Article

The Rights and Interests of the Child

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Assisted Reproductive Technology (ART) creates potential conflicts between the often passionately held desire of women and men to be parents, and the interests of the child they wish to create. Those seeking to be parents are often strong advocates for themselves. In New Zealand, they are protected against discrimination by the Human Rights Act 1993 which states that it is illegal to discriminate in the provision of services on a number of grounds, including sex, marital status, colour, race, national or ethnic origins, disability, age, and sexual orientation.

Without comprehensive, specific legislation on ART, the Human Rights Act is paramount, and there appears to be little enthusiasm among officials in successive reviews of ART for altering the status quo (MCART, 1994; Officials Committee, 1995). The Assisted Human Reproduction Bill currently before select committee does not alter this situation as it reinforces the need to protect the (unspecified) rights of those involved without any countervailing statement about children's welfare.

This leaves the interests of children peculiarly unrecognised and unprotected in the New Zealand ART context.

The Responsibility of the State and Health Professionals

It is sometimes argued that the state should have no particular involvement in ART arrangements, and that no requirements should be made of assisted conception that do not apply to normal conceptions. However, it is generally accepted that the state must take responsibility for the welfare of children who might be born through ART, as it does for children who are to be adopted, where the state sets criteria for and assesses the suitability of parents. While the state and its agencies do not lightly interfere in what families do, they have an over-arching responsibility for children's welfare.

Whereas in normal human sexual relations no one but the man and woman are responsible for the creation of the child, ART requires the assistance of health professionals. This places a responsibility on those governing medical practice, and possibly funding it, to ensure that the outcome is in the best interests of the child created. It can be argued that ART offers a unique opportunity to protect the interests of the children involved.

The Rights and Interests of Children in ART

The rights and interests of children in ART fall into two categories: those of children born through ART, and those of children not yet conceived.

Rights of children born through ART

In the absence of any statement of the rights of the child in ART, international conventions on children's rights offer some guidance. These require signatory states to actively ensure the wellbeing of children. The Convention on the Rights of the Child, which New Zealand adopted in 1989, reinforces the importance of original relationships. It specifically discusses the need in adoption to protect the child's ethnic, religious, cultural and linguistic background and place the child wherever possible in the country of origin. The convention can be interpreted as giving the child rights in terms of knowledge of his or her identity and continuing relationships with his or her genetic/birth family. It explicitly states that the child should not become an object for sale or trade.

In the New Zealand context the need to protect genetic and birth relationships is further reinforced by the Treaty of Waitangi. Protecting and maintaining these links might be seen as providing the child born through ART with a complicated family background, but there are models for extended family networks within many cultures.

The right to a father

More problematic is the matter of whether a child born through ART has a 'right to a father'. Is it acceptable for the state to cooperate in the creation of children where no father will be entered on the birth certificate, and there is no intention for the father to be involved in the upbringing of the child or in the child's life?

This option is of course open to women who conceive through sexual intercourse, or who make private insemination arrangements. But where the insemination involves a clinic, there must be greater consideration of the issues involved, because the state has a responsibility for overseeing medical practice and the welfare of children. Where the birth certificate shows no legal father, and there is to be no involvement by any father, genetic or otherwise, in the child's upbringing, the state may be in breach of its international obligations by facilitating such arrangements.

At the very least, this situation calls for some examination of arrangements for the involvement of alternative 'father figures' in the child's life as required in the UK legislation (HFEA, 1995) and for mandatory openness about the identity of the donor father.

Rights and Best Interests of the Child not yet Conceived

The right not to exist

Is it sometimes in the child's best interests never to be conceived? Is it possible to have a right not to exist? This would involve either banning some forms of ART, or prohibiting access to treatment or to certain types of treatment in certain situations.

Some proponents argue that it is always better for a child to be born, no matter what the outcome, because it is better to exist than not to exist. This is similar to the 'right to life' argument put forward by opponents of abortion. Infertility societies have argued that

as virtually no restrictions are put on conceptions which occur through sexual intercourse, there should be no additional restrictions on conceptions occurring as a result of ART.

The generally accepted counter argument is that it is absurd to argue that every birth is so positive that it outweighs the possibility of harm. The point has been made that whereas prohibiting particular couples from reproducing through sexual intercourse would involve enormous interference with their liberties and bodies, prohibiting reproduction through ART in particular cases involves simply a denial of assistance and access (Shanner, 1995). In addition, as noted earlier, conceptions resulting from ART are intrinsically different from conceptions resulting from sexual intercourse, because they rely on the use of medical technology and often genetically unrelated gametes and embryos. As a result, additional obligations come into play.

The concept of the rights of a person not yet conceived is different from the concept of 'foetal rights', that is, the rights of a foetus after it has been conceived, but when it is not yet born. In general most Commonwealth jurisdictions do not give rights to the foetus. The approach taken has been that the foetus is part of the mother until born, and has no rights as a separate entity until then. There is no right to be born.

The concept of the rights of a child who has not been conceived is even more problematic. Rights attach to existing persons. It is possible to imagine future experiences which might give rise to an argument for a right of 'non-conception' or 'non-existence'. But such rights on behalf of a non-existent person could not have any legal status. There can be no right not to be conceived any more than there can a right to be conceived. So other ways must be found to address the dilemmas raised by ART.

It is possible to project the existence of potential future children and decide that their creation should not be allowed in particular circumstances. The state already does this by prohibiting certain types of sexual relationships, for example, incestuous relationships, and by allowing the sterilisation of non-competent children and adults in some circumstances.

Protecting the child's interests

Probably the most useful concept in such situations is that of protecting the child's interests. This is the central tenet of New Zealand family law yet it has not been integrated into ART practice.

Protecting the interests of the child in ART involves projecting into the future to see whether certain actions, if allowed, would result in harm to the child created in this way.

Preventing harm centres on two broad sets of issues:

1. Are the prospective parents or parent capable of providing an adequate environment and upbringing for the child?

This can be answered by reference to criteria such as those developed in the UK (HFEA, 1995).

2. What is the effect on children of being conceived through the use of medical technology within a market environment?

This is a much larger question than the first. It could give rise to legislation controlling ART which circumscribes the freedom of individuals.

The Perfect Child

The idea that the wellbeing of any resulting children is guaranteed by the fact of their being so wanted is often raised in defence of complete freedom of access to ART. But this overlooks the implications for the child of the fact that ART has the potential to change people's expectations of the child and profoundly alter the relationships formed through the process of conception, gestation and birth.

There is already a general social trend to expect that medical intervention can consistently deliver a perfect child (for example, through increased surveillance of pregnancies for foetal imperfections). ART pregnancies are even more likely than others to be subjected to a battery of prenatal tests. Where donated gametes and embryos are involved, these are often 'screened' for defects before use. Selective reduction is another aspect of 'product control' in ART.

The degree of choice parents have about what kind of child they get is also exaggerated by ART. ART clinics are already offering prospective parents a choice of features – physical, mental and emotional – through the choice of donor egg, sperm, embryo or surrogate. New Zealand clinics are considering offering the choice of the child's sex. This level of choice introduces the idea of a 'designer baby', who is exactly what parents have ordered.

In this respect, ART involves a new type of positive eugenics. Where parents are offered so much control over the attributes of the child, there is the risk of rejection if the child is 'defective' in some way. The fact that money is always involved means that the child who is being 'bought' becomes a 'product' or a 'commodity'. The gamete or embryo is given so little status in ART that genetic siblings are commonly split up. A medical journal recently reported that eight embryos from one couple resulted in eight children born at different times to three different sets of parents (Marcus et al, 1996).

If gametes, embryos or the services of a surrogate are provided as part of the purchase of infertility treatment, this amounts to a trade in children. The child arrives as a result of commercial contracts with other parties, rather than as the result of a relationship between the human beings who will be responsible for the child.

In New Zealand, gametes and embryos are regarded as 'gifts'. This also applies to the services of a surrogate, if she is not paid a fee, but only 'expenses'. But this too is problematic. There is an argument that a child or the means of producing a child should never be regarded as a 'gift', that is, an object that can be given away, because this is simply another way of commodifying the child.

Taken together, these aspects risk imbuing the child born through ART with the characteristics of a product, and the process of producing the child with the characteristics of a market exchange. This poses risks of harm to the child.

Setting Limits

No form of ART is currently illegal in New Zealand. It is possible that conception through some forms of ART would cause such trauma to the child that they should not be permitted. This is behind some countries' decisions to forbid the taking of ova from the bodies of dead women, or from aborted foetuses, and the practice of cloning humans.

Similar thinking has informed some countries' decisions to outlaw surrogacy, especially commercial surrogacy, on the grounds that it involves the commodification of children, and that this is not in their best interests.

Other forms of ART that could be banned as not in the best interests of the child include:

- births to postmenopausal women using donated ova;
- large, multiple pregnancies;
- multiple use of gametes from one donor;
- using donated embryos from one couple for a number of recipients;
- inter-racial gametes donation;
- inter-generational gametes donation;
- births to parents with severe disabilities.

The proposed Assisted Human Reproduction Bill outlaws cloning and animal/human hybrids, but other practices, such as the use of eggs from dead women or foetuses and those listed above are not included as prohibited practices.

A case can be made for prohibiting some forms of ART on the grounds that it is not in the child's interests to exist. If there is a strong likelihood that the child's welfare will be seriously jeopardised because an adequate upbringing cannot be provided, or if the manner of the child's conception deviates extremely from the norm, these could be grounds for prohibiting such conceptions. Alternatively, a legal process might be required to ensure that the potential child's interests are represented and adequately considered.

At the very least there should be some criteria and/or processes which override the strict application of the Human Rights Act.

The Assisted Human Reproduction Bill fails to grapple with this issue. Instead it reinforces adults' rights but is silent on the matter of the interests of the child. The drafting of more comprehensive legislation would provide a process of debate about what procedures should or should not be allowed and who can have access to them. This would provide the opportunity for the rights of the child and the interests of the child to be defined and receive statutory protection.

An extended version of this paper is contained in the publication *Protecting Our Future: The case for greater regulation of assisted reproductive technology*, edited by Sandra Coney and Anne Else, and available from Women's Health Health Action, PO Box 9947, Newmarket, Auckland at a cost of $20. Email mckayl@womens-health.org.nz

References

Human Fertilisation and Embryology Authority (HFEA) (1995). *Code of Practice* [UK].

Marcus S.F., Marcus N.K., Brinsden P.R. (1996). 'Astonishing fertility from a single oocyte recovery'. *Human Reproduction, 11*(10): pp. 2136-37

Ministerial Committee on Assisted Reproductive Technologies (MCART) (1994). *Assisted Human Reproduction: Navigating Our Future*. Tribunals Division, Department of Justice.

Officials Committee (1995). *Assisted Human Reproduction: A commentary on the report of the Ministerial Committee on Assisted Reproductive Technologies*. Department of Justice.

Shanner, L. (1995). 'The right to procreate: Where rights claims have gone wrong.' *McGill Law Journal*, 40: pp. 823-74

Cont'd from page 10

involved in surrogacy arrangements and any child. The Law Commission's discussion paper asks important questions about ensuring the legal status of children born of a surrogacy arrangement.

However, there are bigger questions. Who *is* responsible for making decisions about matters as momentous as surrogacy? Is what is involved really any more than ensuring the safe and agreed-to applications of technology which compensate for inadequacies in the functioning of a human body, comparable, for example, to kidney dialysis or organ transplant or the dispensing of a new drug? Should we dismiss the present mix of political monitoring and intervention, non-specific legislation, professional self-regulation, ethical review, and law making because it is 'confused', 'piecemeal', and often demand-driven and reactive? Should we view the current approach as enlightened, flexible and enabling, and justly advancing the wishes of individuals in a diverse and dynamic society? And what can we learn from these experiences of the last six years to apply to other situations where technological developments are outstripping foresight and the traditional means of ensuring scrutiny and, where appropriate, regulation and control?

References

Assisted Human Reproduction: Navigating Our Future Report of the Ministerial Committee on Assisted Reproductive Technologies. Wellington. Tribunals Division, 1994.

Code of Practice for Units Using In Vitro Fertilisation and Related Reproductive Technologies. Australia. The Fertility Society of Australia Reproductive Technology Accreditation Committee, 1992.

Coney, Sandra & Else, Anne, (Eds), (1999). *Protecting Our Future: The case for greater regulation of assisted reproductive technology*. Auckland. Women's Health Action Trust.

Department of Health (1992). *Draft National Standard for Ethics Committees*. Wellington. Department of Health.

Graham, Rt Hon Sir Douglas. *Current Medico-Legal Issues Speech Notes*. Auckland. Institute for International Research 7th Annual New Zealand Medico-Legal Conference, February 1999.

Law Commission (1999). *Preliminary Paper 38. Adoption Options for Reform: A discussion paper*. Wellington.

Ministry of Health. *Minutes of 10th Meeting of NECAHR 30 July 1997*. Wellington. Ministry of Health.

Ministry of Health (1995). *Non-Commercial Surrogacy by Means of In Vitro Fertilisation Report of the Interim National Ethics Committee on Assisted Reproductive Technology*. Wellington. Ministry of Health.

Royal Commission on New Reproductive Technologies, *Proceed with Care: Final report of the Royal Commission*. Canada. 1993.

Ministry of Health (1993). *Terms of Reference for the Interim National Ethics Committee on Assisted Reproductive Technology*. Wellington: Ministry of Health.