Welfare of the child assessments in assisted conception: A social constructionist perspective

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Assisted conception services in the UK have been subject to state regulation since 1991. One of the key, if controversial, requirements of the Human Fertilisation and Embryology Act forbids the provision of ‘treatment services’ to a woman ‘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’ (Section 13(5)). In practice, fertility clinics have found it difficult to operationalise this requirement and critics have complained that it has been used to discriminate against (mostly) women and (occasionally) heterosexual couples. In 2006, the UK statutory regulator, the Human Fertilisation and Embryology Authority (HFEA), revised its guidance to fertility clinics on undertaking Section 13(5) ‘welfare assessments’. The government has also indicated its intention to remove reference to a child’s need for a father as part of its proposed overhaul of the Act. This paper uses a social constructionist perspective to examine the revised requirements to take account of the welfare of the child and argues that welfare assessments should be underpinned by ‘respectful uncertainty’ and ‘healthy scepticism’.

Introduction

Following implementation of the Human Fertilisation and Embryology Act 1990, the UK became one of the first countries in the world to introduce a statutory regulatory framework for the provision of assisted conception services. The Act contains a specific obligation on fertility clinics (‘treatment centres’) that:

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 (Section 13(5)).

From its inception, clinics have found the child welfare requirement difficult to implement (for a fuller discussion see Blyth, 2006). In 1999 (a full eight years after the Act had been in operation), the British Fertility Society noted:

A definition of the meaning of ‘welfare of the child’ has not yet been agreed and in its absence, implementing the assessment is, in practice, the subject of confusion and debate while Tizzard (1999) lambasted ‘talk of child welfare [as] really a smokescreen for the more unpalatable reality of weeding out unfit parents’.

Meanwhile, researchers and advocates had found that Section 13(5) was being used by at least some clinics as a means of discriminating against women seeking

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assisted conception services, primarily on the grounds of their marital status, sexual orientation, and age; however, variable approaches towards the welfare of the child meant that women denied a service in one clinic might well find another clinic prepared to offer them treatment (Blyth, 1995; Deech, undated; Douglas, 1993; Saffron, 2004). Two comments worth noting here are, first, since studies undertaken before implementation of the Act had revealed similar findings, it seems that the Act did not significantly affect clinics' practices (Douglas, 1992; Douglas & Young, 1992; Steinberg, 1986). Second, the reluctance of (at least some) clinics to offer services to single women and lesbian couples (Saffron, 2004) was not very far removed from government aspirations. Although the government had not explicitly excluded from accessing assisted conception services women who were not in a heterosexual relationship, reference to the child’s ‘need for a father’ was designed to make it more difficult for them to do so (Blyth, 2006). Furthermore, during parliamentary debate, the then Lord Chancellor, Lord Mackay, articulated his expectation that clinics would engage in ‘counselling out’ women who did not have a male partner:

> With the child and welfare amendments we have just discussed there is a likelihood that through counselling and discussion with those responsible for treatment [women without a male partner] may be dissuaded from having children once they have fully considered the implications of the environment into which their child would be born or its future welfare (Mackay, 1990, p. 1098).

Over time, further potential contraindications to disqualify women on child welfare grounds have been identified. These include: ‘advanced’ maternal age; a life-threatening illness; a significant learning or physical disability; a serious mental health condition; alcohol or drug misuse, conviction for a sexual or violent crime, or child protection measures taken regarding an existing child or children (Brazier, 2004; Mumford, Corrigan, & Hull, 1998; Shakespeare, 2004). Donor Conception Network (2004), a support group for families that have used donor conception, donor-conceived people and donors, advocated for donor procedures to be restricted to people giving an advance undertaking that they would tell their child about his or her conception. In practice, the Human Fertilisation and Embryology Authority (HFEA) noted that people are ‘rarely turned down’ by clinics on welfare grounds; the main reasons for doing so were: medical (because the person requesting services had a serious health condition); psychiatric (mental illness or alcohol or drugs misuse) or social (a couple requesting services are not living together) (HFEA, 2005a, p. 9). However, although barriers for women without a male partner are diminishing, access to assisted conception services in the UK, particularly those funded by the NHS, is usually restricted to women within certain age limits who are in a stable monogamous heterosexual relationship (Kennedy, Kingsland, Rutherford, Hamilton, & Ledger, 2006).

During 2004 and 2005, the House of Commons Science and Technology Select Committee undertook an extensive review of the Act, during which it invited both written and oral evidence. This provided an opportunity for individuals and organisations to comment on Section 13(5). As might be expected, wide views were expressed. Some commentators considered that the existing child welfare requirements should be tightened, including those who considered that married heterosexual couples only should be permitted to access assisted conception services (All-Party Parliamentary Pro-life Group, 2004; Catholic Bishops’ Conference of England and Wales and the Linacre Centre for Healthcare Ethics, 2004). The
Minister of State for Public Health suggested that the child’s welfare should be ‘paramount’, a condition self-evidently lacking in the existing formulation (Johnson, 2005). Others, including representatives from the British Fertility Society (Kennedy, 2004) and the Royal College of Obstetricians and Gynaecologists (Templeton, 2004), considered the child welfare requirement to be redundant, although the British Medical Association (2004, p. 225) proposed a welfare assessment focusing on identifying ‘those few cases in which a future child is at clear risk of serious harm, rather than seeking to restrict treatment to couples who conform to some traditional notion of an “ideal” family set up’. The Science and Technology Select Committee itself advocated a radical proposition that would remove clinics’ responsibility to take into account any child welfare considerations before offering a service, but would merely require them to alert social services if they became concerned for the welfare of any child born as a result of the treatment they were providing (House of Commons Science and Technology Select Committee, 2005, p. 103).

Following completion of the Committee’s deliberations and publication of its report, the government undertook a further public consultation, and in 2006 issued a White Paper (Department of Health, 2006) indicating its intentions of revising the Act’s welfare of the child provision that would remove the ‘need for a father’ requirement.

In the meantime, the HFEA undertook a consultation exercise on the operationalisation of Section 13(5) (HFEA, 2005a, 2005b). Until then, the HFEA’s guidance to clinics on undertaking welfare assessments contained in its Code of Practice (HFEA, 1992, 1993, 1995, 1998, 2001, 2003) had remained virtually unchanged, drawing heavily on the government’s emphasis on parenting competence and the suitability of those seeking assisted conception services.

Revised child welfare requirements

At the completion of its review, the HFEA revised its Code of Practice, taking effect from 1 January 2006, removing ‘vague and subjective social questions’ and implementing a ‘more focused interpretation’ of the Act’s welfare provision to provide a ‘reasonable, proportionate, fair and practical system’ for undertaking welfare of the child assessments (HFEA, 2005c). Such assessments should be predicated on a presumption to provide assisted conception services ‘unless there is evidence that the child to be born would face a risk of serious medical, physical or psychological harm’ (HFEA, 2005d).

The revised Code of Practice itemises as factors to take into account previous convictions relating to the harming of children, child protection measures in respect of existing children, and serious violence or family discord (HFEA, 2005c, 3.8(i)). It also refers to less specific aspects of the ‘patient’s …. circumstances’ which are ‘likely to lead to an inability to care for the child’ (HFEA, 2005c, 3.8(ii)) or are ‘likely to cause serious harm to the child’ (HFEA, 2005c, 3.8(iv)), and the ability of a woman who intended to raise her child without the support of a father to meet her child’s needs (HFEA, 2005c, 3.9).

A social constructionist approach encourages the critical interrogation of such provisions, rather than simply accepting these as uncontested ‘facts’ encapsulating the inherent nature of the people and groups they describe. It views them as assumptions founded on social and cultural values and expectations about
families, children and parents that are embedded in society and that serve particular interests.

After a brief account of the key theoretical tenets of social constructionism, we will look at motherhood, the family and childhood from this perspective and then comment on issues raised by the ‘risk factors’ contained in the revised *Code of Practice*.

**Social constructionism: Motherhood, childhood and the family**

Social constructionism, as a theory of knowledge and how we acquire it, challenges the social sciences’ understanding of the relationship between the nature of the social world and our knowledge of it. The rise of social constructionist theory within the social sciences has been grounded in a concern with the power relations and political effects of the knowledge that they produce. It involves a radical questioning of positivist social science; a foundational premise is the claim that knowledge and ‘truth’ are not fixed, but are culturally and historically local and produced within communities which share symbolic and communicative resources, especially language. What can legitimately be claimed as knowledge is said to be culturally and historically variable, and is thought to be grounded in local values and common-sense assumptions. ‘Reality’ can therefore be seen to be constructed, local and depends upon shared assumptions. Knowledge, including both ‘common sense’ and (in the present context) social science, becomes the product of the discursive practices of linguistic communities such as institutions, societies and cultures (Burr, 2003; Gergen, 1985).

Rather than constituting ‘natural’, biologically defined events, phenomena such as motherhood and childlessness are socially constructed and depend upon culturally shared understandings. Furthermore, knowledge is neither value-free nor objective (Henriques, Hollway, Urwin, Venn & Walkerdine, 1984). Socially constructed knowledge reflects the dominant values and opinions of a particular culture at a particular time and discursive practices represent political interests (Weedon, 1987; Taylor, 1989 cited in Stainton Rogers & Stainton Rogers, 1999). Foucault (1979) pointed to the power relations implicit in the knowledge that we create. It is no accident that what counts as ‘knowledge’ or ‘truth’ in a society often serves the interests of relatively powerful groups; reciprocally, those who are in positions of power; for example, the state and health care professions, are more able to define what counts as knowledge and truth. Dominant ideologies sustain social practices that may be oppressive and marginalising, revealing a need to radically question these.

Social constructionism thus requires that all knowledge and all practice must be subjected to critical doubt, including current professional wisdom or government policy, no matter how well-intentioned (for example, in assisted conception, for the welfare of the resulting child). Such reflective practice acknowledges that no group has a monopoly on truth or the right to determine what is valued, and recognises that comfortable resolutions between competing interests may be impossible. It also acknowledges the deployment of power, especially through institutional and bureaucratic means, including both professional expertise and academic knowledge (Stainton Rogers, 1989).

With respect to assisted conception, the taken-for-granted assumptions, local knowledge and associated practices that we most need to interrogate are those surrounding the family, women and motherhood. Assessments conducted by IVF
clinics of course encompass prospective fathers as well as mothers. However, it may
be argued that longstanding societal assumptions about the importance of mothers
for children's well-being and the view that motherhood is central to the identity of
healthy women (Phoenix, Woollett, & Lloyd, 1991; Rowland, 1992; Ulrich and
Wetherall, 2000) bring prospective mothers under particular scrutiny. The dominant
discourses constructing these phenomena are inevitably infused with values, political
and religious interests and power relations which have far-reaching implications for
practice, for example in screening and assessment of potential parents. Foucault
(1979) reconstrues the work of the 'helping' professions as a form of social control;
through the process of 'normalisation' individuals are compared and differentiated
according to a desired social norm, and this is part of what Foucault termed
'disciplinary power'.

Gergen, Gloger-Tippelt and Berkowitz (1990) present evidence for historical
shifts in the conception of motherhood and argue that this is socially constructed
and culture-bound. In contemporary western societies the prevailing social
constructions of motherhood constitute a powerful ideology. Motherhood is
regarded as the natural, desired and ultimate goal of all 'normal' women
(Mauthner, 2002; Stanworth, 1994); it is assumed that all women need to be
mothers, all mothers need their children, and all children need their mothers (Oakley,
1974). Although today this 'compulsory motherhood' (Pogrebin, 1983; Rowland,
1992) may be weakening as more women remain in the labour force, postpone
marriage, choose not to marry, or elect to remain childless (Coltrane, 1998), the role
of 'mother' is nevertheless confined to a narrow ideal: preferably one who is married
(and therefore assumed to be heterosexual), the 'right' age, white, middle class and
healthy. Women are compared to this ideal, to which they may or may not conform
(Cahill, 2005; Carabine, 1996; McCormack, 2005). For women on the margins of
'acceptable femininity' (such as lesbians, women with disabilities or of low socio-
economic status), exclusionary discourses are deployed, rendering motherhood less
appropriate (Baker, 2004; Tasker & Golombok, 1997), as a means of determining
eligibility for, or access to, limited welfare resources.

Such constructions can be seen to support political and religious ideologies about
the family and have themselves been shored up by notions of good mothering within
argues that developmental psychology has contributed to discourses surrounding
motherhood. To the extent that developmental psychology has influenced or has
been consistent with the views and practices of politicians and health care
professionals, we may see how constructions of knowledge articulate with
established power relations and become legitimated; the ideology of motherhood,
to which psychology has contributed, is confining and does not reflect the reality of
many mothers' lives (Choi, Henshaw, Baker, & Tree, 2005; Woollett & Marshall,
2000). Current social constructions of 'normal' motherhood fail to recognise
structural differences between mothers, such as class, and difference is seen as
pathological or deviant (Phoenix & Woollett, 1991). Furthermore, the developing
child as a cultural construction has been discussed by Gergen et al. (1990) and by
Aries (1962) in his account of the historical changes in conceptions of childhood, and
Hoffman (2003) argues that our unspoken assumptions about the nature of the child
vary cross culturally and are a powerful influence on practice and policy.
Developmental psychology has had a significant input to popular ideas about the
nature of and needs of the child, ideas which may bolster conservative views of the family and locate women and mothers as largely responsible for children’s welfare. However, Burman (1997) argues that development is not a natural, universal process; such thinking serves to render as ‘natural’ the child-rearing practices and abilities of dominant groups. It renders problematic those children who lie outside of prescribed norms, drawing attention away from the social conditions and power inequalities that contribute to their difficulties. Woodhead (1999) claims that ‘developmental psychology has traditionally projected a standardised image of childhood’. Culturally specific features of children have been assumed to be universal and taken as a prescription for ‘normality’, marginalising children whose development does not match this ideal. And Wong (2004) argues that the model of childhood as a developmental process has infiltrated the practices and policies of healthcare providers, social workers and educators, with sometimes negative consequences. Bowlby’s work (e.g. Bowlby, 1946) on maternal deprivation has been highly influential, although often mis-represented, bolstering the view that children of working mothers are deprived and that children need mothers (rather than other carers). Such ideas have been subjected to criticism (Rutter, 1972; Stacey, 1980). Reviewing the empirical evidence, Rutter (1972) argues that mothers are not necessarily any more important than other carers to whom the child becomes attached; he further argues that the psychological damage noted by Bowlby is more accurately seen as caused by a lack of care or a distortion of the caring relationship (whether with the mother or other carer) rather than deprivation per se. Just as we may see ‘the child’ as a social construct, the concept of ‘the family’ must be recognised as being socially constructed; what counts as a ‘family’ can be expected to vary with changes in social, economic, political, cultural, and personal conditions (Coltrane, 1998). However, research by van den Akker (2001) suggests that the concept of the family as a man, woman and biological offspring is still very dominant. Burman (1997) draws attention to the way that psychology, especially developmental psychology, is implicated in reproducing normative conceptions of the family that need to be challenged. Such conceptions include assumptions that lesbian and gay people cannot be adequate parents, or that all children need a father. These conceptions are undoubtedly also political, and have been successfully challenged (for example, Bigner & Bozett, 1989; Bigner & Jacobsen, 1989; MacCallum & Golombok, 2004; Patterson, 1992).

Phoenix and Woollett (1991) point out that the normative concept of ‘family’ drives welfare policy and has given rise to arguments that children should be raised in ‘real’ families (i.e. by heterosexual couples) (as appears—until recently—to have dominated UK legislators’ thinking in deliberations concerning the Human Fertilisation and Embryology Act), and debates about the age beyond which women should not give birth. Reproductive technologies allow the possibility of unconventional family structures (for example, same-sex parents and conception by post-menopausal women), and this has of course been used as an argument against their use. However, Pujol (1999) argues that they can also allow us to reproduce and endorse the mythical ‘mum, dad and two kids’ model of the family. Pujol (1999) and Leonard (2003) argue that reproductive technologies are in fact designed and implemented in ways that reinforce the cultural value placed upon having a biologically related child and support traditional notions of the nuclear family.
Assessment: A social constructionist approach

Traditionally, assessment is perceived as an activity performed by a professional and to which a service user/patient/client is subjected; the professional, ‘informed’ by a particular set of assumptions that make knowledge possible, ‘ferrets out facts’ and makes judgements. The professional’s expertise and superior competence are privileged in comparison with the experiential knowledge of the service user/patient/client (Iversen, Gergen, & Fairbanks, 2005). Although not all professionals would necessarily prescribe to this view, and some (for example systemic practitioners) may work within a social constructionist perspective, it remains the dominant model.

Within this context, the screening and assessment of those who apply for assisted conception services is inevitably informed by prevailing, dominant constructions of the family, motherhood and the child. Dill (2001) argues that the use of social criteria is necessarily subjective, and that value judgements can be made based on ‘old-fashioned prejudices masquerading as new ethical dilemmas’. As we have indicated above, people may be denied access to assisted conception for widely different reasons.

A social constructionist approach to assessment, which perceives assessment as an instrument that ‘makes’ rather than simply ‘finds’, demands the application of a radical scepticism to the knowledge, values and political interests informing assessment criteria. The ‘welfare of the child’ as a consideration in assisted conception is one that may be regarded as inherently discriminatory, since such considerations are not applied to fertile individuals who wish to create a child. Although social constructionism would not necessarily have any further comment to make on this question, it does, however, remind us that the concept of ‘welfare’ must itself be a social construction and therefore requires critical interrogation in the same way as the concepts of ‘family’, ‘motherhood’, etc.

The ‘risk factors’ itemised in the revised Code of Practice (HFEA, 2005c) at 3.8(ii), (iv) and 3.9 leave unchallenged or endorse prevailing social constructions of motherhood and the family and may result in the exclusion from assisted conception services, without sufficiently good reason, of those who do not reflect dominant cultural norms. Thus, ambiguities remain, despite the HFEA’s intentions to remove ‘vague and subjective social questions’. We recognise here that the HFEA, as a statutory regulator, has an obligation to consider the statutory requirement regarding the welfare of the child in its entirety, and that any substantive reform requires legislative revision. 3.8(ii) seeks to exclude on the basis of ‘any aspect of the patient’s past or current circumstances which is likely to lead to an inability to care for the child’, including physical or mental conditions, alcohol and drug abuse; and 3.8(iv) takes this further with ‘any other aspects of the patient’s circumstances which treatment centres consider to be likely to cause serious harm to the child to be born or any existing child of the family’. Thus opportunities remain available to those who continue to see non-heterosexuals and other people whose lifestyle may not fit conventional social norms as unable properly to care for a child or as potentially harmful to a child. As argued above, prevailing social constructions of motherhood and the family may exclude those of alternative sexualities as well as problematising those who are working class, have poor health or are simply considered ‘too old’. In addition, constructions of masculinity and femininity mean that alcohol and drug use, like crime, are seen as less acceptable in women. Since constructions of
femininity and motherhood are intimately related, women who drink or use other
drugs for recreational purposes are likely to be seen as unfit for motherhood and as
failed women. With regard to 3.9, this guidance clearly endorses the view not only
that children need two parents but that one of these ought to be male (interestingly,
the legislation does not even seem to consider the possibility that a child may not in
effect have a ‘mother’ and may be cared for by one or more males- as has occurred,
albeit apparently infrequently). The specific reference to fathers reproduces rather
than challenges the prevailing social construction of ‘parents’ as a heterosexual
couple, each person providing vital but different and complementary attributes. It
reproduces rather than challenges prevailing assumptions about gender differences in
personality and ability and invokes a mythical image of family life out of step with
the diversity of successful family forms in the UK today.

A social constructionist approach to assessment offers a way forward. It
recognises, as Lord Laming observed in his review of the role of the health and social
services in the life of Victoria Climbie, that assessment needs to be underpinned by
‘respectful uncertainty’ and ‘healthy scepticism’ (Laming Report, 2003, p. 205). It
also means moving away from the ‘doing to’ approach to assessment to engaging in a
more empowering model in which ‘the client is thus not assessed in an essentialist
fashion, but is assisted collaboratively and dynamically’ (Iversen et al., 2005, p. 699).
The usual power imbalance between clients and service providers creates an
environment where social control can readily be packaged as ‘helping’, an argument
that Foucault (1973, 1979) and others (e.g. Rose, 1985) have been keen to make.
Nevertheless, in some therapeutic fields where practitioners have taken on board
social constructionist arguments, attempts have been made to redress this power
imbalance; practitioners attend to the needs of ‘service users’ rather than ‘treat
patients’. For example, in the UK psychiatrists working within the Hearing Voices
Network (available at http://www.hearing-voices.org/) provide help and support for
people who ‘hear voices’ without pathologising them through medicalised
discourses.

We suggest that a similar redistribution of power and questioning of ideological
discourses could be applied to assessment within assisted conception units. The
concept of ‘multidisciplinary assessment’ (HFEA, 2003, 3.21–3.24) provides the
context in which a social constructionist approach could impact on practice in UK
licensed treatment centres. First, it suggests engaging in a much greater level of
dialogue between service providers and those seeking fertility services than in
traditional assessment. Second, clinic teams should strive to develop a mutually
supportive and collaborative environment which facilitates genuine discussion of
different member’s views, ensuring that taken-for-granted assumptions are routinely
exposed to interrogation.

Notes
1. ‘Treatment services’ for the purposes of the Human Fertilisation and Embryology Act
   include all procedures that involve the fertilisation of human eggs outside the human body
   and/or the storage of egg, sperm or embryos.
2. DC Network subsequently acknowledged that, in practice, such a requirement could not be
   enforced and that parents should be encouraged to tell their children (Merricks, 2004).
References


Human Fertilisation and Embryology Act 1990 (Chapter 37).


