantive Due Process Right to In Vitro Fertilization*, 118 HARV. L. REV. 2792 (2005) (arguing that access to IVF is a fundamental right) with Ruth Deech, *Losing Control?—Some Cases*, in BIOMEDICINE, THE FAMILY AND HUMAN RIGHTS, *supra* note 45, at 581, 592-96 (Marie-Therese Meulders-Klein, Ruth Deech et al. eds., 2002) (arguing that access to assisted reproduction is not a fundamental right).

⁸⁰ *Cameron v. Bd. of Educ.*, 795 F. Supp. 228, 237-38 (S.D. Ohio 1991) (declaring that a woman has a constitutional privacy right to become pregnant by artificial insemination); see also *Lifchez v. Hartigan*, 735 F. Supp. 1361, 1377 (N.D. Ill. 1990) (embryo transfer). In *J.R. v. Utah*, 261 F. Supp. 2d 1268 (D. Utah 2003), the genetic-parent plaintiffs argued that Utah's statutorily mandated determination of parentage in surrogacy cases violated their constitutional right to procreative liberty. The court saw the issue less as one of whether surrogacy was a constitutional right (the statute did not outlaw surrogacy *per se*, and the court admitted the U.S. Supreme Court had made no pronouncement on the matter, see *id.* at 1275-76) but whether the statute unduly restricted their parental rights by forcing genetic parents to adopt their own children. See *id.* at 1279. In combination, *Lifchez*, *Cameron* and *J.R.* suggest that procreative liberty encompasses surrogacy, since third parties collaborated in the reproductive process in all three cases. This conclusion is of necessity tentative and may need to be narrowed to say that privacy protection extends only to intending parents who contribute their gametes to the reproductive process. This would mean that both intending parents could have a privacy interest in gestational surrogacy, but not in traditional surrogacy.

⁸¹ Debora Spar, *Reproductive Tourism and the Regulatory Map*, 352 NEW ENG. J. MED. 531, 532 (2005) (noting the "patchwork of competing and conflicting regulations").

⁸² *In re Baby M.*, 537 A.2d 1227, 1253 (N.J. 1988) ("The right to procreate, as protected by the Constitution, has been ruled on directly only once by the United States Supreme Court.") (citing *Skinner v. Oklahoma*, 316 U.S. 535 (1942)).

⁸³ *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

in which the state seeks to prevent abortion. The contraceptive liberty, frozen-embryo, and sterilization cases are of the first type. As in *Griswold v. Connecticut*, they pit individuals who wish to prevent pregnancy against a state that would bar their access to the requisite means or, as in *Davis v. Davis*, against another individual with a countervailing interest in achieving pregnancy.⁸⁴ The eugenically motivated sterilization cases are similar in that there the state seeks to prevent certain individuals from ever exercising their procreative capacity.⁸⁵ These cases of the past involved inmates in prisons and psychiatric hospitals and are still being raised and debated in the prisoners' reproductive decisionmaking cases of the present. Although the outcomes of such cases have been uniform, the rationale has changed from one about a broad societal commitment to genetic purity to one based more on specifically penological interests.⁸⁶ Unifying these cases are generalizations about what is preferred in a free society—autonomy in reproductive decisionmaking or the avoidance of reproduction that has deleterious social effects.⁸⁷ Seen as an interrelated group of cases, these decisions counsel that the scope of procreative liberty in any individual case depends upon the class of the potential parents involved and the potential for harm that their procreation poses to society.

The second branch of procreative liberty embodies the notion that the potential for harm to specific third parties arising from the exercise of a particular method of contraception justifies the erosion of procreative liberty in specific cases. The abortion-rights decisions are the most well known of this type. Although the right to abortion has received significant attention from the judiciary, it nonetheless remains highly contested. The most important instruction emerging from the abortion-rights decisions is that procreative autonomy is far from monolithic when placed in the balance against the state's interest in the life of the fetus. This mirrors the clinical gatekeeping function described in Part I wherein procreative liberty is certainly recognized but must potentially give way to the gatekeepers' right and responsibility to safeguard the welfare of potential offspring.⁸⁸ The congruency between clinical gatekeeping and the abortion cases ends here, however. In the abortion context, the state's position is simply

⁸⁴ *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Davis v. Davis*, 842 S.W.2d 588 (Tenn. 1992).

⁸⁵ *Skinner*, 316 U.S. at 541 (the aggrieved are forever deprived of a basic liberty).

⁸⁶ *Gerber v. Hickman*, 291 F.3d 617, 623 (9th Cir. 2002).

⁸⁷ Whether of "imbeciles" because of the burden their offspring place on the public treasury, *Buck v. Bell*, 274 U.S. 200 (1927), or of criminals, because of the state's interest in preventing criminality, *Skinner*, 315 U.S. at 536-38.

⁸⁸ Gurmankin, *supra* note 26, at 64; Peterson, *supra* note 64, at 282.

that the fetus's right to life outweighs the woman's right to make a procreative decision, at least at a certain point in time. No comment is made about the parenting ability of those who might wish to terminate their pregnancies.⁸⁹ By contrast, gatekeeping reverses these positions. The gatekeeper's commitment to vindicating the interests of the unborn militates *against* allowing the individual to have a child *because* the individual cannot advance the best interests of that child. Although the liberty of an otherwise autonomous actor is curtailed in both contexts, the closer factual analogy to gatekeeping is actually that of the sterilization cases generally, which raise concerns about societal integrity, and more specifically that of probationers' reproductive autonomy cases, wherein those whose parental neglect of existing children has landed them on probation may be stripped of their procreative liberty. *State v. Oakley*⁹⁰ is the most recent decision of this type. Given the case's unique context, it is unquestionably a shaky basis from which to launch any argument about whether gatekeeping raises concerns about procreative liberty, but what it does reveal is that any critique of gatekeeping from the point of view of procreative autonomy will of necessity be incomplete. This is because what is meant by procreative autonomy from the point of view of assisted reproduction patients (and from a society that wishes to scrutinize their choice to reproduce with the aid of medicine) is bound up with and inseparable from notions of parental autonomy, which attaches to the parental recognition that assisted reproduction patients actually seek. In this vein, the *Baby M.* court reasoned:

[T]he parties' right to procreate by methods of their own choosing cannot be enforced without consideration of the state's interest in protecting the resulting child, just as the right to the companionship of one's child cannot be enforced without consideration of that crucial interest.⁹¹

Whether assisted reproduction is a procreative liberty, then, is really a question about who we should allow to be a parent. And though the contours of procreative autonomy are not well defined, the contours of parental autonomy, by contrast, are. The problem is, the one does not necessarily lead to the other. Since it is true that procreative activity leading to the birth of a child usually results in legal recognition of parentage and attendant parental autonomy rights, we begin to assume that exercises of procreative autonomy invariably lead to that desirable

⁸⁹ See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of S.e. Pa. v. Casey*, 505 U.S. 833 (1992); *Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976); *Bellotti v. Baird*, 443 U.S. 622 (1979); *Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502 (1990).

⁹⁰ *State v. Oakley*, 629 N.W.2d 200 (Wis. 2001), *cert. denied*, 537 U.S. 813 (2002).

⁹¹ *In re Baby M.*, 537 A.2d 1227, 1254 n.13 (N.J. 1988).

result. But the assumed seamless flow between procreative autonomy and parental autonomy is called into question by cases of assisted reproduction. When the intended social parents in both *Baby M.* and *J.R. v. Utah* complained that the state would not recognize their parentage, the courts refuted the claim that the intending parents' procreative liberty had at no point been infringed. The courts stressed that nothing the state had done prevented the claimants from engaging in a procreative act. What the claimants were actually seeking—recognition of parenthood—did not of necessity flow from that act:

The right to procreate very simply is the right to have natural children, whether through sexual intercourse or artificial insemination. It is no more than that. Mr. Stern has not been deprived of that right. Through artificial insemination of Mrs. Whitehead, Baby M is his child. The custody, care, companionship, and nurturing that follow birth are not parts of the right to procreation; they are rights that may also be constitutionally protected, but that involve many considerations other than the right of procreation. . . . Our conclusion may thus be understood as illustrating that a person's rights of privacy and self-determination are qualified by the effect on innocent third persons of the exercise of those rights.⁹²

Since the issue of access to assisted reproduction is a snapshot of the larger debate about who society should allow to become parents, the relevant concern is harm to children through the recognition of parental rights in the progenitors, not the fact that the progenitors might procreate in the first instance. To regulate access to adoption or assisted reproduction in a particular way, then, becomes a question of to what extent the state should be permitted to pass judgment on one's decision to become a parent. This is not to say that nothing about procreative autonomy theory is helpful to the infertile. Where a genetic tie exists between the parent and the child, the law often associates the recognition and promotion of parental rights as a benefit to the child.⁹³ In this way, the best interests of children can be promoted through the law's deference to parental rights. But where this genetic relationship is missing, as is so often the case in assisted reproduction, and even sometimes where it is not, the best interests of the child, as we see in the next section, are taking on a new and controversial primacy.

Given the undefined and contested nature of procreative autonomy and the doubt about whether receiving assistance to reproduce from

⁹² *Id.* at 1253-54; *see also* *Santosky v. Kramer*, 455 U.S. 745, 753-54 (1982) (limiting the right of natural parents to procedural due process in the determination of the child's legal parentage).

⁹³ *See, e.g., J.R. v. Utah*, 261 F. Supp. 2d 1268 (D. Utah 2003) (in case of gestational surrogacy, court found constitutional right to custody stemming from genetic relationship).

medical personnel is subsumed within that right, the mere existence of the gatekeeping function in infertility clinics is probably insufficient to raise a viable procreative-liberty issue under existing constitutional jurisprudence.

B. *Child Welfare*

Prominent in both legislative and clinical gatekeeping is the message that child welfare is the most important guiding principle.⁹⁴ In the law, child welfare is a multi-faceted concept ranging from narrow inquiries about protecting children from physical harm and abusive parents on the one end of the spectrum to expansive questions about what promotes a child's best interests on the other.⁹⁵ To understand the

⁹⁴ IFFS Surveillance 2004, *supra* note 5, at S33-S34. In Europe, gatekeeping is governed in only the most general sense via the directive that the welfare of the child be considered prior to the delivery of infertility treatment. Emery, *supra* note 70 (using the example of Switzerland); Shenfield, *supra* note 10, at 14, 15, 16, 18; Guido Pennings, *Multiple Pregnancies: A Test Case for the Moral Quality of Medically Assisted Reproduction*, 15 HUMAN REPROD. 2466, 2468 (2000). Within Britain, the principle is codified as follows:

A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth. Human Fertilisation and Embryology Act, 1990, c. 37 § 13(5) (U.K.). The Human Fertilisation and Embryology Authority (HFEA), the regulatory agency charged with carrying out the provision, promulgated a code of practice purporting to guide clinics in their assessment of patients according to the welfare of the child. Undergirding the code of practice was the ethic that[t]he involvement of a medical team in assisted conception means that certain third parties have significant responsibility towards the child to be born. Consequently, clinics should not provide treatment unless they are satisfied that the welfare of the child to be born will not be affected negatively. See HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY, TOMORROW'S CHILDREN: REPORT OF THE POLICY REVIEW OF WELFARE OF THE CHILD ASSESSMENTS IN LICENSED ASSISTED CONCEPTION CLINICS 6 (2005) [hereinafter TOMORROW'S CHILDREN]. In Canada, "the health and well-being of children born through the application of assisted reproductive technologies must be given priority in all decisions respecting their use." 52-53 Elizabeth II, chap. 2(2). Legislative proposals related to parentage determinations may also contain a gatekeeping function. The old UPA restricted surrogacy on the basis of marriage. However, the new UPA, citing the best interests of children specifically, did away with the restrictions. UNIF. PARENTAGE ACT § 801 Comment ("This reflects the Act's comprehensive concern for the best interest of nonmarital as well as marital children born as the result of a gestational agreement.") What the best interests are is not explained beyond a reference to equality of treatment with marital children. Presumably this means that all children are better off being raised by parents who planned and prepared to create them and to raise them. Although single women may become the sole parents of their children under the UPA, same sex couples and single individuals are not recognized as competent to enter into a gestational agreement under the UPA. The restriction to heterosexual couples is not explained.

⁹⁵ See Robertson, *supra* note 10, at 7 ("Concerns about the welfare of offspring resulting from ARTs cover a wide range of procedures and potential risks. In addition to physical risks from the techniques themselves, they include the risk of providing ART services to persons who could transmit infectious or genetic disease to offspring, such as persons with HIV or carriers of cystic fibrosis. Risks to offspring from inadequate parenting may arise if ARTs are provided to persons

interplay between child protection and best interests is to recognize that child protection is subsumed within best interests. In other words, although exposing children to serious harm is of necessity inconsistent with their best interests, what is not best for a child does not necessarily harm the child.⁹⁶

Table 1: The Classic Paradigm of Child Welfare

INTACT FAMILIES	<i>Parent's Interests</i>	<i>State's Interests</i>
<i>Harm principle</i>	No state interference absent a showing of unfitness	Child protection
<i>Best-interests principle</i>	Presumption that parents act in best interests of child	Child welfare

Table 1 captures the classic paradigm of the harm and best-interests principles as they apply to legally recognized parents. The table applies most directly to coital progenitors whose parental status requires the least amount of legal intervention to establish,⁹⁷ but it applies with equal force to legally recognized adoptive or other intentional parents. All of these parents benefit from a presumption of fitness that frees them to exercise their parental prerogatives without state intervention.⁹⁸ This is because parents are uniquely positioned to ensure “the child’s chances for the full growth and maturity that make eventual participation in a free society meaningful and rewarding.”⁹⁹

with mental illness or serious disability. Questions of offspring welfare also arise from the use of ARTs in novel family settings, such as surrogacy, the posthumous uses of gametes and embryos, or with single parents or a [sic] same sex couples. Finally, both physical and psychological risks may result from alteration or manipulation of genes, gametes, and embryos.”); ROBERT G. LEE & DEREK MORGAN, HUMAN FERTILISATION & EMBRYOLOGY: REGULATING THE REPRODUCTIVE REVOLUTION 161 (2001) (“The concept of the welfare of the child is broad and all-embracing. A very wide range of factors must be taken into account when considering the future lives of children who may be born as a result of the licensed treatment services.”); Pennings, *supra* note 70, at 1146.

⁹⁶ Annette R. Appell & Bruce A. Boyer, *Parental Rights vs. Best Interests of the Child: A False Dichotomy in the Context of Adoption*, 2 DUKE J. GENDER L. & POL’Y 63, 64-65 (1995).

⁹⁷ *J.R.*, 261 F. Supp. 2d. at 1284 n.24, 1288; ROBERTSON, *supra* note 7, at 31; JACKSON, *infra* note 131, at 276.

⁹⁸ *Parham v. J.R.*, 442 U.S. 584, 602–03 (1979) (holding that parents possess control over their children’s upbringing, absent a finding of neglect or abuse). Emily Jackson of the London School of Economics explains our reluctance to question parental prerogatives just because someone else can provide the “best” set of circumstances for a child as the result of our desire that parents be free to make mistakes without losing the right to parent. JACKSON, *infra* note 131, at 195 n.195 (quoting Heather Draper & Ruth Chadwick, 1999, at 117).

⁹⁹ *Bellotti v. Baird*, 443 U.S. 622, 638-39 (1979).

The presumption that parents act in the best interests of their children means that the state will not interfere with a parent's exercise of her autonomy absent a showing of her unfitness.¹⁰⁰ The court cannot sidestep parental autonomy¹⁰¹ to promote, as *parens patriae*,¹⁰² the best interests of the child, because *parens patriae* is not properly invoked "except when necessary for the protection of the child."¹⁰³ The law does not permit the question of a minor's best interests to be determined by anyone other than the minor's parent unless the presumption that a parent acts in his child's best interests has been rebutted or called into question.¹⁰⁴ The incapacity of the state to rebut the best-interests presumption except upon a showing of parental unfitness adequately expresses the state's interest in child protection and safeguards the parent against intrusive scrutiny of her actions. The principle of parental autonomy, by recognizing a sphere of family privacy and defining the boundaries of individual families, is precisely what some commentators consider the bedrock of "societal integrity."

Since in the law child welfare has a range of meanings, when legislation governing access to assisted reproduction mandates consideration of child welfare, then, it is not known for certain whether the intended focus is on child protection or on the best interests of the child.¹⁰⁵ The admonition to consider welfare or best interests is invariably couched in very general terms, and the proper assessment of welfare is confounded by the "large psychosocial components"¹⁰⁶

¹⁰⁰ *Parham*, 442 U.S. at 602.

¹⁰¹ See *Planned Parenthood of the Blue Ridge v. Camblos*, 155 F.3d 352, 372 (4th Cir. 1998), cert. denied, 525 U.S. 1140 (1999) (describing this as "an arrogation of the parental role by judicial fiat").

¹⁰² See *Turner v. Melton*, 402 P.2d 126, 128 (Kan. 1965) (defining *parens patriae* as a doctrine "recogniz[ing] the right and duty of the state to step in and act for what appears to be the best interests of a child").

¹⁰³ *Wilson v. Wilson*, 474 P.2d 789, 792 (Colo. 1970).

¹⁰⁴ See *Parham*, 442 U.S. at 602-03 (holding that parents retain a substantial, if not a dominant, role in their children's upbringing, absent a finding of neglect or abuse).

¹⁰⁵ See, e.g., ARLENE JUDITH KLOTZKO, A CLONE OF YOUR OWN? THE SCIENCE AND ETHICS OF CLONING 114 (2006) ("Assisted reproduction in Britain is a carefully regulated affair and the law protects the best interests of children."); Savulescu, *supra* note 52, at 53. I disagree with Françoise Shenfield that the use of the term "welfare" in the British legislation adequately "differentiates between the future child, whose 'welfare' must be taken into account, and the 'best interest' of a born child, which is considered to be paramount." Françoise Shenfield & Claude Sureau, *The Welfare of the Child: Whose Responsibility?*, in CONTEMPORARY ETHICAL DILEMMAS IN ASSISTED REPRODUCTION 73, 76 (Françoise Shenfield & Claude Sureau eds., 2006). The legislation she cites in support, the British Children Act of 1989, makes scant reference to best interests and makes child welfare explicitly paramount. Of course, Shenfield's invocation of the "maximal" standard of child welfare, see *id.* at 79 (citing Pennings, *Measuring the Welfare of the Child*, *supra* note 70), is simply another term for the best-interests standard. She has explained elsewhere that no European consensus exists on the meaning of child welfare. See Shenfield, *supra* note 10, at 18.

¹⁰⁶ IFFS Surveillance 2004, *supra* note 5, at S33.

involved. Taking the expansive view with respect to these provisions, some commentators may assume that “child welfare” is synonymous with “best interests.” Other commentators believe inquiries into the best interests of unconceived offspring make little intuitive sense and cannot be defended as the standard against which to determine access to assisted reproduction.¹⁰⁷ Disagreement over what the interest in child welfare actually contemplates and how it should apply leads to charges of its inconsistent or biased application.¹⁰⁸ Under these circumstances, confusion about how such provisions should apply in practice is hardly surprising.

To determine how parental fitness and best interests meld with the interests triggered by seeking access to assisted reproduction requires a look at how the best interests and the fitness standards apply to different ways of becoming a parent. This is the objective of Table II.

Table II: Scrutinizing Paths to Parenthood

	<i>Parental Fitness</i>	<i>Best Interests of the Child</i>
<i>Legally recognized parents</i>	Undermined by showing of harm (abuse or neglect)	Presumed; must show harm to rebut
<i>Stranger Adoption</i>	Measured by pre-placement evaluation	Measured by post-placement evaluation

Table II reveals that once the parents of a child are legally recognized, they benefit from a presumption that they will act in the best interests of their child. Only evidence that the parents are unfit in some manner that harms the child will undermine the best-interests presumption. We already know from Figure I, as qualified by Part II.A., that unassisted reproduction involves no gatekeeping by governmental or private actors; thus, the path to parenthood from unassisted reproduction is relatively straightforward. The state bestows the best-interests presumption upon these procreative actors at the moment of the child’s birth.

By contrast, there is no overlay of procreative liberty or parental

¹⁰⁷ See, e.g., JACKSON, *infra* note 131, at 192-93, 322 (criticizing child-welfare provision as grounded in “inherently speculative” views about the harm that arises from assisted reproduction); Douglas, *supra* note 62, at 70 (noting difficulty of assessing child welfare without evidence of parenting ability).

¹⁰⁸ See Pennings, *supra* note 94, at 2468; Richard F. Storrow & Sandra Martinez, “Special Weight” for Best-Interests Minors in the New Era of Parental Autonomy, 2003 WIS. L. REV. 789.

autonomy as regards potential adoptive parents. Adoption begins after a child or fetus already exists. Those who seek to adopt, then, face a two-tiered system of gatekeeping consisting of both fitness and best-interests screening. Adoption culminates in the termination of one set of parents' rights and the recognition of a new set of parents. No parental rights attach until the fitness and best-interests standards are satisfied and until after the child has resided with the prospective parent for a period of time.¹⁰⁹ The fitness assessment, otherwise known as the pre-placement evaluation, is made first and before a child is ever placed with the prospective parents.¹¹⁰ The assessment is used to satisfy the state that the prospective adoptive parents are not likely to harm a child placed in their care. It measures whether the prospective parents have at least minimal competency to provide for a child's basic needs.¹¹¹ If the prospective parents satisfy the fitness standard, the state will place a child with them, but before the adoption is finalized there must be a best interests assessment, otherwise known as the post-placement evaluation.¹¹²

Two important factors distinguish best interests screening from fitness screening. First, in fitness screening the focus is on the prospective parents' competency to perform parental duties adequately.¹¹³ The focus of the best interests of the child inquiry (as its name would suggest) is on the child and whether his or her specific interests can be maximized in a particular home with a specific set of parents.¹¹⁴ Understandably then, the best interests inquiry is a highly individualized and multidimensional fact-based inquiry,¹¹⁵ in contrast to the fitness inquiry's reliance on generalizations about minimal parenting competency. Under this reading, the application of the best-interests standard at the very least presupposes the existence of those whose best interests are to be assessed. A second important distinction between the best-interests and the fitness tests lies in the "best" part of the best interests label. "Best" signals the important comparative dimension of

¹⁰⁹ See, e.g., N.Y. COM. REL. LAW §§ 112, 116; S.D. CODIFIED LAWS § 25-6-9 (2007).

¹¹⁰ See, e.g., MONT. CODE ANN. § 43-3-201(1); TEX. FAM. CODE ANN. § 107.0511(d) (2007); VT. STAT. ANN. tit. 15A § 2-201(a) (2007); Joel D. Tenenbaum, *Introducing the Uniform Adoption Act*, 30 FAM. L. Q. 333, 338 (1996).

¹¹¹ See, e.g., CAL. FAM. CODE § 8811.5(a) (2007); UTAH CODE ANN. § 78-30-3.5(1)(a) (2006); VT. STAT. ANN. tit. 15A § 2-203(13).

¹¹² See, e.g., VT. STAT. ANN. tit. 15A § 3-602.

¹¹³ See Joan Heifetz Hollinger, *The Uniform Adoption Act: Reporter's Ruminations*, 30 FAM. L. Q. 345, 366-67 (1996).

¹¹⁴ *In re W.A.T.*, 808 P.2d 1083, 1086 (Utah 1991) (noting that the purpose of the best interests standard is to give courts latitude within which to make "fact-specific" inquiries about whether "the interests of *these children* will not be promoted . . . by *these petitioners*") (emphasis added).

¹¹⁵ See Hunfeld & Passchier, *supra* note 58, at 281.

the best-interests assessment. Since the goal of the best interests assessment is the maximization of the well-being of the child, the screener evaluating a specific placement asks whether, within the realm of available options for the specific child, an alternative placement might be better.

The best interests of the child standard has a venerable history in the law. It figures prominently not only in cases contemplated by Table 1, where parental autonomy and religious freedom are relevant—cases like third-party visitation,¹¹⁶ parental notice of abortion,¹¹⁷ and consent to or withholding of medical treatment that may raise issues of public health¹¹⁸—but also in cases where parental autonomy is not an overriding concern—involving, for example, custody,¹¹⁹ visitation rights,¹²⁰ child support,¹²¹ termination of parental rights,¹²² adoption,¹²³

¹¹⁶ See, e.g., MINN. STAT. § 518.1752 (2001) (grandparent visitation).

¹¹⁷ See Storrow & Martinez, *supra* note 108, at 791 (“best-interests minor’s entitlement to a bypass, although seeming to contradict time-honored respect for parental autonomy, is justified by her decision’s entitlement to ‘special weight’”).

¹¹⁸ See, e.g., Andy Newman, *City Questions Circumcision Ritual After Baby Dies*, N.Y. TIMES, Aug. 26, 2005 at B1; *In re Green*, 292 A.2d 387, 392 (Pa. 1972) (“We are of the opinion that as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent’s religious beliefs when the child’s life is *not immediately imperiled* by his physical condition.”) (emphasis in original); *Newmark v. Williams*, 588 A.2d 1108 (Del. 1991) (applying the best interest standard); *In re Hamilton*, 657 S.W.2d 425 (Tenn. Ct. App. 1983) (ordering treatment). These cases tend to turn on whether denial of treatment exposes the child to some form of threat to health and welfare. See, e.g., *In re Phillip B.*, 156 Cal. Rptr. 48, 51 (Ct. App. 1979) (Before intervening, “[t]he state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm [and] . . . the risks involved in medically treating the child . . . Of course, the underlying consideration is the child’s welfare and whether his best interests will be served by the medical treatment.”). See generally Michael W. Homer, *The Precarious Balance Between Freedom of Religion and the Best Interests of the Child*, in CHILDREN IN THE NEW RELIGIONS 187 (Susan J. Palmer & Charlotte E. Hardman eds., 1999).

¹¹⁹ See ROBERT H. MNOOKIN & D. KELLY WEISBERG, CHILD, FAMILY AND THE STATE: PROBLEMS AND MATERIALS ON CHILDREN AND THE LAW 913 (2000); *Holley v. Adams*, 544 S.W.2d 367 (Tex. 1976); *Pikula v. Pikula*, 374 N.W.2d 705, 711 (Minn. 1985); MINN. STAT. § 518.17, subd. 1(a); MINN. STAT. § 518.18(d) (modification of custody). Chapter 518A of the Uniform Child Custody Jurisdiction Act contains a “best interests” jurisdiction provision, where the child and at least one parent reside in the state or have resided in the state recently and have significant connections with the state.

¹²⁰ See, e.g., MINN. STAT. § 518.175.subd.1; MINN. STAT. § 518.175, subd. 5 (visitation modification).

¹²¹ See Marygold S. Melli, *Guideline Review: The Search for an Equitable Child Support Formula*, in CHILD SUPPORT: THE NEXT FRONTIER 113 (J. Thomas Oldham & Marygold S. Melli eds., 2000); MINN. STAT. § 518.551 (deviation from child support guidelines).

¹²² The standard for termination requires a finding that the termination is in the child’s best interests. See, e.g., *In re Romance M.*, 641 A.2d 378, 383-84 (Conn. 1994); *In re J.J.B.*, 390 N.W.2d 274, 279 (Minn. 1986).

¹²³ See Hollinger, *supra* note 113, at 354. On the controversy surrounding transracial adoption in particular, see Elizabeth Bartholet, *Cultural Stereotypes Can and Do Die: It’s Time to Move on with Transracial Adoption*, 34 J. OF THE AMER. ACAD. OF PSYCHIATRY & THE L. 315 (2006).

and guardianship.¹²⁴ The standard is also a cornerstone of the “separate system” of juvenile justice.¹²⁵ In these contexts, assessments of the best interests of the child exist at “the intersection of social work and the law.”¹²⁶ The standard grows out of the ancient doctrine of *parens patriae* and was designed specifically “to improve the consistency and quality of decisions made about children.”¹²⁷ Given the prominence of the standard in all manner of legal decisions involving children’s rights, it is unsurprising that it serves as a crucial underpinning of the United Nations Convention on the Rights of the Child.¹²⁸

It is also unsurprising to find the best-interests standard used as the guiding principle of proposals to regulate various aspects of assisted reproduction. In debates over the confidentiality and disclosure of the identities of gamete donors and surrogates, posthumous conception, and parentage disputes in surrogacy,¹²⁹ the best-interests principle is salient. Each of these areas involves the potential inability of a child to know and be reared by someone who made a genetic or gestational contribution to her existence. The supposition that such a child cannot fail but come to harm in such a setting has produced a great deal of anxiety in some circles. Where it is most prominent is in situations where a child has already been born and the course of his or her life is believed to be altered by some decision about how the law should resolve the issue presented. Although there is little evidence that children are harmed by issues arising from third-party or posthumous reproduction so as to warrant state curtailment of these forms of procreation, and although no data exists showing that special patient groups—gays, lesbians, single women, and those too aged to procreate naturally—are invariably poor parents, it is nonetheless unsurprising, given the emotions gamete donation and surrogacy engender, that laws have been passed and proposals raised to make the best interests of the child standard operable before conception to stop the exercise of the technology in a way that will harm a future child. As a practical matter, too, it is more convenient to prevent a child who will be born into harmful circumstances from being conceived in the first instance than to wait to intrude in the parent-child relationship once the child is born and

¹²⁴ HANDBOOK OF FAMILY LAW TERMS 77 (Bryan A. Garner ed., 2001).

¹²⁵ See Marygold S. Melli, *Juvenile Justice Reform in Context*, 1996 WIS. L. REV. 375, (describing the primary concerns of the “separate system” of juvenile justice).

¹²⁶ Mary Banach, *The Best Interests of the Child: Decision-Making Factors*, FAMILIES IN SOCIETY, May/June 1998, at 331, 337.

¹²⁷ Banach, *supra* note 126, at 338.

¹²⁸ See Jane Ellis, *The Best Interests of the Child*, in CHILDREN’S RIGHTS IN AMERICA: U.N. CONVENTION ON THE RIGHTS OF THE CHILD COMPARED WITH UNITED STATES LAW 3, 3 (Cynthia Price Cohen & Howard A. Davidson eds. 1990).

¹²⁹ Vanessa S. Browne-Barbour, *Bartering for Babies: Are Preconception Agreements in the Best Interests of Children?*, 26 WHITTIER L. REV. 429.

important presumptions related to parentage attach.

What is striking about these regulatory maneuvers is not their expression of concern for children born of reproductive technology but that they recommend applying the best interests of the child standard to the unconceived, a class to which that standard's application is unknown in any other family law context.¹³⁰ The test, as applied to parentage, is used to transfer parentage after a period of placement (as in adoption) or to bifurcate parental rights and responsibilities between divorcing or separating parents (as in custody cases). Recognizing this, Emily Jackson surmises that the child-welfare provisions governing assisted reproduction in Great Britain necessarily contemplate "tak[ing] into account the prospective parent's aptitude for parenthood" rather than the puzzling inquiry "as to whether to attempt to bring a child into the world [is consistent with] that child's welfare."¹³¹ Jackson is rightly puzzled, because it is one thing to say that certain individuals are ineligible for assistance in becoming parents because they are unfit to parent *any* child. It is quite another thing, and even tautological, to suggest that the best interests of an unconceived child cannot be met by helping the child's potential parents bring her into existence.

Further support of Jackson's view is found in the provisions themselves. The British legislation governing access to assisted reproduction contains the strongest admonition to consider child welfare, but amplification of this requirement in the statute reveals that a primary concern is that those to be financially responsible for the child be readily identifiable. Other factors to be considered include "commitment, age, medical histories, ability to meet the needs of child or children, any risk to the child, including that of inherited disorders, and the effect on any existing child of the family."¹³² It is not at all clear, in other words, that the statute requires a best-interests inquiry at all.¹³³

To enlist the best-interests standard for clinical gatekeeping where harm is not shown is to employ the admonition to consider child welfare

¹³⁰ Françoise Shenfield has declared that the view that a child is never harmed by being born is a counterargument "rarely used nowadays apart from a few philosophical circles." Shenfield, *supra* note 10, at 17; *see also* Ethics Committee, *supra* note 4, at 566 ("We think that such a judgment takes too narrow a view of the relevance of offspring welfare in determining ethical conduct. Although a child may not strictly speaking be 'harmed' as a result of fertility procedures that made its birth possible, we think that concerns about future harm to offspring validly may be taken into account in making ethical assessments about those treatments.").

¹³¹ EMILY JACKSON, *REGULATING REPRODUCTION: LAW, TECHNOLOGY AND AUTONOMY* 192 (2001).

¹³² IFFS Surveillance 2004, *supra* note 5, at S33.

¹³³ The vagueness of the statutory language has resulted in no official action being taken. *Id.* at S33; LEE & MORGAN, *supra* note 95, at 164 ("has largely been ignored by clinics"); LEE & MORGAN, *supra* note 95, at 166 ("little effective assessment of individual fitness to promote the welfare of the child").

as a means of expressing a preference for and channelling individuals in the direction of forming certain idealized types of families.¹³⁴ Even if this were not the legislative intent, it would nonetheless remain little more than an example of legislative window dressing¹³⁵ or at the very least an unfortunate lack of precision in language. If family law is to be any sort of guiding principle in the regulation of access to assisted reproduction, decisionmakers should embrace the clear distinction between the best interests and the harm standards so that access to

¹³⁴ See JACKSON, *supra* note 131, at 174 (“[U]nless we are concerned to prevent reproduction in anyone who may offer a suboptimal environment for their children’s upbringing, then restricting the reproductive options of the infertile people on the basis of some vague appeal to child welfare may be both disingenuous and discriminatory.”). Carl Coleman has posited, in the context of preimplantation genetic diagnosis that “selective application of ethical principles’ suggests that level of the interests of the future child may simply be pretexts for decisions motivated by illegitimate considerations, such as bias against people with particular disabilities.” Carl H. Coleman, *Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies*, 50 UCLA L. REV. 17, 66 (2002). Professor John Robertson has asserted that “[h]ow a child is treated after it is born, not the motivation in conceiving it, determines whether reproduction is ethical.” *Embryo Screening for Tissue Matching*, 82 FERTILITY & STERILITY 290, 290 (2004). On the symbolic function of law, see Sally Sheldon, *Fragmenting Fatherhood* 68 MODERN L. REV. 523, 526 (2005) (cautioning that the recognition of fatherhood in the regulation of assisted conception “is often grounded primarily in deep-rooted beliefs in the symbolic importance of fathers rather than, as might be assumed, in more practical concerns with ensuring the presence of a social father”); Elisabeth Boetzkes, *Symbolic Harm and Reproductive Practices*, in 3 LAW AND MEDICINE 327 (Michael Freeman & Andrew D.E. Lewis eds., 2000). Despite the level of disagreement among feminists about the value of reproductive technology, one unifying concern revolves around how decisions about who is a suitable case for infertility treatment are made. Hilary Rose, *Victorian Values in the Test-tube: The Politics of Reproductive Science and Technology in Reproductive Technologies: Gender, Motherhood and Medicine* 151, 172 (Michelle Stanworth ed. 1987) (“Now is it precisely this agreement (between obstetrician and ethicist)—that doctors naturally are the right profession to decide who is a suitable case for infertility treatment or gene therapy—that must be a major source of political and particularly feminist concern.”). This is unsurprising, given that a law of medical technology that channels people in the direction of “responsible” procreation is a particularly potent premise for unequal treatment on a variety of levels. Single mothers, gays and lesbians, and the poor all suffer exclusion from reproductive technology under initiatives that categorize married heterosexual couples as more deserving than others to benefit from reproductive technology, see Margarete Sandelowski & Sheryl de Lacey, *The Uses of a “Disease”: Infertility as Rhetorical Vehicle*, in INFERTILITY AROUND THE GLOBE 33, 36 (Marcia C. Inhorn & Frank Van Balen eds., 2002) (citing Lisa C. Ikemoto, *The Infertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007 (1996)), or style exclusionary policies as in the best interests of the not yet conceived. See RICHARD F. STORROW, ASSISTED REPRODUCTION AND THE LIMITS OF THE LAW (work in progress). Thus, aside from whether the medical establishment conspires to oppress women through reproductive technology, tying a woman’s reproductive choices to whether she is or is not coupled with a man is a matter of general feminist preoccupation and concern. Such a concern would seem to transcend the labels “radical” and “liberal” and to be consistent with a “gendered institutions perspective” toward understanding the power of gender in social life. Amy S. Wharton, *Gender Inequality*, in HANDBOOK OF SOCIAL PROBLEMS: A COMPARATIVE INTERNATIONAL PERSPECTIVE 156, 157, 168 (George Ritzer ed., 2004).

¹³⁵ Warnock, *supra* note 7, at 45 (recalling that “it sounded good”); Douglas, *supra* note 62, at 72 (M.D.A. Freeman & B.A. Hepple eds., 1993) (suggesting the admonition to consider child welfare might be a “lip-service provision”); JACKSON, *supra* note 131, at 195 (describing the provision as “essentially cosmetic”).

assisted reproduction is not irrationally or frivolously denied. To misuse the standard as a means by which to make blanket judgments about whole classes of persons who might wish to employ assisted reproduction or about specific types of assisted reproduction is not the direction family policy should take.¹³⁶ It does not challenge, however, the validity of applying a harm standard in the clinical setting,¹³⁷ a recommendation that will be explored in more detail in Part III.

C. *Virtual Representation*

As we have seen above, only the child-welfare interest in family law parallels the child-welfare interest in clinical gatekeeping and only in the narrow sense of questioning parental fitness. The analogy is imperfect, however, given that family law expresses an interest in a child's welfare at the earliest after a child has already been conceived and most often after a child has already been born.¹³⁸ Clinical gatekeeping, on the other hand, aims to assess the welfare of a child prior to that child's conception. Although it might be possible to evaluate a couple's aptitude for parenting with reference to generalities about what makes good parents, it becomes an exercise in philosophical abstraction to attempt an assessment of what set of circumstances will best promote the interests of a not-yet-conceived child. Thus, family law is not supportive of the use of the best-interests standard to make clinical decisions about who may have access to assisted reproduction.

None of the foregoing discussion, however, is meant to suggest that the law is devoid of an analogous model for best-interests screening practices. In a little-discussed area of the law in which the best interests of the unconceived are of paramount concern, trust law doctrine prohibits the living beneficiaries of a trust to invade the trust's corpus after the settlor has died unless it would be in the best interests of the unborn or unascertained beneficiaries of the trust.¹³⁹ As with donative freedom generally, the law is protective of the way in which owners of assets choose to dispose of their property and will not carry out a

¹³⁶ *In re W.A.T.*, 808 P.2d 1083 (Utah 1991). *Cf. In re E*, 279 A.2d 785, 796 (N.J. 1971) (reversing trial court's determination that petitioners were unfit to adopt given their lack of belief in a "Supreme Being").

¹³⁷ *Contra* Bayles, *infra* note 159, at 300 ("Liberty-limiting laws which protect the well-being of unconceived persons must be supported by a principle other than that of private harm.").

¹³⁸ See JACKSON, *supra* note 131, at 195 (remarking that family law's protective function applies only to a child who already exists, and has no bearing upon a couple's choices prior to conception).

¹³⁹ See generally W. E. Shipley, Annotation, *Power of Guardian Representing Unborn Future Interests Holders to Consent to Invasion of Trust Corpus*, 49 A.L.R.2d 1095 (1956).

requested modification or termination simply because the beneficiaries desire it.¹⁴⁰ To do justice in such cases would require the court to ensure that the best interests of the unborn beneficiaries be adequately represented. Instead of outlawing this kind of trust modification petition, though, in the interests of convenience and necessity, the common law developed the doctrine of virtual representation, which permits living beneficiaries to represent unborn beneficiaries as long as their interests are sufficiently similar to ensure adequate representation.¹⁴¹ This doctrine has become one of several legal devices designed to protect the interests of the unborn¹⁴² and developed in the interest of settling controversies that cannot await the birth of all contingent remaindermen.¹⁴³ The constitutionality of these provisions, some of which are statutory in nature,¹⁴⁴ has been settled.¹⁴⁵

When studied closely, cases developing the doctrine of virtual representation in the trust context have much more to do with advancing the policy of adhering to the terms of a donative document than they do about safeguarding any set of generally accepted notions about what is best for children. They are, in essence, cases about vindicating the property rights of adults. Seen in this light, the virtual representation cases are at first blush a poor analogy for the extension of the best-interests standard into the realm of defining what degree of control we as a society will permit adults to have over the conception of children. Nonetheless, a look at trust modification actions in which potential

¹⁴⁰ See *In re Stuchell*, 801 P.2d 852 (Or. Ct. App. 1990).

¹⁴¹ See *Nationsbank of Va., N.A. v. Grandy*, 450 S.E.2d 140 (Va. 1994); *In re Putignano*, 368 N.Y.S.2d 420, 424 (Sur. Ct. 1975). For a list of the many proceedings in which the doctrine of virtual representation applies, see 51 AM. JUR. 2D *Life Tenants and Remaindermen* § 15. The use of this doctrine in this trust law context is similar to its use in mass torts and bankruptcy, where classes are sometimes constituted by persons of uncertain identity or by persons not in being. *Brown v. Bibb*, 201 S.W.2d 370, 374 (Mo. 1947) (likening equitable doctrine of virtual representation to statutory class actions); *Ross v. Arkansas Communities, Inc.*, 529 S.W.2d 876, 879 (Ark. 1975) (“The theory underlying a proceeding as a class action is that of virtual representation.”); 59 AM. JUR. 2D *Parties* § 69; Lawrence B. Rodman & Leroy E. Rodman, *Virtual Representation: Some Possible Extensions*, 6 REAL PROP. PROB. & TR. J. 281, 281 (1971); Mark J. Roe, *Bankruptcy and Mass Tort*, 84 COLUM. L. REV. 846 (1984).

¹⁴² See generally 2A POWELL ON REAL PROPERTY § 296 (1981) (authorizing various legal devices to protect interests of unborn).

¹⁴³ See *Blocker v. Blocker*, 137 So. 249 (Fla. 1931); *Drake v. Fraser*, 179 N.W. 393 (Neb. 1920) (interest in quieting title); *Mabry v. Scott*, 51 Cal. App. 2d 245, 252-53 (Cal. Ct. App. 1942) (noting that the interests of justice may require adjudicating the rights of living persons); JESSE DUKEMINIER & STANLEY JOHANSON, *WILLS, TRUSTS & ESTATES* 656 (4th ed. 1990) (“necessity of effectively adjudicating title when not all interested parties are available”). It is not unknown for the trustee herself to represent the unborn remaindermen. See *Mabry*, 51 Cal. App. 2d at 257-58.

¹⁴⁴ See 51 AM. JUR. 2D *Life Tenants and Remaindermen* § 10.

¹⁴⁵ See 51 AM. JUR. 2D *Life Tenants and Remaindermen* § 8; *Putignano*, 368 N.Y.S.2d at 424 (“The doctrine when properly applied complies with the constitutional commands of notice and opportunity to be heard.”).

parents claim to be the virtual representatives of their unborn children affords insight into how the law should respond to clinical screening practices.

The doctrine of virtual representation is one of narrow application. Since the doctrine derogates from the rule that all parties must be before the court to be bound,¹⁴⁶ it is applied with caution.¹⁴⁷ The degree of caution with which virtual representation is allowed depends upon the degree to which the action places the contingent remaindermen's interests in jeopardy.¹⁴⁸ The doctrine applies only where the living and the unborn beneficiaries have identical, congruent interests.¹⁴⁹ This congruency-of-interests requirement assures the court that the parties in court are motivated to argue the merits of the position so as best to advance the interests of those who cannot be in court.¹⁵⁰ Congruency of interests is determined based on "the similarity of their interest, whether the representor has any interest that is adverse to the party being represented, and whether the representor can adequately represent the interests of those virtually represented."¹⁵¹ Remoteness is also a factor.¹⁵² The caution employed before applying virtual representation suggests that modification would be difficult to achieve and termination doubtful.¹⁵³ Where a court determines virtual representation is inappropriate, it may choose to appoint a guardian ad litem to represent the interests of those who cannot consent.¹⁵⁴ But where virtual representation is achieved, the judgment is binding on the unascertained

¹⁴⁶ See *McPherson v. First & Citizens Nat. Bank of Elizabeth City*, 81 S.E.2d 386, 398 (N.C. 1947); *Knioum v. Slattery*, 239 S.W.2d 865, 866 (Tex. Ct. App. 1951) ("Generally, only parties and privies are bound by judgments.").

¹⁴⁷ See *McPherson*, 81 S.E.2d at 398. Cf. *Ross v. Arkansas Communities, Inc.*, 529 S.W.2d 876, 880 (Ark. 1975) ("Class actions are in derogation of the general rule of procedure and in addition to commonality of questions of law and fact it should be shown that the procedure is superior to other available methods for the fair and efficient adjudication of the controversy.").

¹⁴⁸ See *Elmore v. Galligher*, 87 So. 349 (Ala. 1921) (cited in 51 AM. JUR. 2D *Life Tenants and Remaindermen* § 13).

¹⁴⁹ See *Nationsbank of Virginia, N.A. v. Grandy*, 450 S.E.2d 140 (Va. 1994); *McPherson*, 81 S.E.2d at 398-99; 51 AM. JUR. 2D *Life Tenants and Remaindermen* § 11 ("In all cases, the doctrine or [sic] virtual representation is planted squarely on the ground of the identity of interest between the parties to the action and the persons they are held to represent."); 59 AM. JUR. 2D *Parties* § 69; RESTATEMENT (FIRST) OF PROP. § 183(a); *Rodman & Rodman*, *supra* note 141, at 281-82. In *McPherson*, the court ruled that virtual representation was unavailable because the interests were insufficiently congruent. See *McPherson*, 81 S.E.2d at 398-99.

¹⁵⁰ See *Los Angeles v. Winans*, 109 P. 640, 647 (Cal. Dist. Ct. App. 1910) ("The interests of representative and represented must, however, be so identical that the motive and inducement to protect and preserve may be assumed to be the same in each.").

¹⁵¹ *In re Holland*, 377 N.Y.S.2d 854, 857-58 (Sur. Ct. 1974); *In re Dickey*, 761 N.Y.S.2d 473, 474 (Sur. Ct. 2003).

¹⁵² *In re Eyre*, 133 N.Y.S.2d 511, 517 (Sup. Ct. 1954).

¹⁵³ See, e.g., *In re Small's Estate* (1953, Pa) 67 York Legal Record 1 (Pa. Orphan's Ct. 1953); *Deal v. Wachovia Bank & Trust Co.*, 11 S.E.2d 464 (N.C. 1940).

¹⁵⁴ See, e.g., *Dickey*, 761 N.Y.S.2d at 474.

parties.¹⁵⁵ In all of these respects, the inquiry into congruency of interests in trust modification actions mirrors best-interests screening of applicants for infertility treatment.

The typical case in which congruency-of-interests screening takes place is where the virtual representatives and the unconceived beneficiaries are takers of the same remainder in the property. Sometimes, though, the life tenants who bring trust modification petitions claim they are the virtual representatives of the unconceived takers in remainder. The general view of the relationship of life tenants and remainder takers would suggest that life tenants are not particularly well suited to represent the interests of remainder takers. This is because their interests are so often opposed.¹⁵⁶ As income beneficiaries, life tenants are interested in maximizing the income stream to be derived from the property; remainder takers are interested in capital appreciation. Since maximizing income so frequently has a detrimental effect on underlying value, the interests of life tenants and remaindermen are often in opposition.

What is most instructive about virtual representation cases is that when a life tenant who is a potential parent purports to represent her unconceived children's remainder interest, courts are prone to relax the congruency-of-interests requirement; in other words, courts will forego best-interests screening. Courts in this context begin to speak less in terms of there being a need for perfect equality of interests and more along the lines of it being appropriate to allow the parent to sufficiently defend the potential children or offer the court reasonable assurance that she will adequately protect them.¹⁵⁷ This stance of course is that of the fitness screening that was described above in reference to minimally competent parenting ability. When the court relaxes the congruency-of-interests requirement, it in essence indulges a presumption that a potential parent will act to promote even her unconceived children's best economic interests. This stance grows out of the recognition of the law generally that the interests of prospective parents and their unconceived offspring are "inextricably intertwined." The motivation for parenthood under this view is dual, driven not only by self interest but also by affection and beneficence. Only where the potential parent proves herself unfit to advance the economic interests of her offspring, as where she seeks to extinguish the entire remainder and thus exposes the clear adversity of her interests to those of her offspring, will she be

¹⁵⁵ *Brown v. Bibb*, 201 S.W.2d 370, 374 (Mo. 1947); *Rodman & Rodman*, *supra* note 141, at 282.

¹⁵⁶ *See In re Zirinsky*, 802 N.Y.S.2d 923, 924 (Sur. Ct. 2005).

¹⁵⁷ *See, e.g., Roe*, *supra* note 141, at 902 n.176 (reporting that the *Mullane* court believed those who would receive actual notice were "reasonably good surrogates in advancing the interests of those not identifiable").

denied the status of virtual representative.

III. RECOMMENDATIONS FOR CLINICAL GATEKEEPING

Several problems emerge from the application of the best interests standard in the clinical evaluation of applicants for infertility treatment. First, the academic literature on the subject reveals a lack of precision in distinguishing the best interests of the child standard from the harm standard. Without question, exposing children to serious harm undermines their welfare. What does not promote a child's welfare, however, does not of necessity harm the child.¹⁵⁸ Using the best interests standard as the gatekeeper in assisted reproduction fails to give adequate weight to the prospective parents' interest in procreation as against society's interest in child welfare. This is because in assisted reproduction parental interests are not assumed to be subordinate to the child's as they are in adoption and disputes over child custody, the contexts that the best interests standard was designed to address.

Second, the use of the best interests standard in decisions about access to assisted reproduction risks injecting an element of arbitrariness into the clinic's gatekeeping function. The best interests standard was developed to afford decisionmakers a tool with which to make fact-specific inquiries into whether the interests of a particular child would be served by particular parents. The best interests test in the context of adoption is a multi-dimensional fact-specific inquiry focusing on whether the interests of an identifiable child will be promoted through adoption by identifiable, prospective parents. As such, application of the best interests standard at the very least presupposes the existence of the child whose best interests are to be assessed. The standard is thus not well suited to clinical decisionmaking about children who have yet to be conceived and about whom little is known. The interaction of the parents with their as yet unconceived children would of necessity remain within the realm of pure speculation. Furthermore, clinical concern about litigation that might arise from abandoning best-interests screening practices is fanciful. Children do not always live in circumstances that promote their best interests. This does not mean that such children are harmed in any way. If a child is born via assisted reproduction and is not thereby harmed, it is difficult to imagine any form of remediable injury that would arise from proceeding with the conception and eventual birth. If

¹⁵⁸ See Bayles, *infra* note 159, at 298 ("From the fact that a person would be better off were one to act in a certain way, it does not follow that failure to so act harms him."). Put another way, depriving one of benefits does not of necessity harm that person. *Id.* at 299.

there is no remedy for a failure to perform best-interests screening, then the use of that standard in the clinic draws the line in the wrong place. To address these problems, I use this section to explore what guideposts the law can offer clinicians as they go about making what are unquestionably difficult assessments.

The law contains no perfectly congruent model for the kind of screening that recent studies show takes place in infertility clinics. Family law is certainly no stranger to child-protection and best-interests assessments made about already existing children. Indeed, family courts struggle with question of parental fitness and the best interests of the child on a daily basis. Facets of trust law explore the best economic interests of unconceived beneficiaries. But even trust law stops short of disregarding the interests of potential parents and goes as far as raising a presumption that potential parents act in the best interests of their unconceived offspring in the absence of good evidence to the contrary. The presumption is borrowed from constitutional family law cases involving already existing parent-child relationships and refashioned to fit the trust-law context. These elements of the law counsel that in assisted reproduction, a context in which potential parents are not seeking modifications of a trust but are actively attempting to conceive a child, a presumption in favor of their gaining access to reproduction assisting technologies is all the more appropriate. I recommend that clinics refer, perhaps with the aid of in-house counsel, to decisions involving the termination of parental rights, cases in which courts on a daily basis are deciding what constitutes minimally adequate care.

To the extent clinics wish to prevent applicants who are unsuited to parenthood from gaining access to infertility treatment, they should adopt the harm standard. The harm standard allows parental fitness to be measured through the application of widely accepted criteria. It helps us avoid becoming mired in unhelpful questions such as whether assisted reproduction is more like unassisted reproduction or more like adoption. Its use in the clinical setting will lead to greater consistency and neutrality in decisions regarding access than will the use of the best interests standard in tandem with the harm standard or the best interests standard alone.

Table 3: Recommendations for Clinical Gatekeeping

	<i>Parental Fitness</i>	<i>Best Interests of the Child</i>
<i>Legally recognized parents</i>	Undermined by showing of harm (abuse or neglect)	Presumed; must show harm to rebut
<i>ART</i>	Measured by pre-	Presumed; must show

	conception screening	harm to rebut
<i>Stranger Adoption</i>	Measured by pre-placement evaluation	Measured by post-placement evaluation

The close examination of best-interests principle conducted in Part II.B. helps us see the incompatibility between it and the kind of screening that makes the most sense in assisted reproduction. The best-interests test requires looking at a specific child's age, health, social and cognitive abilities, etc. This means that any application of the test presupposes the existence of the child about whom the assessment is being made. This dimension of the test makes it inapplicable to decisions about children who have yet to be conceived and about whom nothing is known.¹⁵⁹ The use of the best-interests principle in family law thus supports doing away with best-interests screening in infertility clinics, which may use it not only to turn away persons unfit for parenthood but also persons who, in the opinion of gatekeepers, would merely be less than ideal.

Fitness screening in infertility clinics is defensible from a family law perspective, though, for two reasons. First of all, it can be harmonized with adoption. It is performed pre-placement in adoption, and in assisted reproduction is performed pre-conception. At neither point in time is there yet an identifiable child. Since the point of fitness screening is to assess only minimum parenting competency, the fitness assessment can function in the very same way in both assisted reproduction and adoption. Second, fitness screening in assisted reproduction can be harmonized with unassisted reproduction. In assisted reproduction we have to account for the interests of medical personnel whose code of ethics requires them above all to do no harm. It is thus reasonable to allow clinics to perform a fitness assessment, since its purpose is to prevent harm to others. Clinics should be free, however, to choose not to perform a fitness assessment if it is their practice to treat persons who need assisted reproduction the same as

¹⁵⁹ Cynthia B. Cohen, *The Morality of Knowingly Conceiving Children with Serious Conditions: An Expanded "Wrongful Life" Standard?*, in CONTINGENT FUTURE PERSONS 27, 27 ("[T]heoretical future persons constitute an enormously large hypothetical group about whom we cannot know much."); AMY AGIGIAN, *BABY STEPS: HOW LESBIAN ALTERNATIVE INSEMINATION IS CHANGING THE WORLD* 127 (2004) ("Of course, it is impossible to know what an individual's best interests will be before he or she is even conceived."); HELLER, *supra* note 7, at 10 ("[B]etter' appears to be a relational concept that requires us to make a comparison between a person's earlier and later states. . . . [W]e cannot meaningfully compare non-existence with existence."); Philip G. Peters, Jr., *Protecting the Unconceived: Nonexistence, Avoidability, and Reproductive Technology*, 31 ARIZ. L. REV. 487, 499 (1989) (discussing the limitations of an inquiry into the best interests of an unconceived child); Michael D. Bayles, *Harm to the Unconceived*, 5 PHILOSOPHY & PUB. AFFAIRS 292 (1976).

persons who do not¹⁶⁰ In performing fitness screening, clinics could find many useful guideposts in the law applicable to the termination of parental rights, an area in which courts on a daily basis are determining what falls below “minimally[] acceptable care.”¹⁶¹ Although it is difficult to generalize an area of the law in which the factual background of the cases varies so widely, in general what courts deem legally significant in such cases is whether the “parent’s care falls beneath minimally adequate standards or jeopardizes the well being of the child”¹⁶² or whether “there is a showing of parental unwillingness or inability to provide basic care for the child.”¹⁶³ Such cases often involve physical violence in the home, drug abuse, “extreme physical incapacitation,”¹⁶⁴ incarceration or severe mental illness.¹⁶⁵ By contrast, clinics should not look to custody cases, where courts focus on the best interests of the child and make decisions based on marital status, sexual orientation, diminished financial resources and even mere eccentricity.

The doctrine of virtual representation used in trust modification cases underscores the importance of limiting clinical screening to a fitness test. Applicants for infertility treatment are in no different a position from potential parents who seek to be the virtual representatives of their unborn children in trust modification cases. Like the parental virtual representatives in those cases, applicants for infertility treatment should also benefit from a presumption that they will act in the best interests of their children.¹⁶⁶ They should be denied treatment only when they show themselves to be incapable of providing minimally adequate care.

Great Britain has been supportive of this proposal. Britain has had a significant period of time since the enactment of its Human Fertilisation and Embryology Act in 1990 to observe how clinics grant or deny access to reproduction with the use of the Act’s child-welfare provision.¹⁶⁷ For over ten years, British legislation has mandated that

¹⁶⁰ My sense from participating in several interdisciplinary conferences on assisted reproduction is that most clinics do feel they have a responsibility to screen their clients, but they experience difficulty developing criteria for a fitness assessment. This presents the danger that well-intentioned medical efforts to screen out unfit parents might inadvertently tend in the direction of screening out those who merely appear less than ideal.

¹⁶¹ MISS. CODE § 93-15-103(3)(e)(i). We would also want health professional to bear in mind the important social science evidence demonstrating that gay or lesbian sexual orientation does not render a person unfit to parent.

¹⁶² See Appell & Boyer, *supra* note 96, at 64.

¹⁶³ See *id.* at 65.

¹⁶⁴ MISS. CODE § 93-15-103 (3)(e)(i); see also Shenfield & Sureau, *supra* note 105, at 79.

¹⁶⁵ 32 AM. JUR. PROOF OF FACTS 3D 83.

¹⁶⁶ See Douglas, *supra* note 62, at 71 (remarking the inconsistency between a presumption that parents can be trusted but prospective parents cannot).

¹⁶⁷ HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY, TOMORROW’S CHILDREN: REPORT OF THE POLICY REVIEW OF WELFARE OF THE CHILD ASSESSMENTS IN LICENSED ASSISTED

the welfare of the potential child be taken into account in every case of infertility treatment, and the agency responsible for executing this legislation has permitted clinics to engage in a wide range of screening practices, including best-interests screening. The clinical application of the standard came under sustained attack by infertile couples and individuals, scholars and even members of Parliament¹⁶⁸ as varying widely across clinics and resulting in discriminatory and arbitrary screening within individual clinics.¹⁶⁹ In response, for most of 2005, the Human Fertilisation and Embryology Authority (HFEA) conducted a study of the clinical screening practices.¹⁷⁰ In a remarkable turnabout said to be motivated to “provide greater clarity and give clinics more confidence about deciding whether or not treatment is appropriate,” the HFEA has quite pointedly embraced the avoidance-of-harm principle in gatekeeping¹⁷¹ and has revised its code of practice with appropriate language.¹⁷² A new guidance issued by the HFEA in November of 2005 permits nothing beyond fitness screening. Henceforth, clinics in the United Kingdom must entertain a presumption in favor of providing treatment and may not refuse treatment unless there is evidence that the child is likely to suffer serious physical or psychological harm.¹⁷³ The new approach, supportive of the proposal described above, has been fully implemented as of January 2006.¹⁷⁴

I think this proposal has the important virtue of making it unnecessary to resolve definitively the question whether assisted reproduction is more like adoption or more like unassisted reproduction. We can simply harmonize the standards used in these three areas by taking into account their similarities as well as their differences. Permitting the fitness assessment pre-conception is justified and allows us to recognize certain important distinctions between assisted

CONCEPTION CLINICS 2 (2005).

¹⁶⁸ HOUSE OF COMMONS, SCIENCE & TECHNOLOGY COMMITTEE, INQUIRY INTO HUMAN REPRODUCTIVE TECHNOLOGIES AND THE LAW (2005).

¹⁶⁹ Shenfield, *supra* note 10, at 18.

¹⁷⁰ See HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY, *supra* note 94.

¹⁷¹ See *id.* at 9; see also *id.* at 6 (“The involvement of a medical team in assisted conception means that certain third parties have some responsibility towards the child to be born. However, the importance of patient autonomy means that clinics should only refuse to provide treatment where there is evidence that the child is likely to suffer serious physical or psychological harm.”).

¹⁷² See Human Fertilisation & Embryology Authority, REVISED CODE OF PRACTICE pt. 3 (2005), at <http://www.hfea.gov.uk/AboutHFEA/HFEAPolicy/TomorrowsChildren-ReviewoftheHFEAsguidanceonWelfareoftheChild/Revised%20Guidance.pdf>.

¹⁷³ See Human Fertilisation & Embryology Authority, REVISED CODE OF PRACTICE 3.1 (2005), at <http://www.hfea.gov.uk/AboutHFEA/HFEAPolicy/TomorrowsChildren-ReviewoftheHFEAsguidanceonWelfareoftheChild/Revised%20Guidance.pdf>.

¹⁷⁴ Press Release, Human Fertilisation & Embryology Authority, Improved Welfare Checks System Will Be Better, Fairer and Clearer for Fertility Patients, GPs and Clinics (Nov. 2, 2005), <http://www.hfea.gov.uk/cps/rde/xchg/SID-3F57D79B-9A1950ED/hfea/hs.xsl/1113.html>.

reproduction and unassisted reproduction. There certainly is a distinction to be drawn between unassisted reproduction and assisted reproduction along the lines of the triad of interests that exists in the latter and not in the former. The interests of physicians are going to be expressed in one way or another in this context and it seems rational to allow medical personnel to satisfy themselves that they will not be an instrument of harm. We could bring this assessment as closely in line with unassisted reproduction as possible by not forcing clinics to perform fitness assessments, leaving the policy of those who already treat assisted reproduction like unassisted reproduction intact, and we might also ask that physicians limit such assessments to those that would conform as closely as possible with judicial opinion on what justifies the termination of parental rights in cases where parents abuse drugs or exhibit psychopathology. We would also want health professionals to bear in mind the important social science showing that gay or lesbian sexual orientation does not render a person unfit to parent.

Second, I think that a fitness assessment pre-conception is more consistent with the treatment of natural procreation than we might otherwise think. Procreative liberty and the attendant recognition of parental autonomy are protected but are not monolithic. Parents have to be fit to retain their parental rights; furthermore, the law is beginning to permit fitness assessments to take place in the prenatal context. But a fitness assessment for natural procreation also would not be constitutionally workable. It would pose grave constitutional questions of sexual privacy and autonomy in contraceptive decisionmaking that do not exist in the assisted reproduction context and would call forth a system of licensing of parents which is not something our society is ready to embrace at the present time.

Some will experience discomfort with my proposal, likening it to a threat to women's liberty or to indefensible discrimination. Some will believe that seeking guideposts in the jurisprudence of the termination of parental rights sets the bar too low. But at least a standard that announces that those we know will harm children cannot have access to assisted reproduction because of their extreme psychopathology or their pattern of harming their existing children does not exhibit invidious discrimination or a deprivation of a kind of liberty we believe people should enjoy. We know of instances where parental conduct crosses the line into the realm of abuse and neglect, and we are not particularly upset when state machinery is set in motion to remove children from the care of harmful parents. Our discomfort really lies in the potential of the judicial system we have vested with the grave responsibility of applying the harm standard in individual cases to abuse that trust and deny or curtail parental rights by subjecting parents to a standard that

encompasses more than harm. Our discomfort with clinics that, outside of public view, would undertake to make such judgments to deny an individual the chance to become a parent is all the more pronounced. If clinics will look to the law for guidance on how to make reasoned judgments in what are admittedly very difficult cases, they will succeed in investing the work of their profession with greater integrity and consistency.

CONCLUSION

Assisted reproduction continues to be the subject of calls for regulation in this country and around the world. Responses to this issue attempt to mediate between procreative autonomy and countervailing societal values, among them concerns about children's welfare. For some, safeguarding the best interests of children, even if they are yet to be conceived, warrants strict gatekeeping against access to assisted reproduction. Others react with uneasiness, fearing that increasing regulation of reproductive technology threatens reductions in hard-won reproductive freedoms. Although this issue has received exposure in any number of public fora, primarily in response to headline-grabbing issues, what remains less well known are the practices employed by private infertility clinics to exclude certain applicants from receiving treatment.

Parenthood via assisted reproduction contains elements both of parenthood via natural means and adoption. It is thus not surprising that the proper scrutiny to be applied is unclear. It should be clear, however, that adopting the best-interests standard from family law is not the answer. Requiring a multidimensional assessment in each case, the best interests standard contemplates the examination of a specific child in a specific environment in order to reach conclusions about what situational alternative is better for that particular child. Hence, the best interests of the child standard is not the best standard for developing abstract assessments about what is harmful for or ideal for children who have not yet been conceived. Instead, such assessments should be made with reference to well-settled understandings of what constitutes abuse and neglect.

Trust law, as analogous as it is to clinical screening practices, offers an important insight for doing away with best interests screening in infertility clinics. The common law developed the doctrine of virtual representation to allow those who are before the court to represent those who are not. This doctrine is carefully applied so as to protect the interests of those who cannot be in court and speak for themselves.

This doctrine, though, embodies a presumption that potential parents act in the best interests of their children. The trust law analogy, then, is disapproving of subjecting infertility patients to best-interests screening. It is supportive, though, of fitness screening in infertility clinics.

We can see that a vision of responsible parenthood is emerging from screening practices aimed at preventing certain individuals from becoming parents via assisted reproduction. Given that there is no consensus regarding assisted reproduction as a procreative liberty, it is understandable that great solicitude for children is present in policy discussions about the regulation of reproductive technology. By and large, appeals to child welfare in legislation tend to contemplate that applicants will be judged on their fitness to parent. What is becoming clear, though, is that some clinical practice tends in the direction of gatekeeping against parenthood for those deemed incapable of providing for a child's best interests. The job of bringing open-ended and weighty concepts such as procreative liberty, equality of treatment, and child welfare to bear when classifying infertile individuals as suited or unsuited to parenthood cannot be an easy one for medical personnel performing the important work of an infertility clinic. Use of the harm standard will protect applicants against unjustifiable denials of access to infertility treatment and will promote consistency and neutrality in decisions about who should be eligible for assisted reproduction.