THE BEST INTERESTS STANDARD RECONCEIVED: 
APPEALS TO THE UNCONCEIVED IN THE LAW OF ASSISTED 
REPRODUCTION 

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Abstract 

More than a quarter-century after the birth of the first “test-tube” baby, regulation of the fertility industry is becoming more commonplace around the world. While much of the regulation arose in rapid response to the sensational court cases and media reports of the last two decades, other regulatory regimes have only recently been enacted after prolonged periods of national soul-searching and intensive study by specially selected commissions. Whatever the impetus behind the regulation of the fertility industry generally, regulation of consumer access to fertility treatment is an attempt to balance procreative autonomy with the welfare of children. Indeed, where the law of assisted reproduction is significantly evolved, as in jurisdictions of socialized medicine, the best interests of the child standard is the measure by which access to assisted reproduction in the first instance is gauged. New proposals to regulate assisted reproduction, whether they address mandatory disclosure of gamete donors’ identities, prohibitions on compensating gamete donors and surrogates, restrictions on postmenopausal pregnancy, or pre-implantation genetic diagnosis and sex selection, are also punctuated by recommendations that the best interests standard assume primacy. What is curious about these regulatory maneuvers is not their expression of concern for children born of reproductive technology but that they recommend applying the best interests of the child standard to the unconceived, a class to which that standard has typically not been applied in the family law context.
The objective and purpose of this study are to examine, analyze, and make recommendations about the use of both the best interests of the child standard and the harm standard in the regulation of assisted reproduction as it pertains to the clinical psychotherapeutic evaluation and screening of applicants for infertility treatment. The argument unfolds via a bioethical, legal and policy analysis that draws on (1) recent scholarly monographs and academic articles treating the evaluative, administrative, and psychotherapeutic issues involved in screening applicants for infertility treatment and (2) case law and legislation construing and applying the best interests and harm standards.

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

Second, the use of the best interest standard in decisions about access to assisted reproduction risks injecting an element of arbitrariness into the clinic’s gatekeeping function. The best interests standard was developed to afford decisionmakers a tool with which to make fact-specific inquiries into whether the interests of a particular child
would be served by particular parents. The standard is thus not particularly well suited to clinical decisionmaking about children who have yet to be conceived and consequently about whom little is known. To the extent clinics wish to prevent applicants who are unsuited to parenthood from gaining access to infertility treatment, they should adopt the harm standard. The harm standard allows parental fitness to be measured through the application of widely accepted criteria. Its use in the clinical setting will lead to greater consistency and neutrality in decisions regarding access than will the use of the best interests standard.

These observations about the use of the best interests standard in the clinical setting find support in the law. The best interests of the child standard has a venerable history. It figures prominently in family law decisionmaking involving not only adoption and child custody but also child support, termination of parental rights and parental notice of abortion. The best interests standard is a cornerstone of the juvenile justice system. The standard has its origins in the ancient doctrine of parens patriae and was designed specifically “to improve the consistency and quality of decisions made about children.” Given the prominence of the standard in all manner of legal decisions involving children’s rights, it is unsurprising that it serves as a crucial underpinning of the United Nations Convention on the Rights of the Child.

As applied in the judicial setting, the best interests of the child standard gives courts latitude within which to make “fact-specific” inquiries about whether “the interests of these children will [] be promoted [] by these petitioners.” As such, application of the best interests standard at the very least presupposes the existence of those whose best interests are to be assessed. To misuse the standard as a means by which to make blanket
judgments about whole classes of persons who might wish to employ assisted
reproduction or about specific types of assisted reproduction is not the direction family
policy should take.

This is not to say that the law has never exhibited concern for the best interests of
the unconceived. In a little-known area of the law in which the best interests of the
unconceived are of paramount concern, trust law doctrine prohibits the guardian or
representative of an unborn person to consent to the invasion of the corpus of a trust
unless it would be in the best interests of the unborn person. When studied closely, cases
developing this legal theory have much more to do with adhering to the terms of a
donative document and thus about vindicating the property rights of adults than they do
about safeguarding any set of generally accepted notions about what is best for children.
Seen in this light, the virtual representation cases are a poor analogy for the extension of
the best interests standard into the realm of defining what degree of control we as a
society will permit adults to have over the conception of children.

The best interests of the child standard figures prominently in existing and
proposed regulation of access to assisted reproductive technology. The standard is well
known internationally for its use in the adjudication of legal disputes implicating
children’s interests. Requiring a multidimensional assessment in each case, the standard
contemplates the examination of a specific child in a specific environment in order to
reach conclusions about what situational alternative is better for that particular child. As
such, it is not particularly well suited to the development of abstract assessments about
what is harmful to children. Instead, such assessments are made with reference to well-
settled understandings of what constitutes abuse and neglect. Invoking the best interests
standard instead of the harm standard to deny certain adults access to assisted reproductive technology finds no support in the law. In the assisted reproduction context, the best interests standard should apply to cases where the subject is actually in existence; in this way, decisions based on the best interests standard will comport with the purposes behind and the goals of the standard. Decisionmakers and policymakers should embrace the clear distinction between the best interests and the harm standards so that access to assisted reproduction is not unduly or frivolously denied.