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Children of Choice: A Doctor's Perspective

Howard W Jones, Jr.*

The introduction of in vitro fertilization (IVF) into North America in the early 1980s brought unanticipated and vigorous opposition from orthodox moral theologians of several traditions and from right-to-life groups, who erroneously equated IVF with abortion. If IVF proponents, including myself, had known of John Robertson and his advocacy of the constitutional concept of procreative liberty at the time, we would have found considerable protection behind the constitutional shield of procreative liberty. As simple IVF has grown to include donor sperm, donor eggs, cryopreservation, a variety of microtechniques, and other permutations and combinations known as Assisted Reproductive Technology (ART), procreative liberty and John Robertson have become staunch allies of these technologies. Procreative liberty has indeed shielded these procedures and may even shield some procedures that do not yet exist. Therefore, the medical practitioner can find comfort in giving presumptive priority to procreative liberty when seeking to resolve the legal issues surrounding new reproductive technologies.

I. Various Perceptions of Procreation

Nonetheless, in the consulting and examining rooms, the fact that procreative liberty may have presumptive priority from a legal perspective is but one consideration that the physician must examine when attempting to resolve the patient's dilemma. As this Article will show, many considerations other than legal ones impinge on reproductive problems and options, such as contraception, elective termination of pregnancy, the pathological condition of repeated miscarriage, and problems with menopause. To sharpen the focus of this discussion, however, I will limit my study to those patients who suffer from infertility

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What indeed is procreative liberty as it exists between the doctor and patient?

To establish what procreative liberty means in a particular situation, it often helps to ask infertility patients an important preliminary question: "Why do you want a baby?" In my twenty or more years of asking this question, I have elicited a variety of responses.

- Sometimes I get an astonished stare, which conveys the message that the questioner must be slightly daft, to say the least. Other times, there is an expressionless silence for a prolonged period of time.

Couples in these categories probably have not thought about this preliminary question specifically and, as events unfold, seem to represent those who think that children follow marriage like night follows day. Medical follow-through in this group is problematic and spotty. Some of these couples are from the religious right and are comfortable in explaining reproductive vagaries in terms of "the Will of God." I remember one couple who consulted me after ten years of infertility, and then only on the urging of a friend who had been successfully treated at my clinic. The patient was a schoolteacher, and her husband was a lawyer — both highly educated individuals. Although they missed a few appointments along the way, they did finally complete the work-up, which revealed a condition likely amenable to IVF. This therapy was too much for their convictions, however, and they disappeared, hopefully better prepared to accept childlessness as a result of being confronted by the preliminary question.

- "From childhood, as I played with dolls, I fantasized and anticipated marriage and motherhood. Not to have a baby shatters my childhood dreams." This response calls for a second question: "And what does your husband think of all this?" The answer is usually reassuring, but it sometimes gives the impression that the sought-for baby is really a replacement for the childhood doll. How important is it in this situation for the physician to initiate a discussion on the seriousness of childbearing and the responsibilities, as well as the joys and rewards of parenting?

Edgar Guest, a populist poet of the early twentieth century, put it this way:

"How much do babies cost?" said he
 The other night upon my knee;
 And then I said: "They cost a lot;
 A lot of watching by a cot,
 A lot of sleepless hours and care,
 A lot of heart-ache and despair,

A lot of fear and trying dread,
 And sometimes many tears are shed
 In payment for our babies small,
 But every one is worth it all."¹

- "To tell you the truth, my husband and I have been having a problem — we have even seen a marriage counselor. I think a baby would help." Sometimes it turns out that the husband is unaware that the wife is seeking help. The physician, of necessity, automatically and instantly becomes a marriage counselor, however reluctantly. Is reproduction an individual choice in this circumstance?

Childbearing is only the first event in the life-long process of parenting. A conscientious doctor might be expected to consider the rearing environment. Indeed, the Code of Practice of the Human Fertilization and Embryology Authority, the British governmental agency that oversees ART, requires the assisting physician to consider the welfare of the potential child, including the presence of a father. There are studies that seem to indicate that childbearing, particularly if multiple children are involved, is a strain on the marital relationship. It may even be the final event that ruptures the tie that binds.

- "My slowness in becoming pregnant has not seemed so important until recently. It turns out now that all of our friends have little ones. We feel isolated — we are social outcasts among our circle of longtime friends." Such an answer raises the suspicion that procreation for this couple is not for childbearing or rearing a child, per se, but rather to achieve parental social acceptability. Once again, the physician must open a discussion regarding the welfare of the potential child.

- Not infrequently, the question brings tears and no immediate verbal reply. This response often comes from those who harbor guilt. For one reason or another, some patients believe that some past act on their part is responsible for their present predicament. Often this is true, but not always. For this group, procreation is very important because one of its purposes is to help the couple live with themselves. If necessary, they will use almost any facet of ART.

- "I like children, I am a pediatric nurse, kindergarten teacher, or pediatric social worker, etc. and find myself lonely without children of my

1. EDGAR A. GUEST, *What a Baby Costs*, in COLLECTED VERSE OF EDGAR A. GUEST 5 (1934).

own." A gung-ho answer. The physician can expect great cooperation from this patient, and hopefully from her husband, although it should be noted that in her reply, she used the singular personal pronoun. The infertility specialist likes to hear "WE."

- "I have a new husband who has no children, and I am anxious to have a child for him." This answer obviously comes from a second- (or third-) time married mother who typically is older, sometimes by several years, than her latest husband.

This is an increasingly frequent response as a result of the contemporary acceptability of sequential partners. This couple will surely be cooperative during the "honeymoon" phase of the new marriage. But they nevertheless face the troubling influence of the female partner's advanced reproductive age. As the unavoidable tests become more and more intrusive, the female partner reveals, often inadvertently, by a missed appointment or by a conflicting obligation preventing an appointment, that she might be just as happy if pregnancy does not occur. After all, she does have children, and the suspicion is enhanced that the infertility work-up is only to please her husband. This is, of course, quite laudable, but she nevertheless conveys an unexpressed hope that the investigation will not be successful.

- "My husband and I have a very happy marriage, but have been distressed that we have not had a child. I think we will make ideal parents. We hope the problem can be solved."

If there is a best answer, this is certainly the one. Notice that it is expressed in terms of "we" rather than "I." It is expressed in terms of the long-range opportunity to parent, as well as to have a child. Fortunately, this answer, in one or another form, is the one most frequently heard as an answer to the first question.

Childbearing is only the first step to a life-long commitment. Perhaps society would be better if not only the infertile, but the fertile as well, asked themselves prior to attempting to get pregnant — "Why do we want a baby?"

The preliminary question helps orient the physician to the patient's concept of procreation, but there are other clinical situations that speak to the meaning of procreating for some patients. For example, the situation in which the husband is sperm-deficient, and the wife requests surreptitious donor insemination, or the situation in which the clinician discovers motile sperm in the cervix of the woman whose husband has no sperm.

I believe that a physician should expose the patient to the notion that human procreation is purposeful, not only a matter of becoming preg-

nant — a child should be a child of choice, and child rearing is implicit in that choice. I will discuss later the importance of family in child rearing, but it can be mentioned that, from an evolutionary point-of-view, the higher in the evolutionary scale, the longer the time required to prepare the offspring to be on its own, that is, prepared to "join the herd." The anthropological evidence is intriguing and persuasive that family formation is important. Therefore, to the physician, procreation must be legal, but the doctor must also give consideration to other factors, including the welfare of any offspring.

If the shifting of a presumed priority from an individual to a shared biological interest involving a couple and potential child has any merit, it excludes procreation as defined from the unpaired individual and raises serious doubts about procreation by individuals of the same sex.

II. Procreative Liberty — A Shared Interest

John Robertson recognizes procreative liberty in the context of the couple, but clearly states that it is *first* and *foremost* an *individual interest*.² I must point out, as a clinician, that an interventional interest in procreative liberty can function only if it coincides with the individual interest of a heterosexual partner. The clinician must deal with two individual interests, neither of which can have presumptive priority, especially as to some technology and to some clinical circumstances. This view does not exclude the use of donors, however, the use of donors requires meticulous attention to the details involved in each individual interest.

This shared interest is based on the simple biological fact that to start the procreative process, the part typically referred to as insemination, a female gamete from one individual is required, and a male gamete from another individual is required. However, procreation involves more than merely insemination. In my view, procreation also involves rearing the potential child. If the parents fail to rear the child, then procreation has not been fulfilled. Reference has been made to the anthropological evidence. In the barnyard or on the range, insemination takes place only when the female is in heat — when she gives an external sign indicating that she is ovulating. She will not accept the male at any other time. Any resulting offspring requires minimal attention and promptly joins the herd, probably not identifying its father.

2. JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 24 (1994).

In humans, the external sign of ovulation has been lost, and insemination is necessary throughout the menstrual cycle to assure insemination at the time of ovulation. Modern science has identified the time of ovulation, but until the twentieth century, the necessity for, or the time of, ovulation in the human were unknown. Furthermore, human offspring require care for a prolonged period of time measured in years before they can join the human herd on anything like equal terms. The family serves this purpose. Thus, the concept that procreation not only involves the germ cells from two people, but also rearing, is rooted in the biological and sociological aspects of reproduction and human interaction.

. III. *Legislation and Reproduction*

From the point-of-view of the clinician, what should be the role of legislation in human reproduction, especially when reproduction involves the use of ART? I do not believe that projected biological events are a productive topic for serious biolegal discussion. Discussions of these tentative situations make delightful cocktail conversation, but often lead one down the primrose path. The biologically uninformed often cannot distinguish fact from fiction. For example, it is impossible at the present time to inject DNA from a dead mammal or other creature into an egg and, thereby, clone the dead creature. Indeed, the biological facts are that this cannot be done with DNA at all in any circumstance — DNA packaged in chromosomes must be obtained from very early pre-embryos for cloning to occur in any sense. Jurassic Park is intriguing, but it is still fiction. Thus, contemplating legislation requires a thorough and unambiguous biological understanding of the problem that the proposed legislation seeks to remedy.

It is clear that "housekeeping" type problems can benefit from legislation. These include such things as recognizing rearing parents as the legal parents of children born from the use of donor gametes, and excluding the donor from rights or obligations. Many states have laws regarding male donors, and a few states have now included female donors. Some effort to achieve uniformity among the states would seem to be a worthy goal.

Some people may think it inappropriate, for a variety of reasons, to use extraconjugal gametes. They, of course, are not required to do so. The "housekeeping" legislation referred to above legalizes the use of extraconjugal gametes for procreation by identifying the legal parents, specifying rights, and limiting liability. There are many states without laws, however, and it is therefore reassuring for those who operate in such states that legal

scholars like John Robertson regard the use of extraconjugal gametes as falling under the umbrella of the constitutional right to privacy

Cryopreservation has the potential to create additional litigation, especially over the proper disposition of unused or unwanted cryopreserved material. These difficulties have arisen because of a failure to have a clear agreement between the parties as to an alternative disposition of the cryopreserved material in the event it is not required or used for procreation by the initiating couple. Specifically, some of the problems may be as follows:

1. Death or disability of one or both prospective parents.
2. Legal separation of the prospective parents.
3. Divorce of the prospective parents.
4. The cryopreserved material remains in storage beyond the reproductive limit of the prospective mother, or beyond some other agreed-upon time limit.
5. Loss of contact with the prospective parents, resulting from failure to pay current or delinquent cryopreservations and charges, and other unpredictable reasons.
6. Loss of interest by the prospective parents in attempting a pregnancy
7. Wish of one prospective parent to remove the cryopreserved material from the original program.
8. Wish of both prospective parents to remove the cryopreserved material from the original program.
9. Voluntary or involuntary discontinuation of a cryopreserved program by a program of assisted reproduction.³

In an effort to circumvent these problems, the Norfolk IVF program requires candidates for cryopreservation to sign an agreement in which they designate the ultimate disposition of the cryopreserved material in the event some of the circumstances mentioned above occur.⁴

This agreement has not been tested in court, but there do not seem to have been any problems to date. In view of the current apparent absence of problems regarding cryopreserved material, it seems doubtful that legislation covering these problems should be pursued at this time. However, it needs

3. See Howard W Jones, Jr., *Cryopreservation and Its Problems*, 53 FERTILITY & STERILITY 780, 780 (1990).

4. See Howard W Jones, Jr. et al., *A Step Toward Solving Some of the Problems of Cryopreservation*, 57 FERTILITY & STERILITY 278, 279-84 (1992).

to be noted that there is probably a very large number of cryopreserved pre-embryos in storage at this time and that it is unlikely that all will be used for the intended purpose of the originators. Many of these pre-embryos are probably not covered by agreements such as the one referred to above.

IV *The Legal Definition of Personhood*

The time during development when the conceptus acquires personhood has been debated without consensus for centuries. The U.S. courts have faced this issue in one way or another in mid- and late development, most notably in *Roe v Wade*.⁵ However, there seem to be only two cases in which this question became an issue during very early development, that is, during the pre-embryonic period (the first 14 days). In *Davis v Davis*,⁶ the trial judge applied the laws of custody, i.e., he regarded the concepti as persons. It is irrelevant to this discussion that his decision was later overturned. On the other hand, in *York v Jones*,⁷ the trial judge regarded the concepti as chattel. The physician-observer smiles as he notes the same biological phenomenon referred to as such different entities. It seems that, from a legal perspective, a conceptus must be either a person or a thing. I cannot help but wonder if the law should examine the proposition that the biological conceptus prior to the acquisition of personhood occupies a unique and previously unrecognized legal status that is neither chattel nor human. If there is any merit to this notion, it is a project for the academic legal community to explore. Justice Blackmun, in his opinion in *Roe v Wade*, traced the history of thought concerning the acquisition of personhood. That discussion might be a good starting point for this new project to begin.

5. 410 U.S. 113 (1973).

6. No. E-14496, 1989 WL 140495, at *1 (Tenn. Cir. Ct. Sept. 21, 1989), *rev'd*, 59 U.S.L.W. 2205 (Tenn. Ct. App. Sept. 13, 1990), *aff'd*, 842 S.W.2d 588 (Tenn. 1992), *cert. demed*, 113 S. Ct. 1259 (1993).

7. 717 F. Supp. 421 (E.D. Va. 1989).