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# article

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## After the 'need for ... a father': 'the welfare of the child' and 'supportive parenting' in assisted conception clinics in the UK

Ellie Lee, E.J.Lee@kent.ac.uk

Sally Sheldon, s.sheldon@kent.ac.uk

Jan Macvarish, j.macvarish@kent.ac.uk

University of Kent, UK

The law governing assisted conception in the United Kingdom (UK) (the Human Fertilisation and Embryology Act 1990) mandates through section 13(5) that clinicians make 'child welfare' assessments before proceeding with treatment. In the 1990 Act, section 13(5) stated that assessment should take into account 'the need ... for a father', but in section 13(5) of a revised Human Fertilisation and Embryology Act in 2008 the words 'a father' were replaced with 'supportive parenting' in order to signal official recognition of same-sex parents. This article challenges the idea that this might be seen as an unequivocally progressive development through reference to a growing body of scholarship that critically evaluates the attention that policy makers have come to pay to 'parenting'. It discusses the sociopolitical context that gave rise to section 13(5) and the pressures that led to its reform. Findings from an interview study with members of staff who work in assisted conception clinics in the UK are then discussed, focusing on staff's perceptions of the new policy, the meanings they ascribe to the term 'supportive parenting' and their opinions about the responsibility they are given under law for child welfare. The article concludes that professionals' understandings of their role resonate strongly with the wider realities of the oversight of parent-child relations considered characteristic of policies on parenting.

**key words** supportive parenting • assisted conception • child welfare • family values • morality

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### Introduction

The emergence of 'explicit' family policy over the past two decades, focused on influencing the ways that parents 'parent', has been noted and explored (Clarke, 2007; Furedi, 2008; Gillies, 2011; Rudoie, 2014). Critical engagement with this rise of 'parenting' has highlighted that policy has become more 'child centred' with children's 'needs', 'welfare' and 'rights' emphasised as requiring greater attention from policy makers. The position of the parent in relation to policy making has, it is argued,

changed as a result, as the individual parent has become the target of intervention to address perceived deficits or risks to the welfare of children, presented by what is termed ‘poor parenting’. Gillies (2011) has concluded, of the re-shaping of family policy as a result, that ‘governments have come to see families more in terms of their practices than structures, with “what families do” readily translating into a new ideology of family competence’. Family policy has moved away from a focus on ‘structure’ to instead lay claim to an interest in the everyday conduct of family life, in particular what parents do with their children and how they interact with them. Some emphasise the expansion and changing forms of policy-driven professional oversight over (particularly working-class) parents as they go about ‘parenting’ their children associated with this emphasis on ‘practices’ (Jensen, 2010; Wastell and White, 2012).

Hennum (2014: 441) has argued that while ‘child-centred’ policy of this kind can appear benign and progressive, the effect of the focus on ‘competence’ in relation to ‘the child’s needs’ is to position both children and their parents as ‘objects rather than subjects in their own lives’, requiring that they ‘live up to the standards of life defined for them by experts’. ‘The child’ is seen as less as a unique individual, than as a general child, with expert-identified, generically defined ‘needs’. In turn, ‘the parent’ is defined as a person who needs to gain ‘parenting skills’ or ‘competencies’, or risks failing to meet these ‘needs’. One outcome of this sort of policy, it is argued, is the opening up of the parent–child relationship in a way that reconfigures privacy (Lee, 2014). Gillies (2011) summarises the situation the following way:

Since the advent of the New Labour government in 1997 there has been a remarkably aggressive attempt to re-position a family life as a public rather than a private concern. Previous legislation and sensibilities which placed everyday personal and family life as largely outside the remit of state intervention have been explicitly challenged through a moral focus on children as the most important constituents of family life.

Many thousands of people become parents through assisted conception, and here too the term ‘parenting’ features in policy concerned with child welfare. Assisted conception services are regulated by law through the Human Fertilisation and Embryology (HFE) Act 1990 (which came into force in August 1991). In 2008, the HFE Act was reformed, and the term ‘parenting’ came to feature in it. Section 13(5) of the Act now reads:

A woman shall not be provided with [infertility] 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 supportive parenting*), and of any other child who may be affected by the birth. (Emphasis added)

The inclusion of the words ‘supportive parenting’, and the effects of this reform, are interesting matters to consider in the light of the wider assessment of policies on ‘parenting’ noted above. In the context of assisted conception, use of the term ‘supportive parenting’ may appear as a more ambiguous development than oppressive expansion of professional oversight of ‘parenting’ suggested by Gillies (2011). The version of the ‘child welfare’ clause that pertained up to 2008, as we discuss further below, required consideration of a child’s need for ‘a father’ (rather than ‘supportive

parenting'), signalling that clinics must consider very carefully the merits of treating single women or lesbian couples. Reform of section 13(5) resulted in part from arguments that the law should no longer encourage discrimination against these groups of (prospective) parents (or indeed any other would-be parents). As the Department of Health put it, the 1990 Act had been 'framed in terms of heterosexual couples' and should be changed better to 'recognise the wider range of people who seek and receive assisted reproduction services in the 21st century' (Hinsliff, 2004). The term 'supportive parenting' is in this way presented as a progressive measure to increase social equality, not as an effort to encourage scrutiny of 'parenting' competence.

Further, the guidance on interpreting the law given by the Human Fertilisation and Embryology Authority's (HFEA) Code of Practice (CoP)<sup>1</sup> suggests a definition of 'parenting' dissimilar to that characteristic of family policy more generally. The eighth edition of the CoP (published in 2009) emphasises the importance of clinics not discriminating against those seeking treatment because of their sexuality (and also on any other ground, for example disability). The CoP details what 'taking account' of 'child welfare' might mean in practice, and recommends that clinics should henceforth take a 'lighter touch' approach (Cranshaw, 2009; Lee et al, 2012). It states that prospective patients should be 'presumed' to be future 'supportive parents' and that clinics need only carry out further investigations where there is an indication of a need to follow up about a possible problem with providing treatment because of information provided by a prospective patient on the preliminary assessment form that they complete. (The CoP lists factors that may suggest that follow-up is needed as including: past or current circumstances that may lead to any child experiencing serious physical or psychological harm or neglect; past or current circumstances that are likely to lead to an inability to care throughout childhood for any child who may be born; mental or physical conditions; and drug or alcohol abuse; HFEA, 2009.)

This new regulatory framework thus appears to be more permissive than the previous one, and apparently utilises the term 'parenting' in a different way from other areas of family policy. Yet it is nevertheless still the case that section 13(5) in its present, as well as its past, form makes it illegal for *anyone* to be provided with treatment unless the clinic first carries out a 'welfare of the child' assessment. One study into the workings of the old section 13(5) argued that this approach has an inescapable consequence: 'This process forces providers of fertility services into making decisions as to who will make the 'better' parents by implication' (Savas and Treece, 1998: 246). Some who have written about the new section 13(5) contend that regardless of the 'lighter' touch of the assessment process and the wording of the latest CoP, this underlying presumption remains. Fenton et al (2010: 278) conclude, for example, that 'the retention of the welfare principle in its new form still means that clinicians are the gatekeepers: they, rather than women, still have the final say as to who has access to treatment'.

The study reported here is grounded in these apparent ambiguities in the use of the term 'parenting' as part of the regulation of assisted conception. It goes beyond the existing literature in providing the first, detailed empirical study of how the new section 13(5) is being interpreted and applied in practice. Here, we report findings from an interview study with members of staff (nurses, counsellors and embryologists as well as doctors) who work in 20 of the around 80 registered assisted conception clinics in the UK.<sup>2</sup> In the following section we expand on points made above about

section 13(5) and its context. We then move on to briefly outline the methodology we used for the study before discussing findings.

### 'Family values' and section 13(5) of the HFE Act

In vitro fertilisation (IVF) was developed in the 1970s, and 1978 saw the birth of the first baby whose conception was assisted using IVF. However, these developments in medicine occurred at a time when public debate in Britain included a powerful discourse highlighting the perceived moral decay of society and the loss of 'family values'. The 1980s has been considered a decade of 'moral panic' (Furedi, 1992); as political scientist Martin Durham (1991: 5) described it, 'in article after article' at this time, 'rising divorce rates, one-parent families, abortion, homosexuality, pornography – all have been cited as indices of a nation facing moral collapse' (1991:5). The furious debates that took place through the 1980s about assisted conception and embryo research can be usefully understood within this context, with three points worthy of emphasis.

First, opposition to assisted conception became a clear focus for 'family values' campaigners. Indeed, moral panics about what had become possible because of new medical techniques continued after the passing of the 1990 HFE Act, for example in the 'virgin birth' frenzy of 1991 (Barney, 2005). Second, these concerns about 'moral collapse' came to be expressed in law, through section 13(5) of the HFE Act. The committee charged with developing the basis for the HFE Act found in its final, highly influential report that it was morally wrong to create a child to be born into a non-traditional family:

[T]he interests of the child dictate that it should be born into a home where there is a loving, stable, heterosexual relationship and that, therefore, the deliberate creation of a child for a woman who is not a partner in such a relationship is morally wrong. (Warnock, 1984, para 2.11)

Third, this outcome was atypical. Durham's (1991) study of a range of 'moral' issues makes it clear that there was a general reluctance on the part of the government to commit to policies and laws about the family that would 'remoralise' society. Gillies (2014) suggests that this gap between the oftentimes fervent rhetorical moralism of the 1980s, set against actual policy change, can be explained by the Conservative Party government at this time viewing the family as 'off limits' for overt state intervention; while moralism may have appeared attractive to some politicians rhetorically, the propensity for this to translate generally into the government enacting a political programme based on moralised precepts was for this reason limited. In this respect, section 13(5) stands out as anomalous compared with the general trend in law and policy at the time (the other obvious exception being section 28 of the Local Government Act 1988; Durham 1991). It is arguable that the novelty of the medical technology, the fact that this technology was about the manipulation of the embryo, bringing with it the spectre of scientists 'playing God', combined with the wider sensibility of moral decline, meant that IVF became a lightning rod for moralistic concerns that could find actual expression in law.

Parliament came close to deciding that Warnock's (1984) moral imperative should mean an outright ban on doctors treating anyone other than married couples.

However, this ban was rejected in favour of the legal demand that those who provide treatment 'take account' of the 'welfare of the child' not yet born, as well as that of any child already born 'who may be affected by the treatment', and that this must include 'the need ... for a father'. The understanding on the part of some at least in 1990 was that in practice this *would* mean that clinicians would understand that they should exclude certain women from treatment, and that in particular the candidates for exclusion would be single women and lesbians. 'It would appear', explain Gurnham and Miola (2012: 30), 'that it [section 13(5)] not only implied but actually envisioned that treatment should in most (if not all) cases be provided to heterosexual couples, with all the consequences that flow for those outside this group'. However, even if it was believed by some in Parliament that section 13(5) would constitute a long-term bulwark against the treatment of single women and lesbians, this was not the eventual outcome. Rather, section 13(5) became the subject of continual debate through the 1990s (and led to eventual reform).

In 2008, furious debate accompanied the reform process and the removal of the words 'a father' from section 13(5) proved extremely contentious (McCandless and Sheldon, 2010). It is arguable, however, that section 13(5) was destined for reform, because of its atypical upholding of a particular form of family. In part, the demise of 'a father' was because of the level of tension that had come to exist, and was recognised to exist, between the law, on the one hand, and practice in assisted conception clinics, on the other. While studies indicated that section 13(5) was being used by some clinics to discriminate in the way some in Parliament had intended, others found to the contrary (Blyth et al, 2008). Changes outside the clinic also forced legal reform. The inconsistency between a law on assisted conception that upheld 'the father', on the one hand, and sex equality legislation and developments permitting same-sex couples to adopt, on the other, led policy makers to perceive a need to change the terms of the welfare clause (McCandless and Sheldon, 2010). Further, from the New Labour government onwards, the official position regarding family policy more generally came to be that there are 'families' that take a variety of forms, rather than one unitary 'family' (Macvarish, 2014).

Yet although 'the need for ... a father' came to be seen as problematic, section 13(5) *in toto* did not. Arguments were made during the reform process for the deletion of section 13(5) altogether. Echoing the arguments made by the legal scholar Jackson (2002), the House of Commons Science and Technology Select Committee advocated 'a radical position' that would 'remove the clinic's 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 treatment they were providing' (Blyth et al, 2008: 33). However, this approach to section 13(5) gained little traction; the debate 'proceeded on very constricted terms' (McCandless, 2013: 136), an outcome suggesting that, for policy makers in Parliament at least, two aspects of section 13(5) are non-negotiable.

The first is continuing to have the 'welfare principle' as part of the regulation of fertility treatment; as Fenton et al (2010: 277) note, during the passage of the Act 'there was little discussion about the welfare principle as a whole'. In this sense, the Warnock Committee's precept that the 'deliberate creation' of a child is a moral question requiring special regulatory attention continues to resonate, even where helping lesbians or single women to become parents is no longer perceived as immoral. Second, even though some medical bodies argued the case for the attenuation of medical discretion in welfare

assessments, Parliament took the view that clinicians must continue to take responsibility for decision making, under the guidance of the HFEA. According to Jackson (2001), the decision in 1990 to make clinicians responsible in law for ‘child welfare’ was significant because Parliament medicalised this responsibility: ‘moral’ decisions on access to treatment were made contingent on the exercise of medical discretion. The retention of section 13(5) suggests that politicians continue to consider this delegation of responsibility to doctors to be the best approach.

In the remainder of this article we consider how those who remain responsible for assessing child welfare pre-conception view the regulations as they now stand, and their work in implementing them. How do staff think about what it means to ‘take into account’ the ‘welfare of a child’ pre-conception? What do they take ‘supportive parenting’ to mean and how do they take the potential for it ‘into account’? What do they think of the responsibility they are given in law, as assessors of the future welfare of children who may be born to those looking to them to help them to become parents?

## Researching ‘welfare of the child’ assessments in the clinic

Studies into ‘welfare of the child’ assessments carried out from 1990 to 2008 influenced the approach we took in our research (see Lee et al, 2012, for a review of this work). One option was to use a postal questionnaire. However, a set of issues meant that we decided to carry out an interview study at a sample of clinics instead. The demands of ethics approval were one consideration. Previous studies were carried out when the National Health Service (NHS) requirements for ethical and Research and Development (R&D) approval were less extensive than was the case in 2011/12, when the data collection for our study took place. It was judged that gaining approval for all UK licensed clinics and attaining a good-enough response rate using questionnaires could prove very difficult given time and financial constraints. Additionally, we wanted to find out about staff perceptions about a process of change, not simply ascertain facts about clinic practice, so an interview study seemed more appropriate.

The HFE Act mandates that any clinic must have a named person, called the Person Responsible (PR), to whom the license to provide treatment is issued and who is then responsible for ensuring that the clinic acts legally (HFE Act 1990, section 17; HFEA, no date). We were clear that at each clinic we wanted to interview the PR, and if this was not possible an alternative person recommended by the clinic. We were encouraged early in the research process by members of the advisory group<sup>3</sup> for the study to also try to find out about the views of a variety of professionals working in clinics. Their point was that, in practice, although the PR is legally responsible, a variety of members of staff may have an input into discussions and decision making, including, for example, counsellors and embryologists.

We aimed to interview staff at 20 clinics, representing approximately one quarter of the 77 clinics licensed to carry out IVF treatment at the time. Through desk research and discussion with advisory group members, we considered which clinics to approach on the basis of:

- the size of the clinic;
- the range of services offered;
- the balance of NHS and private patients;



- the clinic's reputation regarding a liberal or a more restrictive approach to accepting patients for treatment;
- the location of the clinic.

We approached 44 clinics as a result, with an 'in principle' request that they consider participating in the study and 20 clinics were selected from those that agreed. Clinics were chosen in all regions of the UK, ranging in size from the smallest to the largest type of centre (determined by number of cycles of treatment carried out per year according to HFEA 2009 figures). Ethics approval was granted in May 2011 by the Oxfordshire Research Ethics Committee B and we also obtained consent from the R&D office of each NHS research site. We interviewed staff with different professional backgrounds at all clinics in the sample. Sixty-six interviews were conducted in total, including 18 nurses, 13 embryologists and 12 counsellors as well as doctors.

The interview schedule sought to take into account issues raised by previous studies. Our literature review indicated that prior to 2008 it had already become much less likely that clinics would refuse in advance to treat on child welfare grounds because of the sexuality or relationship status of prospective patients. Our first set of questions thus addressed 'the route to treatment', and we included questions that asked about which patients might be denied treatment by clinics as a result of their approach to the 'welfare of the child' assessment, and asked if this ever occurred in advance or if it happened as a result of the welfare assessment in the clinic. Our second group of questions then sought to find out about the 'welfare of the child' assessment in the clinic, and staffs' perceptions of the procedures involved. Our final set of questions asked about opinions on the old and new versions of section 13(5).

Qualitative data analysis software NVivo (version 9) was used to support the analysis of transcribed interview data. Data analysis was conducted in two stages. Stage one was an analysis of the responses to questions to give us factual and numerical information as far as was possible. For example, we wanted to generate a picture of how many patients were refused treatment on child welfare grounds. To generate this sort of information we restricted the analysis to the transcripts with the PR. Stage two of the analysis was a qualitative, thematic reading of responses in the whole set of interviews. Accounts of the findings overall have been published elsewhere (Lee et al, 2014; Sheldon et al, 2015). Here we focus on discussing what respondents had to say in response to the following questions:

- What have been the effects of removing the requirement to consider the 'need for ... a father'? (Coded as positive, negative, marginal/no effect)
- What does 'supportive parenting' (as used in the 2008 law) mean? (Coded as yes meaningful, not meaningful, ambivalent)
- Does the legal requirement to take into account the welfare of the child serve any ongoing useful purpose? (Coded as yes, no, ambivalent)



## The 'welfare of the child' and 'supportive parenting' in the clinic

### *Non-discrimination and the end of 'the need for ... a father'*

Among PRs, only one out of 20 respondents indicated that they perceived the effects of the removal of the words 'a father' from the law to be 'negative'. However, as the following extract indicates, this respondent was aware that their view was now unusual:

'When I came there [to work in an IVF clinic] first of all, I was not in the minority ... and then as time goes on ... younger people come in with different views and we began to be aware that there was a shift in the mentality of people ... many more people would be quite happy to treat same-sex couples and once you go beyond 50 per cent then it becomes quite difficult to say: "No. We won't do it".'

Seven PRs were 'positive' about the legal change and for 12 PRs, legal reform was 'marginal' or had 'no effect'. Across the interviews as a whole, the pattern was similar; very few were negative about the change to the law and staff overall were mostly keen to stress that they had no difficulties with the new legal requirements:

'Two lesbians, single women, I think we've moved away from that being a "welfare of the child" issue.' (Counsellor)

'Same-sex couples are very much just the norm nowadays. We also changed the paperwork so most of it says patient and partner or female and partner rather than saying female and male because it's quite embarrassing when you're trying to do the paperwork when you've got two ladies and, you know, you're sort of saying: "Could you ... could you sign for the male?" No!' (Nurse)

In so far as there was evidence of disquiet, respondents generally tended to make a distinction between their own sensibilities and how procedures operate. The following counsellor explained how they had come to self-police their language and modify their approach:

'I think for me personally it's made a big difference because I am quite cautious how I talk about that now. I think that I used to have ... law on my side that I could say: ... "What are your feelings about the role of men in your life? What do you think of male role models?" ... I personally feel I have to be much more cautious about that because I don't want to be seen as ... I have some agenda, some judgement, some personal feelings about that, so I have changed the way I work with them.' (Counsellor)

The general impression given, then, was of a strongly perceived need to 'not discriminate' and a sense that the provision of assisted conception has, over time, come to be characterised by this imperative. Indeed, many respondents were keen to emphasise that they worked in a way that was *ahead* of the law; that they had committed to 'non-discrimination' before the law required it, and their practices

had contributed to change. As we now discuss, however, this does not mean that 'the welfare of the child' ceases to function as a major influence over service provision.

### 'Supportive parenting'

At face value, there seemed to be diversity of opinion among the 20 PRs about whether 'supportive parenting' was 'meaningful': four answered 'no', 10 'yes' and six indicated ambivalence in their first response to this question. However, a closer look at their comments indicates an important similarity in the way most discussed 'supportive parenting'. The majority attempted to find a way to *give* the term meaning (rather than, for example, reject it and argue that it could have no possible meaning when there is not even a biological pregnancy, still less a baby). Comments thus projected forward, away from the reality of the present (infertile patients seeking medical help to conceive) into possible future parenthood. Respondents often used tentative and unsure language to sketch the meaning of 'supportive parenting', relying on phrases such as 'I suppose', 'probably' and 'I guess it would...'. However, there was no evidence of a rejection of the idea that it was possible or right to assess future 'parenting'.

This attention to the future pertained even where there were differences in emphasis. First, we found that this was the case where 'supportive parenting' was interpreted as legitimating 'non-conventional' families. One PR told us: "I think the need for a father is old-fashioned ... I don't think it fits with society anymore." However, this rejection meant that the focus now became, directly, 'the child' and how it would be 'looked after': "[I]t basically means: is that child going to be brought up in a way that is for the large part normal? You know, is the child going to be happy? Are they going to be well looked after? Are they going to be well cared for?"

Second, and in contrast, others placed more emphasis on 'supportive parenting' meaning that there was a continued need for discussion about 'male figures' and 'male role models'. While there was no suggestion that treatment would be denied, the following respondent emphasised that discussion should, for 'single women' and 'a same-sex couple', cover them being 'aware' about the role of men:

'Maybe [supportive parenting] is the right word because I don't know what other term there would be but it's the upbringing of the child, isn't it. And recognising that if ... if it's a single woman or a same-sex couple that ... that to give a child an all-round life experience and whatever else that they need to be aware of the role of men in society and relationships.'

However, although the emphasis is different here, similar attention is focused on 'the child' in the future and what 'experience' of 'relationships' might be like if treatment is successful and a baby is born.

Third, some PRs (for example, two who each initially indicated that they did not consider 'supportive parenting' meaningful) suggested more directly that 'supportive parenting' meant having a discussion with prospective parents about what being a parent will entail. One told us that the term 'supportive parenting' "would be considered like management speak" and that it is not a term staff would use. This respondent then went on to explain, however, that "this is all about making sure that the parents can do the job and look after the child properly". Another PR put it in the following way:

‘I don’t think it’s a term that’s used commonly ... I talk more probably about family support ... what level of input are you going to have from parents, siblings, rather than put it as supportive parenting. I will always say, you know: “Are you planning this? Is there anybody else going to be involved in their lives?”’

While discussion about ‘support networks’ or relationships that a child may form in the future with others may appear relatively benign, discussing this goes well beyond what the regulations require as part of a ‘welfare of the child’ assessment. As we noted previously, the CoP states that ‘supportive parenting’ (defined as a ‘commitment to the health, well-being and development of the child’) can be ‘presumed’, but that where ‘centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised’ (HFEA, 2009, para 8.11). In the accounts above, the approach described involves considerably more scrutiny than this ‘light-touch’ one. Taking comments from the set of interviews as a whole, it appeared as though conversations about ‘support networks’ were at many clinics routine, and that ‘supportive parenting’ was about making sure that prospective parents had thought ahead and planned, and could articulate how future ‘parenting’ arrangements would emerge.

While in much of the previous literature, single women and lesbians are discussed together as similarly subject to discrimination, our study consistently found differences in accounts given by different sorts of professionals of these groups’ treatment. This differentiation seemed to turn on how more or less ‘thought through’ or ‘aware’ women were. For single women, the assumption sometimes seemed to be that because these women came to clinic alone, certain questions must be asked during counselling sessions focused on the ‘implications’ of treatment. For example:

- Interviewer:* ‘Single women, are they still routinely brought forward for discussion from a “welfare of the child” point of view?’
- Respondent:* ‘Yes ... well, they have to see the counsellor.... Because she has to look at whether they’ve got their coping mechanisms. I don’t think they any more say that they have to have a male role model ... [it is] to make sure they’ve got support mechanisms and things like that.’ (Nurse)

A range of issues regarding the sorts of discussions it was necessary to have with single women were raised, including addressing with them the serious implications of having a child – for example the costs of childcare, or the demands a child might place on the mother – or more vague worries that a particular single woman was ‘rather odd’ or that her personal circumstances were not conducive to raising a child. In these examples, it was the women’s motivations for having children that coloured perceptions of what needed to be discussed with them:

‘If they haven’t had a serious relationship for a number of years, I will sort of ... wonder why ... is there a commitment issue? You know, a baby is for life, like the dog is for life, not just for Christmas ... and what does a child mean for them? Why do they want a child?’ (Counsellor)

'You have to look at motivation for having children. We have had cases where a single woman has been motivated to come to us to have a child because, not for the sake of having a child, but really it's transpired that they would move into better social housing if they had a child and things like that.' (PR)

These kinds of concerns about single women – focusing on checking for evidence of 'commitment' to a baby, or whether the motivation for treatment is 'for the sake of the child' – were sometimes framed through comparisons with lesbian patients:

'We're looking at why? Why do it on your own. If you look at Susan Golombok's work ... lesbian women couples do the best parenting. Heterosexual couples do the next best but single women struggle.... There's one girl, it's not that I knocked them back, but I really wanted them to find out the actual practical realities of childcare costs and after two sessions with me this girl who was adamant she had to be treated next month, sort of dropped out because she said she just can't afford to do it. It's the practical realities of parenting.' (Counsellor)

Indeed, in general, respondents were keen to point out how 'good' lesbian patients could be as future parents, with the counsellor quoted above making reference to 'the evidence' that lesbian parenting is superior. What was notable about this reasoning was its emphasis on being 'thought through' in relation to the details of future family life and 'parenting'. This was the measure of their competence, a demonstration that they were already putting the welfare of the child first, in contrast to single women who were discussed as being ill-prepared and insufficiently focused on 'the child'. For example:

'In reality, actually lesbian couples are very well thought out often before they come. There still is an awful lot they have to think about, but ... they're often a joy to work with because they really do think about the child and managing difference because they're already managing difference in the fact that their sexuality is different so they're often very, very well thought out but there's still a lot of stuff we need to discuss.' (Counsellor)

Although pre-conception discussion of 'supportive parenting' is inevitably nebulous, it is thus given meaning by clinic staff as they assume the need to discuss the future with those they treat. Further, 'supportive parenting' is interpreted in ways that go beyond the definitions provided in the regulations. Notably, the following were all considered by some to constitute legitimate terrain of discussion: plans for childcare, reasons for wanting to be a mother and perceptions of what parenthood entails.

### *Who needs 'welfare of the child' laws in assisted conception?*

In answer to the question, 'Does the legal requirement to take into account the welfare of the child serve any ongoing useful purpose?', only two PRs replied 'no'. Nine answered 'yes' and the same number were ambivalent. The two respondents who answered 'no' and some of those indicating ambivalence emphasised that their lack of enthusiasm about the law arose from its positioning of staff as insufficiently

trustworthy to do what is needed by merit of being professionals. As one PR who replied ‘no’ to this question told us: “They should just trust the doctors and nurses.” A PR who was ambivalent about whether section 13(5) is useful, told us that “it is a serious issue ... it’s absolutely right for it to figure into your decision making”, but also said, of the law: “Does it really change clinical practice? It doesn’t really.”

At the start of this article we noted how the case has been made (but never seriously considered in Parliament) that section 13(5) should be removed from the law. As the comments above indicate, however, even those PRs who were most lukewarm about section 13(5) did not suggest its repeal. No one made this case to us, and only one PR we interviewed expressed opinions that might be considered at all reflective of this argument for thoroughgoing legal change (indeed, this was the only person in the whole set of interviews who argued such):

‘I skip over the welfare form. I see that they’ve ticked everything. We tick our bit and sign it to say that we’ve gone through the motions but I’m not thinking in a consultation about what ... will they be like and then equally, who am I to judge? If I think: “Oh my god, that’s going to be a terrible parent or people have got totally unrealistic expectations” ... you can’t then discriminate and say: “Well we’re not doing it then” ... the few cases where we’ve not treated, we picked those up at consultation – not through a welfare form.’

This interviewee was unusual in making the distinction between perceptions they might have of another person (that someone might turn out to be a ‘terrible parent’ or had ‘totally unrealistic expectations’) and access to treatment, accepting that their perceptions of who would make a ‘better parent’ should not influence the process of providing treatment. The more common view, typical of those PRs who answered ‘yes’ to our question and widespread across interviewees in general, was that it was appropriate to take advantage of this opportunity to protect future children. For example:

‘The very fact that we go through the process of assessing this in some way gives us a measure of protection in the way that we’re perceived ... that it’s not ... a designer baby factory. It’s not as though you can turn up and have whatever you like. It is a process, we are supposedly about helping families to come about, rather than giving people what they want, giving people their accessory and giving them exactly the sort of baby they want.... It’s been there all the way through ... it makes us consider the consequences of our actions.’

The ‘consequence’ of assisting others to conceive is, then, quite clearly not only about solving a medical problem. It is also about “helping *families* come about” and this means reining in (and being seen to rein in) “giving people what they want”.

In some cases, what happens biologically and the perceived ‘social’ questions were overtly fused in what respondents had to say. The following interviewee (an embryologist) made a strong case for the particular responsibility of those who ‘create embryos’:

'I think ... we have a great responsibility as embryologists. We're the people who are inseminating. We're creating embryos and therefore if there are any concerns, we tend to have ... very, very strong views, you know; well-informed, educated views on whether ... we think that should proceed.'

Across different professions, one theme to emerge was that it is necessary, in order to act properly and in accordance with professional responsibilities, to think of 'the child', not just the person wanting to become pregnant. The following nurse, for example, talked of a 'responsibility to the child':

'It's difficult in a way because a lot of people talk about "playing God" ... people who can go and get pregnant on their own don't have to go through all this. We do sometimes have people say: "Why are you looking into this so much?" ... But we just say to them: "Well because we have to. Because if we are seen to help somebody get pregnant who can't cope with it ... we have a responsibility towards the child."

Another embryologist explained that, however difficult, staff must consider the needs of both the patient and the future child, 'separate the two' and be prepared to set aside the emotions of the patients if it's 'not right for the child' (who can only be imagined):

'We get so involved with the couples that sometimes it's hard to see beyond the couple you've got in front of you ... and I think that's difficult, because actually you do have to be able to separate the two and if it's not right for ... the child, then you have to ignore the emotions that are coming at you from the couple, which is really hard. It's really hard because at the end of the day the couple are in front of you and you can see them and talk to them and the child isn't.'

The connection between 'welfare of the child' assessments and 'taking responsibility' also characterised the following PR's account. The case was made here that the responsibility is to 'the couples' but also to 'the children', and further to 'society', where treatment is NHS funded:

'I think we have a responsibility to the couples that are seeking treatment, to any children born as a result of treatment and we also have a responsibility to society as a whole, particularly when we're accessing public funding for patients, so I think we have a responsibility there. How far that goes as to us assessing who should be a parent or not ... if we have concerns then I think it's our responsibility to raise those.'

Where the 'child welfare clause' was assessed positively, the dominant theme, then, was 'responsibility'. Interviewees communicated that being someone who assists conception in others brings with it a role that is not only about addressing biological problems using medicine to do so. The role of the professional is also to stand for and protect the interests of 'children', and the wider 'society', which may conflict with the interests of adult patients seeking treatment.

## Conclusions

This article began with a summary of ideas in literature critiquing ‘parenting’ as a focus for family policy. This literature places emphasis on the moralisation of ‘the child’ and a subsequent shift to scrutinising parent–child relations in a way that diminishes the previously assumed privacy of the family. Given that policy on assisted conception now makes use of this same term ‘parenting’ in an ostensibly more ambiguous way, the research discussed above sought to investigate what assessment of ‘supportive parenting’ as part of the provision of treatment means in practice, in assisted conception clinics.

It was clear from the study that the change to the wording of the law, almost unanimously viewed positively by staff, *has* been important in encouraging change in practice. Legal change has encouraged staff to ‘not discriminate’ against prospective parents on child welfare grounds. In this sense there is strong evidence of a more uniformly permissive approach to treatment, in particular of same-sex couples, than identified in some previous research. However, the study also identified that this does not mean that practice simply departs from the suppositions about children and parents identified in commentaries about family policy more generally. Indeed, it can be argued that, to the contrary, it is resonant with them.

Under the prior regulatory regime, the idea that child welfare might include the child’s ‘need for ... a father’ forged an explicit link to specific aspects of the potential parent’s life, namely is she married to, or in a stable relationship with, a person of the opposite sex? It has been argued that forming regulations around these aspects of a person’s life already constituted a breach of the line between public and private life, by making relationship status and sexuality the basis on which decisions about the provision of medical treatment are made (Tizzard, 1998). What this study suggests, however, in line with Gillies’ (2011) observations about the repositioning of family life as a public rather than a private concern, is that the giving way of this construction of the meaning of child welfare to that which emphasises ‘supportive parenting’ has, if anything, led to *further* dissolving of the boundary between public and private. This is not to suggest a high incidence of people being denied treatment, although securing funding for that treatment is another matter. Rather, there is dissolution of privacy through the investment of clinic staff in scrutinising prospective parents’ attitudes and future plans, done in the name of encouraging ‘supportive parenting’.

A central point made by Gillies (2011) is that the opening up of private life has come about as part of a shift to preoccupation with family function, rather than form. The research discussed here has detected that this is mirrored, to some extent at least, in what happens in pre-conception child welfare assessments. Staff are no longer directed by law to focus on the relationship between prospective parents, and the future form of family it will give rise to, when taking into account the future welfare of a child that may be born (that is, whether the parents are heterosexual and whether they are married; indeed, to focus on this is now deemed to constitute discrimination). However, it seems that one effect of this move against ‘discrimination’ has been to encourage a more direct focus on ‘child welfare’, taken into account in the clinic through consideration of the style of life, attitudes and feelings of those seeking treatment. In this way, a strong endorsement of ‘non-discrimination’ was found to co-exist, with a ‘bleeding out’ of perceptions of what should be discussed with prospective parents about ‘parenting’. Notably, the perception of what should



be discussed seemed to go in some instances well beyond that considered necessary by the regulations, in particular as set out in the HFEA's COP.

Our research thus detected, first, no real rejection of the idea that it should be part of the work of staff to 'gatekeep' and concern themselves with the welfare of future children. Indeed, many respondents were unexpectedly forthright in their comments about the importance of their responsibility to 'the child' and to 'society', not only (and occasionally in opposition to) the prospective parent's interest in being treated. There is a reality to assisted conception that shapes what staff have to say (there is no conception when welfare assessments are made, 'the child', as far as clinic staff will have any relation to it, will be never more than an established pregnancy, and the only actual person that clinic staff will encounter is the person often desperate to be helped to conceive). This means that it is to be expected that discussion of the 'welfare' of the child can be ambiguous, and some respondents struggled to find the words to explain exactly why they thought it matters. Nevertheless, it appeared 'common sense' to almost all staff interviewed in the study to talk about an imagined, future child and raise issues about what that child might need. In this regard, the workings of 'welfare of the child' assessments resonate strongly with themes identified in critiques of 'parenting'. 'The child' and their 'welfare' (as a generality, rather than as a specific child) are the moralised anchor for perceptions of what it is 'right' and 'wrong' for a clinic to permit.

Given that there is no child, making this moral precept concrete is understandably difficult in the context of assisted conception. The way this was resolved among the staff interviewed for this study was, second, also resonant with preoccupations with 'parenting' more generally, in the ways 'expert' and 'professional' opinion and evidence were referred to. Respondents thus seemed most confident about discussing how to identify the potential for 'supportive parenting' when they could refer to 'the evidence'; for example that which apparently gives knowledge and certainty that lesbian couples will be the most supportive parents (and the associated hierarchy through heterosexual couples to single women). Some interviewees' discussion of 'playing God' was also striking in this regard. 'Playing God' was a phrase used in the 1980s by critics of IVE, to demonise scientists and doctors and arrest the development of assisted conception services, on the grounds that scientific power to manipulate human biology would lead to the moral collapse of society. Today, some clinic staff talk of *themselves* as 'playing God', not in order to indicate that they can manipulate *biology* through technological means, but rather to capture their *social* role as a professional taking responsibility for the welfare of future children. Hennem (2014) notes that the role of professionals of various kinds in protecting the 'interests of the child' has been emphasised and elevated as a crucial as part of policy making, and this study suggests that this construction of the role of the professional exerts a strong influence over those who work in assisted conception too, becoming apparently at least as important to them as their medical role in making a conception occur in those adults often desperate to conceive.

Overall, it can be concluded from this study that taking into account child welfare in assisted conception has developed in a way that resonates strongly with the wider realities of the oversight of parent-child relations discussed in other contexts. This is not to diminish the importance of the more permissive approach to service provision taken, and the effects this has for same-sex couples particularly. It is, however, to indicate that this permissiveness can pertain in a way consistent with the continued and even deeper opening up of private aspects of people's lives to scrutiny by professionals.

In sociological terms, this points to the continuing relevance of research that looks anew at the workings of the medicalisation of family life.

## Notes

<sup>1</sup> The HFE Act 1990 established a statutory body – the Human Fertilisation and Embryology Authority (HFEA) – which publishes a Code of Practice (CoP), which includes direction on how clinics should interpret the law.

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<sup>3</sup> Advisory group members were Eric Blyth (Professor of Social Work, University of Huddersfield), Gillian Douglas (Professor of Law, Cardiff University), Geraldine Hartshorne (Professorial Fellow, Warwick Medical School), Kirsty Horsey (Lecturer, Kent Law School), Jennie Hunt (Senior Infertility Counsellor, Hammersmith Hospital), Clare Lewis-Jones (Infertility Network UK), Sarah Norcross (Progress Educational Trust), John Parsons (former lead consultant at the Assisted Conception Unit, King's College Hospital, London) and Alan Thornhill (Scientific Director, The London Bridge Fertility, Gynaecology and Genetics Centre).

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