

FUTURE CHILDREN: IDENTITY AND PERFECTIBILITY

- Just as conceptions of childhood and views of children have changed in the past, so it is almost inevitable that they will in the future.
- We can already discern elements of change underway in the possibilities opened up by biomedical technologies that make possible the physical re-shaping of individuals, both present and future.
- Such technologies, along with practices such as gestational surrogacy, challenge and call into question taken-for-granted notions of family and kinship.
- The modifications to the individual that such technologies make possible enable the remaking of identity and encourage individual perfectibility.
- Such biomedical interventions have implications not only for the individual undergoing them but also for what it means to be a (human) child in general.

INTRODUCTION

We can see as discussed and demonstrated throughout *Global Childhoods* and from the historical contextualization of what it is to be a child that understandings of childhood have changed over time and vary between cultures. Further, in the interpretations of children and childhood as represented through disciplinary frames (sociology, psychology, medicine, law, education), we have seen that what appear to be static taken-for-granted norms about childhood in daily life and culture are in fact perpetually, if imperceptibly, evolving. Given that childhood and children have been understood differently according to time and place, we should be able to agree that those understandings are highly likely to change again in the future. Further, while sometimes patterns of meaning, representation and intellectual conception are repeated in gently modified forms, sometimes revolutionary change occurs.

In the issues and debates covered thus far, it is evident that the seeds of change are already being sown in a range of visions for the future of childhood, as favoured by both national and international agencies. Whether every one of these

seeds will germinate and flower remains to be seen. As has been demonstrated in earlier chapters, the UN protocols against child sex trafficking and child soldiers, and the ILO's declarations against the worst form of child labour are clear indicators of international movements dedicated to continuing the minimization of unjust or abusive treatment of people under the age of 18. Relatedly, with the two optional protocols that have been added to the UNCRC since 1989, the signatories to each of these documents have been able to note exceptions for their nation's ratification, in recognition of different contextual realities. So the dominant notion of childhood *is* contested. Further, the implementation of aid around the world, by such bodies as UNICEF, is increasingly reactive to on-the-ground or prominent global debates regarding children. This reactivity can be seen in the directions of current preoccupations in public health, as in the fixation on obesity discussed in Chapter 7, and the trend in addressing such issues at a global level through the increased monitoring and controlling of children's bodies.

Attempts to (re)shape childhood and the lives of children may be seen in arguments from both developmentalism and socialization. This can be seen in interventions that re-child the child, intentionally returning the individual child soldier or child head of household to reinstate and reshape the developmental process, and in early childhood education that seeks to set up the conditions of possibility for the ideal citizen. Where socialization (or re-socialization) is the focus, we have demonstrated that it may do so through affecting the habitus. In either case the object of change is the child's sense of self. Our fictional example of Pip in *Great Expectations* demonstrated that, even if it was not entirely successful, Pip's acquisition of the skills appropriate to the middle classes changed not only his aspirations but also his sense of self: his identity. It is to issues of identity – past, present but especially future – that we turn in this chapter.

In our opening, we alluded to the genealogical documentary series, *Who Do You Think You Are?*, in which identity is constructed as heritage, both social and genetic. All of the participants in the series begin by returning to their own childhoods and familial connections to search out the grounding for their sense of self. By the closing credits, each subject's sense of identity has been challenged, realigned, and in some instances radically reshaped. This notion of a search for identity in combination with the status of children forms a common thread with the case studies explored in our final chapter. In the first case study of future children we begin with an example that relates to children's rights to be hormonally 'reshaped' in the process of 'being and becoming'. In the second case study, we will turn to issues related to the reproduction of future children using examples from past practices of artificial insemination in Australia and move on to explore current practices of gestational surrogacy in India. Finally, we offer some observations on the possibility of 'perfectible' children and childhoods that is implicit in much of the discussion around reproductive technologies.

Each of these case studies involves ethically and socially contentious issues which are publicly (and polarizingly) debated in the Global North. That is, they are matters in which the dominant views of children and childhood are being contested from within the dominant paradigm, in contrast to the case studies up to this point

which have been contested largely from ‘below’. Nevertheless, each has potential ramifications that extend to the Global South, particularly as they call into question the meaning of children and childhood, whether as developmental or as socialized human beings. Further, while they are geographically specific (in relating to cases in Australia and India) they encompass issues widely debated and intimately connected to the lived realities of children around the world. The first case study relates to children diagnosed with Gender Identity Disorder (GID) (or Gender Dysphoria (GD)) in Australia; the second, to past practices of artificial insemination (AI) and the rights of the adult children of anonymous sperm donors;¹ the third, to the contemporary internationalization of gestational surrogacy, whereby India has become a major destination for ‘medical tourists’; and our final remarks, to the capacity to screen and select future children. In each discussion, the capacity of individuals to determine identity and the medical-ethical dilemmas that affect their actual ability to do so are at stake.

FUTURE IDENTITY: A CHILD’S RIGHT TO CHOOSE?

For children diagnosed with GID who are seeking hormone therapy in anticipation of puberty, they and their guardians assert that they have the rational capacities to make life- and body-altering decisions. These children feel trapped in a body the genetic sex of which does not match their gender identity (see Zucker, 2005). In 1989, as part of the near-unanimous signing and ratifying of the UNCRC, mainstream Australia agreed to adhere to a conception of children and a definition of childhood as embodied in that document, and to uphold the rights of children accordingly. In requiring nation-states to act in ‘the best interests of the child’, the UN explicitly and implicitly promotes an idea of childhood as a time of innocence and vulnerability, and children as not yet rationally competent. Nevertheless, as we have demonstrated, the understanding of childhood promoted by the UN is a historically and culturally contingent construction that is based in normative expectations of children of the developed world (children don’t work, they play). We have also canvassed subsequent documents in which the UN and the International Labour Organization (ILO) have shown some understanding of the ability (and need) of some children to combine work and education. Nevertheless, children’s rational capacities are treated in general as subordinate to those of adults (Cregan 2013).

In Australia, 18 is the age at which one is generally considered an adult. At 18 one may vote and if found guilty of criminal offences may be sent to an adult prison.² In relation to medical treatment, a child is considered incapable of giving fully informed consent and adults – parents, guardians, doctors and judges – remain the primary decision-makers for and about children. However, it has been recognized that a person over the age of 16, while still legally a minor, has the capacity to give informed consent to medical treatment and to have an independent relationship with their medical practitioner (Cregan 2013). Similarly, a ‘mature minor’ (a child judged intellectually capable of understanding the nature and consequences

of the relevant treatment, at perhaps 14 or 15) may be considered able to make decisions about consenting to medical treatment (ALRC 2008 [2013] 68: 44–5).

The treatment of children with GID is a more socially complex and culturally challenging phenomenon than most in the Global North. The condition is defined by a psychiatric diagnosis and is subject to psychotherapeutic intervention, but the medical treatments used to realize the individual child's desired gender identity are hormonal. In Australia surgery may not be performed until adulthood, that is, at the minimum age of 18. The progression to medical treatment, in addition to psychotherapeutic measures in using puberty-suppressing or hormonal drugs, is considered in law to be a 'special medical procedure' (or more properly 'treatment') and as such cannot be consented to by the child, the child's parents or his or her guardians alone. Such treatment requires consent from a judge of the Family Court of Australia, a federal court which has jurisdiction over family law matters in general and this area of law in particular (Cregan 2013).

The Family Court's powers over 'special medical procedures' originated in a court decision in 1992, which aimed to protect the rights and well-being of children from medical interventions that were considered outside the ordinary scope of parents' or guardians' powers. Among the features that define such procedures are the following: there would be grave consequences from an incorrect decision; there is significant risk to the child's best interests as a result of an incorrect decision; or, where the treatment may not in itself 'be grave and irreversible but may be of significant risk, ethically sensitive or disputed' (Family Court, 1998, vii). Further, in approving such a procedure a judge must be satisfied that treatment is a 'step of last resort' (Family Court, 1998, vi). We can hear in these parameters direct reference to the UNCRC requirement that at all times the best interests of the child be upheld (Cregan 2013).

Initially, this overriding of the powers of a parent or guardian was the outcome of 'Marion's Case' in which the parents of 'Marion', a pubescent female child who had a significant intellectual disability in addition to other medical problems, wished to sterilize their daughter to remove the distress she experienced during menstruation (Family Court, 1998, 2). The eventual outcome of the case was that the sterilization was judged to be a 'special case' and that decisions related to such procedures should be made by a judge of the Family Court. Since the initial judgment, the parameters of a 'special medical procedure' have been broadened specifically to encompass gender reassignment in minors, and otherwise uncontroversial medical treatments where parental consent has been refused. The result has been that a person under 18 in Australia who wishes to undergo hormone treatment in anticipation of gender reassignment must seek consent through the Family Court (Cregan 2013).

Hence, in instances where the treatment teams, the parents and the child concerned have all wished to proceed with medical treatment to avoid the onset of puberty of the repudiated sex and instead hormonally induce the physical characteristics of the sex with which the child identifies, a judge of the Family Court has the final say. With all parties in agreement such treatment is likely to be approved once the child has reached 15 or 16. That is, if the family has the financial resources to cover the expenses involved in seeking the required consent through the court,

which in 2012 was estimated to cost between AU\$20,000 and AU\$35,000 (Robotham, 2012). So, in most states of Australia, a person under the age of 18 may be considered able to consent to sexual activity but incapable of determining their gender identity (Cregan 2013).

The specific case of *Re Jamie* [2011] FamCA 248³ is more challenging than the general case discussed so far as Jamie, born genetically male but socially female since she was a toddler, was not yet 13 at the time the case was heard (Robotham, 2012). In the first stage of this case, in line with the precedent that treatment for GID is a special medical procedure, Dessau J. and the parents assumed that the proposed treatment was within the definition of such procedures and required a determination by the court to proceed with the first stage of gender reassignment (Stewart et al., 2012: 235). The judge supported puberty-suppressing treatment but rejected a request to begin oestrogen therapy, leaving that decision until Jamie reached the age of 15 or 16, the accepted age for beginning such treatment. As Cameron Stewart notes (Stewart et al., 2012: 235), an important aspect of this case is that the parents subsequently appealed the status of the treatment as a special medical procedure. They were successful and obtained an outcome that supports the parents' right to give informed consent and they, rather than a judge, will be able to make the decision to begin stage one of the treatment regime (to suppress puberty), on the basis that it was a reversible treatment (*Re Jamie* [2013] FamCAFC 110). Decisions about whether, when and how to proceed with reversible hormone therapies for children with GID have, thus, reverted to the families and the doctors of the young person concerned. Stage two of treatment, which is irreversible, remains an issue in which the competence of the child to consent (even with medical and parental consent) remains a matter to be determined by the courts (Cregan 2013, 2014).

There has therefore been a perceptible change in the legal, social and cultural recognition of the ability of a young person to make informed decisions about re-forming his or her identity. That recognition is both overtly grounded in developmental assumptions of cognitive capacities, but also implies an acceptance of the kind of child agency supported by socialization theorists. In public reporting of this and other similar cases both in Australia and elsewhere there have been dissenting viewpoints on proceeding with such treatments, aside from contesting the legal restrictions on who may consent to treatment. It is known that there are long-term health risks implicit in the relevant hormone treatments, such as osteoporosis, and irreversible effects, such as diminished fertility, which may adversely affect the individual should there be a reversal in identity later in adolescence or adulthood. Weighted against these potential risks is the real anguish that a child with GID feels, that may lead to suicidal or self-injuring behaviour. At a social level, gender theorists question whether GID itself is at least in part a response to the power and rigidity of gender norms. What remains is the fact that, despite the recognition of the heightened capacity of the child to assert his or her identity, the ultimate decisions affecting the child's identity are still being made on his or her behalf by adults (parents, guardians, doctors, judges) (Cregan 2013).

Here we see the effects of the prevalence of rights discourse in legal and medical debates around 'the best interests of the child' as set out in the UNCRC. Jamie's case

is premised on her 'right' to determine her own identity: to be an agent of her own embodied being. At the same time, the medical treatment that effects the desired gender change is deeply imbricated in her 'becoming': her developmental (biological) status is being reshaped by the recalibration of embodied hormonal levels, a process that will need to be maintained over a lifetime. Gender theorists are more likely to raise the issue of socialization; that the individual's identity is subject to and unable to accommodate the pressures inherent in social phenomena (rigid gender norms). In other words, that what the individual perceives as a problem of personal identity is the result of restrictive social processes rather than a bodily 'problem' that can be 'perfected' by medical intervention (Fausto-Sterling, 1993). There are certainly cross-cultural examples that demonstrate that there are ways to negate the need for the physical reshaping of the body in order to accommodate non-stereotypical gender identities: the Native American *berdache* or 'Two Spirit', the *hijra* of India, the *kathoey*s or ladyboys of Thailand and the *fa'afafines* of Samoa (Blackwood, 1984). Jamie's case, on the one hand, holds promise for the recognition of children's agency in determining their own future lives but, at the same time, also suggests the potential confirmation of rights-based decision-making in relation to children as residing in 'the family' as supported and facilitated by medical opinion (adult experts), based on a biomedical and developmental notion of the body of the child.

FUTURE IDENTITY: A CHILD'S RIGHT TO KNOW?

This issue of parents making biomedical decisions about children's futures leads us directly into the discussion of our second example, where the intersection of identity, children and medicine is imbricated in the complex history of social and medical responses to fertility and infertility. Like other developed countries which experienced the wave of social change that flowed through the 1960s, Australia took part in the sexual revolution largely made possible by the wider availability of the contraceptive pill. Prior to the pill, which made it possible to have sex without a high likelihood of bearing a child as a consequence, the overwhelming social stigma attached to unmarried pregnant women ensured that it was only the strongest personalities, or those with families prepared to weather the stigma to support them, who kept their children (Cregan 2013).

The only alternative to carrying an unwanted pregnancy to term, abortion, was illegal across Australian jurisdictions until interpretation of the relevant criminal law shifted, in the late 1960s and early 1970s. Up until that time abortion was also prohibitively expensive, from the few doctors who would chance prosecution, and a high-risk procedure when undertaken by a 'backyard abortionist'. With the introduction of the single mothers' pension in 1972, unmarried women who wanted to have their babies and keep them were afforded a financial avenue that allowed them to and the statistics incontrovertibly prove that they chose to do so (Cregan 2013). The numbers of babies available for adoption dropped from nearly 10,000 in 1971–72 to fewer than 700 by 1995–96 (Broadbent and Bentley, 1997). This number has continued to fall and in the most recent data, for 2010–11, there were 384 finalized adoptions in Australia (AIHW, 2011).

Until the development of IVF and its flow-on technologies, which did not become viable alternatives until the mid-1980s, the only recourse for infertile couples who wanted to parent children was to foster, to adopt, or if the cause was male infertility, insemination with donated sperm. While human tissues (gametes) and reproductive experimentation are subject to Federal law, each Australian state has its own infertility authority which is also subject to state legislation. Until 1988 in the state of Victoria, medically assisted sperm donation remained an anonymous procedure and any details recorded about the donors were subject to medical confidentiality. The resultant children of these anonymous sperm donors were, and indeed still are, subject to fundamentally life-shaping decisions made for them. The ethical arguments and implications surrounding the current calls for the opening of these records repeat the debates held in the early 1980s discussed in earlier chapters over unsealing closed adoption records (Cuthbert and Quartly, 2012).⁴

Although sperm donation had been available as a medical option for decades prior to the dramatic drop in the availability of babies for adoption in the mid-1970s, its importance rose as an option of last resort for male infertility and because it also became an essential adjunct to IVF experimentation. In Australia, the sale of human gametes is prohibited but donors are (and were) compensated for their time and expenses in providing their donation. In the late 1970s the payment was AU\$20. With more stringent requirements on donations (and inflation) the payment has risen by 1,500 per cent, to AU\$300 per donation.⁵ As we noted above, prior to 1988 sperm donors were guaranteed anonymity. In the state of Victoria, those offspring born between 1988 and the end of 1997 may seek information if the donor consents to making the information available (Hagan, 2012). For any child born as a result of sperm donation since 1998, non-identifying details and a medical history of the donor are provided to the recipient(s) prior to fertilization, and any sperm donor enters into the process on the understanding of the possibility that they will be sought out by their genetic offspring (Cregan 2013).

Offspring of anonymous donation, that is adults who are now at least 25, have no access to the records of their genetic fathers. There is an issue of contention here in that there is significant lobbying and pressure being put on governments – each state having its own regulations – to make available the identities of donor fathers, whether they desire it or not. One of the most prominent advocates for opening the records, on sperm donors prior to 1988, was Melbourne woman Narelle Grech (1980–2013) who had aggressive bowel cancer with a possible genetic link. She wanted to meet her biological parent and to warn her eight half-siblings of their potential risk of developing the disease (Hagan, 2012), but she was also determined to ensure that full medical histories are available not only to those who have been conceived and born since 1998 but to all donor offspring for whom such records exist. Although the opening of anonymous sperm donor records to all those affected remains unresolved throughout Australia, reform has moved one step closer in Victoria, at least in part due to Narelle Grech's activism. In August 2013 the state government tabled its response to the recommendations of the Victorian Parliament's Law Reform Committee

(Law Reform Committee, 2012), that included the opening of existing records of anonymous donors prior to 1989, the facilitation of contact between donor children and their biological fathers, and the counselling of donors and offspring prior to contact (Cregan 2014).⁶

The health professionals who perform AI have publicly resisted calls to facilitate identification of donors on the basis of the original assurance of confidentiality and the potential for undermining of trust in the profession if that assurance is reneged upon (see transcripts at <http://www.parliament.vic.gov.au/lawreform/article/1465>). This is certainly an issue, but it is also precisely the same set of arguments raised in the 1970s and 1980s when adoption lobbyists fought to revoke the anonymity of the files of adopted children, many of whom were in their sixties and had had happy relationships with their adoptive parents, yet remained deeply concerned to uncover their identity.⁷ Those laws were changed and the attitude to adoption itself has radically altered in the decades since. Not only has this led to repeated formal apologies being made for decades of past adoption practices by federal and state governments, state and federal authorities, hospitals and religious institutions, nationally and internationally (Cuthbert and Quartly, 2012), it has also changed approaches towards favouring 'open' adoptions, where all parties remain aware of the child's genetic, cultural and social heritage.

THE 'MATTER' OF CHILDREN

Sperm donation became more valued and important in the context of more effective contraception and lower adoption rates, which meant fewer children were available to infertile couples. As already mentioned in passing, liberalized abortion practices also had an effect on the reduction of available infants: liberalized, but only very recently (and unevenly) de-criminalized in Australia. Around the globe, abortion has been practised and in many instances culturally sanctioned for millennia, but it remains an ethically contested practice. The base matter from which future children are shaped continues to be a source of enormous social, cultural and religious contention.⁸

As exemplified in the British act against infanticide touched upon in Chapter 2, the point at which a human life begins has been taken to be of great importance. The act attempted to exert protection over infants (and warrant the prosecution of errant mothers), and in doing so implicitly took birth as the beginning of a defensible life.⁹ Until at least the late eighteenth century, pregnancy was not considered certain until the 'quickening' (movement) was felt, at around five months' gestation (Duden, 1991). Conversely, by the late twentieth century the assessment of foetal viability and the survival rates of pre-term births were lowered into the second trimester of pregnancy.

While birth as the point at which a foetus becomes an infant is an intuitively appealing demarcation, a number of factors complicate matters. These include the survival of increasingly pre-term births, the personal and emotional investment in the foetus in the first trimester of pregnancy with the availability of sophisticated

ultrasonography, and even the psychological attachment to blastocysts (five- or six-day-old embryos) of those undertaking IVF. When a child's life begins is no longer necessarily as clear cut as the moment at which it takes its first breath (if it ever was). This inevitably leads us back to our first question – what is a child? When does a child's life begin?

The majority of the bioethical debate around abortion is centred on just this point. There are philosophical bioethicists who take sentience (the capacity for thought) as the basis of personhood and argue that an embryo, foetus or even a newborn infant does not yet have that capacity and so does not have the same rights as sentient beings. The logical, if highly contentious, extension of this argument is that infanticide is therefore as rational and supportable as abortion (Singer, 1993, 1995). In polar opposition to such a view some religious authorities, most notably in the Catechism of the Catholic Church, take the moment of conception as the point at which personhood obtains and define the embryo in terms of its status as a potential human being (Paragraph 2270). Clearly these positions are irreconcilable, and in many ways unhelpful in attempting to address issues related to future children. What they do have in common is that each pits the interests and rights of the mother against those of the future child, in contrast to debates we have seen in earlier chapters that conflate the interests of mothers and children.

In drawing, to some extent, on current issues in healthcare ethics we are examining the changes underway in how *children as the intended outcome* of technologies of reproduction are being spoken of and imagined, rather than debating personhood prior to birth. Moreover, we are also concerned to raise the matter of just *whose* future children these technologies are likely to be reproducing. However, we recognize that there is a lack of consensus about the point at which a child is accorded the status of real or potential human person. Indeed, the UNCRC does not define when childhood (or more properly a child) begins, thereby avoiding becoming mired in debates on the beginning of personhood that are entailed in debates on abortion. At the same time, the UNCRC allows individual signatories to define the point at which they take childhood to begin, much as other exceptions are accommodated in practice in individual nation-states. Thus the UK, in common with other states that allow or have decriminalized abortion, upholds the UNCRC specifically in relation to infants who have been born, whereas other signatories (particularly where religious objections to abortion are strong) extend the UNCRC's mantle to the unborn. While it is beyond the scope of this chapter to debate the status of the foetus or embryo in any depth, when we refer to future children we do so in the knowledge that the UNCRC leaves the legal definition of the genesis of a child (and ultimately of personhood) to the discretion of signatory countries.

GESTATIONAL SURROGACY IN INDIA

That plurality in practice is exemplified in differing approaches to the regulation of reproductive technologies and the research practices that flow from it. Where there has been a lack of regulation but high standards in medical technology

(e.g. Singapore in the 1990s), or where the state provides liberal regulatory support in combination with venture capital, as in the state of California in the USA, reproductive biotechnological research has flourished. Such supportive (or lack of) regulation of reproductive practices is also advantageous in the pursuit of gestational surrogacy. Many countries in the world ban gestational surrogacy outright within their own borders, some extend that ban to their citizens travelling to access it, some allow regulated and restricted surrogacy arrangements (often requiring it be altruistic): and a few countries, like India, are unregulated (Teman, 2010).

California is a prominent destination for those seeking commercial arrangements with gestational surrogates, and can accommodate those who require not only a surrogate to carry the infant to term but also the gametes to create the embryo, whether these are required for medical or social infertility. As a state in a highly technologized developed country with liberal laws but a medical system founded on private insurance, pursuing gestational surrogacy in California is out of the reach of many infertile couples, including US citizens. In India, which is only just approaching legal regulation of gestational surrogacy in the proposed Assisted Reproductive Technologies (Regulation) Bill (2013) (*The Hindu*, 2013b), the costs are a fraction of those in the USA, and surrogacy is run on a commercial model. It has therefore become an increasingly popular destination for medical tourists in search of reproductive services.

There has been considerable debate amongst feminists, ethicists, anthropologists and sociologists on the meaning of reproductive transactions between the Global North and the Global South. There is almost invariably an imbalance, much as in the international trade in organs for transplantation, between those with the capacity to contract a gestational surrogate and the woman who will carry a child to term. Even where the outcomes and the surrogate's own reports of her participation in the arrangement are positive (Pande, 2009, 2010, 2011) the women carrying the children are doing so out of personal financial need, as a 'survival strategy and a temporary occupation' (Pande, 2010: 293). In terms of Global Northern ethical norms that relate to the mother, there are issues of coercion and informed consent at stake. In other words, women enter into the process to relieve debt or improve their family's living standard by undertaking procedures (such as hyper-ovulation) the full risks of which they may not be aware of or in which their consent is not wholly un-coerced (Gupta and Richters, 2008). Birth itself is known to carry risks, even when prior pregnancies have been untroubled and the birth is monitored in a well-equipped hospital. What little research has been conducted on the practices and experiences of the Indian participants focuses firmly on the position of the gestating mother. Similarly, the debate around the proposed Bill is firmly centred on the protection of the rights of the commercial surrogates from exploitation. What of the status of the intended children involved?

In reading Amrita Pande's reports of qualitative interviews with commercial surrogates in India, one of the few sustained researchers in the field, it becomes clear that the women who carry the babies see their reproductive labour as entailing kinship relations. The reported comments of the women, who in this case were housed together in hostels and separated from their own families until after the birth, show they believe even when they are implanted with a genetically non-related

embryo that they are contributing to the ongoing life of that child. Pande notes that in some instances this may involve a degree of hopeful fantasy on the part of the women, but they nevertheless understand their experience as one of creating kinship ties (Pande, 2009). This offers a distinct challenge to normative kinship ties, particularly those of the Global North.

As Palattiyil et al. (2010) have noted, those who undertake to commission a commercial surrogate do so for a number of reasons. Of the eight they list (Palattiyil et al., 2010: 689–90), we take three for further discussion that relate most clearly to Global Northerners undertaking international medical tourism (the remainder relate more closely to domestic surrogacy arrangements). Each of these stem from restrictive conditions in their home country: ‘exclusion ... on the basis of age, marital status or sexual orientation’, ‘lower costs’ and ‘a desire to protect their privacy’. As already noted, costs in California are prohibitive for most international medical tourists, which immediately makes India a more attractive prospect for those seeking commercial surrogacy arrangements from the Global North. The medical system, at least where surrogates are cared for, is sophisticated and the medical staff highly trained. The other two reasons mesh more closely with other concerns we have already raised in relation to the child born of such arrangements.

Where couples have been excluded from services otherwise available in their country of origin, international commercial surrogacy makes possible the acquisition of a child. The Bill currently being debated may close one door in this regard: as currently framed, it defines commissioning couples in heteronormative terms (*The Hindu*, 2013b). This closely follows similar dynamics to those that occur in relation to ICA, where in many countries children are only made available to heterosexual married couples. Commercial surrogacy therefore challenges heteronormative family structures.

Finally, while the surrogates Pande interviewed may express a kinship relationship with the infant they carry, one of the key reasons for Global Northerners seeking surrogacy internationally is to access the kind of ‘privacy’ such as that afforded to sperm donors in Victoria prior to 1989. Some prospective parents may want to uphold the fictive kinship relationships claimed by the surrogates: others prefer to maintain a commercial relationship that ends when the child is delivered. In such circumstances, the child is at the centre of a commercial transaction – indeed, is the ‘matter’ transacted. Further, the future child will be subject to the same issues of identity-formation entailed in any closed system, whether of assisted reproduction, adoption or surrogate gestation. While there is considerable debate around the appropriate inclusion of surrogates in the lives of future children in the Global North (Laufer-Ukeles, 2013) the lack of regulation in India means that it is entirely reliant on the goodwill of the commissioning couple whether any such relationship continues either for domestically or internationally relocated infants.

The history of practices of secrecy, the inability to access identifying files and the obstinacy on the part of bureaucracies which were characteristic of prior adoption practices are being replayed in relation to calls to rescind the anonymity of sperm donors, as we have seen they continue to be in relation to international adoptions and also in commercial surrogacy arrangements. It is not clear that the opening of adoption files undermined trust in the institutions that fought that openness. It was

equally possible that the reluctance of those institutions to be open and their resistance to change had a far greater effect in undermining the public's perceptions of them and fostering negative views of their actions. What has drawn wider approval is the ability of the parties involved to realize that an earlier practice was unjustifiable, open to harming those involved by not being sufficiently thought through, and manifestly not 'in the best interests of the child'.

In the preceding discussion of AI, the rational capacities of adult children born of anonymous sperm donations who seek access to records about their biological fathers are not in question. They are searching for the unknown half of their genetic identity, which has been denied them since conception. Many of them are concerned about the potential health risks to which they may be prone or the possibility of unwittingly entering into incestuous relationships, playing out the same arguments we saw mounted in the debates around adoption. In all our case study examples thus far, decisions over how (or whether) these individuals may proceed are issues in which socially, historically and politically contingent ideas of childhood, and what it is to be a child, prevail.

With regard to anonymous sperm donation, in the middle are the children who could not be asked if they wanted to be conceived and who may live to develop medical problems of which they have been denied forewarning and/or who, as a result of secrecy, lack the capacity to take precautions to avoid developing conditions of which they are at risk. The 'best interests of the child' who would result from a sperm donation, now adult, were considered in a manner subordinate to the wishes of adults. The adult children of sperm donors, like adult children of closed adoptions, were conceived in an act that failed to foresee or fully appreciate the consequences for the child once they are adult. Like children with GID, their interests remain subordinated *into adulthood* because of decisions made by adults on their behalf, 'in the best interests of the child'. The case of unregulated international commercial surrogacy replays the same debates and the same prospects for future children.

The debates around sperm donation and past adoption practices also bring into focus the potential consequences of other means of conceiving and reproducing children that entail similar concerns around identity and the impact of decisions being made on behalf of future children. The fact that decisions made in the relatively recent past about future children continue to have ramifications in the lives of those children-now-adults should give us pause for thought in relation to current or future decisions about the creation of future children, particularly when we can see history so obviously repeating itself in the debates and issues that attend the lobbying of the children affected.

FUTURE PERFECTIBILITY

Conservative political scientist, Francis Fukuyama, prominently, publicly and emotively questioned the effects of enhanced reproductive techniques and biotechnologies in 2002 in his book, *Our Post-Human Future*. His negative response to the ability to manipulate reproduction and the effects that might have for the future of humanity

were focused on the future of liberal democracy, but in essence his arguments were based around the possible effects of biotechnologies on the creation of future children (as potential future citizens). He was writing, primarily, in reaction to the first successful cloning of a mammal – Dolly the sheep (1996–2003) – and from concerns that cloning would be applied in human reproduction.

Fukuyama's reactionary response led to a repeat of the all-too-common (and unhelpful) polarization of ethical debate around medical advances – science versus religion – that also characterizes related debates on abortion and women's reproductive rights. However, the central point raised by one social and political critic of Fukuyama remains pertinent and largely unanswered. Simon Cooper (2002) argued that Fukuyama never dealt with the larger question of addressing 'the meanings of biotechnological change from a cultural perspective' (2002: 36); that '[b]ecause biotechnology cuts across many of our assumptions about embodied life and social being it must also change our relation to the world' (*ibid.*: 38). Cooper is suggesting that the biotechnologies under debate do so by challenging our assumptions about embodied life and social being, in and through reproduction. They must therefore also challenge and change our relation to ourselves and by extension to our children and to childhood in general. And they do so by projecting a notion of children as 'perfectible'.

What, then, do biotechnological attempts at creating perfectible children mean? In a deeply material sense, future children are already being shaped, in the range of increasingly sophisticated reproductive technologies that are emerging. Different countries have reacted in disparate ways to the regulation or openness to the biotechnological possibilities for creating future humans, in ways that are rooted in the accepted understandings of when human life begins of the respective society. Further, there are clear divisions in who is able to access such biotechnologies that extend beyond the borders of individual nations, as we saw in relation to surrogacy in India. In this final section of the chapter we look to some of the more contentious propositions around reproduction, and therefore those obvious signs of change already underway, that are related to future children and the future of childhood.

Over more than 50 years of concerted research, assisted reproductive technologies (ARTs) – such as the *in vitro* fertilization and implantation of viable human embryos (IVF) – have gone from being science fantasies, to experimental possibilities, to institutionalized medical realities. In the space of a generation, from the birth of Louise Brown in 1978, IVF became a normalized part of the suite of reproductive interventions. In developed Global Northern nations, IVF is now almost as uncontroversial as the regular ultrasound imaging of foetal development, another bio-technology that has revolutionized parental perceptions of pregnancy and psychological attachment to the infant-yet-to-be born over much the same timeframe. Even though assisted conception remains the exception – even in countries such as the UK, where fertility treatments are well-established, expertly performed and readily available, 98 per cent of pregnancies remain naturally achieved (2010 data, HFEA, 2012: 39) – it is central to the possibilities around the creation of future children, and the techniques involved enable the idealization of a 'perfectible' child.

The initial conditions of possibility that paved the way for IVF and reproductive biotechnologies to affect understandings of children lie in the achievement of effective contraception. It is widely acknowledged that the public release of the contraceptive pill, first trialled in Puerto Rico in 1956 and first distributed for contraceptive use in the USA in 1961, made for a massive difference in the capacity of human beings to monitor and order the number of children they brought into the world (Martin, 1992). Contraception has been available for centuries – if not millennia – in a variety of forms, from douches, barrier methods and abortifacients, to non-vaginal sexual activity and periodic abstinence (Duden, 1999). Apart from the latter two, such methods were not wholly reliable and (hetero-)sexual activity was highly likely to eventuate in pregnancy. From the seventeenth century the likelihood of pregnancy became significantly more manageable, at least for the rich, who were more likely to have access to the latest scientific explanations of the means of conception thanks to microscopy, and to new-fangled and expensive (reusable) sheep-gut condoms (Collier, 2007). Until at least the end of the nineteenth century, for the vast majority of the population in the middle classes and below, children were considered a natural (almost inevitable) consequence of sex. That situation began to change early in the twentieth century with the increasing move towards ‘marital’ education and making available more reliable contraceptive measures (Rose, 1992). This was as a result of the activism of women like Dr Marie Stopes in the UK (see www.drmarie.org).¹⁰ Although most of the contraceptive methods remained far from foolproof and in some instances difficult to obtain, wider access to the Dutch cap and the rubber condom meant a notion of greater choice came into discussions around childbearing. As a result, children could be ‘planned’.

The phenomenon of the child or family-planning accelerated rapidly after the introduction of the contraceptive pill, with its low failure rate.¹¹ By the late twentieth century, children were no longer an expected consequence of heteronormative sexual activity throughout the Global North and increasingly in the Global South; rather children became a matter of ‘choice’. This in itself has affected the perception of children, as discussed in relation to the ‘valuable’ child. Reproductive medicine is a very particular process of rationalization and anatomization of the human body in which post-modern bodies become ‘organs without bodies’ (Braidotti, 1989) and women are constructed ‘as wombs and childbearing machines, instead of whole persons’ (Gupta and Richters, 2008), in which the child is the ultimate product.

Pregnancy can now be avoided indefinitely: however, delayed reproduction is not without cost. At the same time that the physical limits of fertility in females continue to be tested, with IVF now regularly being attempted over the age of 50, the reality remains that conception and child-bearing become more difficult beyond the age of 32, accelerating from the age of 35 onwards. This has, in turn, already influenced the meaning of children and of childhood beyond the notion of a choice that can be planned. Since the increase in the effectiveness of assisted reproductive techniques, for which reliable statistics give a success rate of close to a 25 per cent live birth rate (HFEA, 2012: 4), there has been a shift in the discourse around human reproduction in the developed world. Child-bearing is increasingly spoken of in terms of ‘rights’ (of parents to have and bear children), a phenomenon in which we have already seen that children, in many ways, are

confirmed as parental chattels. Further, the relatively straightforward enhancement and extension of the capacity to bear children is already altering notions of children as objects of value (see Nauck, 2007) and altering the lived experience of childhood by extending the age gap between child, parent and grandparent. Those enhanced capacities have also raised the possibility of further 'choices' and 'rights' that are not so straightforward, which relate back to the known long-term effects on offspring of AI.

It seems unlikely that Fukuyama's fears of human cloning for the creation of fully formed infants is a viable prospect, at least for the foreseeable future, both on practical and ethical grounds. It is strongly opposed at the UN on the basis that it contravenes human dignity.¹² However, there are a number of reproductive practices either possible or in restricted application that do challenge our current relation to children and our notions of childhood. Amongst these are included techniques that stem from IVF technologies and procedures, including the ability to perform pre-implantation diagnostic (PID) screening and/or selectively implant embryos on the basis of choices that go beyond issues critical to the prospective child's health.

PID screening can encompass searching for all manner of genetic markers, which may or may not involve diseases or syndromes, but which are thereby identified. Selection of embryos (for implantation and gestation, or rejection) is already practised on the basis of a range of heritable conditions (Pilnick, 2002). Depending on the legislation of the country in which one lives that might include selecting on the basis of gender, where the condition is chromosomally linked, but gender selection of embryos might also be practised for 'family balance' or on the basis of parental preference (Ettorre, 2002). Screening for chromosomal abnormalities *in vitro* is promoted as a means of avoiding the termination of pregnancy, particularly in cases where there is a known incidence of a condition within a family history. There have also been bioethical debates mounted around allowing screening and selection for virtually any trait that a prospective parent might prefer, such as eye colour, hair colour or 'intelligence'. This has sometimes overtly appealed to the parents' liberal rights to choose 'in the best interests of the child' as formulated by the UNCRC (Robertson and Savulescu, 2001: 39, 49). We also know that children have been brought into being as a result of embryonic selection, specifically to be able to become compatible tissue donors for pre-existing siblings (Ettorre, 2002). In all of these instances, it is the parents' rights that appear paramount, and the implicit outcome of parental decision-making is both a 'perfectible' and an economically or pragmatically 'valuable' child.

If we take a future child to be a potentially real (rather than a hypothetical) being, when someone argues in favour of parents being able to use pre-implantation IVF techniques to determine facets of that future child's physical and mental characteristics the future child that is the product of such a procedure is at stake. To conceive a child expressly to harvest biological materials to assist in the medical treatment of a sibling or other relative, similarly and demonstrably has resultant effects for the lived reality of that child. That child may feel privileged to have been born in such circumstances, but he or she may equally feel they are not valued for themselves but for their biomedical usefulness. If we can extrapolate nothing else from the histories of adoption and of AI, it is that in making decisions on behalf of future children what we choose will have consequences for that

child, some of them undoubtedly unforeseeable. What we can foresee from adoption and AI is that as the future child grows his or her identity is bound up in the processes of his or her conception. That identity is affected by any decision made consciously on his or her behalf.

Further, the promises offered by biomedical technologies of the perfect or the perfectible child cannot be confined to the individual couple or their direct offspring. The legitimization in law or policy of the capacity to choose traits or conditions has demonstrable effects on the make-up of a culture or society made possible through the biomedical management of children. Disability activists, amongst others, have understandably been concerned at the denigration of actual people in the selection against (or aborting of pregnancies involving) the more common genetic conditions such as Down's syndrome and achondroplasia and at the potential for anyone with a genetically identifiable condition to be 'selected out' of the population (Shakespeare, 1998).

Debates from bioethics and medical ethics that are based around the bringing into being of children rarely go beyond the hypothetical consideration of a future child, often in terms of its future rights but usually in order to place someone else's rights in competition with or ahead of that possible child; parents, siblings, doctors, society, government. Our aim, here, is not to propose answers but to provoke the rethinking of some of the issues that arise in those debates in the light of the discussions and analyses canvassed in the preceding chapters. Given that the majority of the case studies have centred on developing or under-developed countries, one of the most obvious comments to make is that the kinds of debates around choice and rights that pervade the Global Northern discussion of reproductive technologies simply do not obtain in conditions where the basic means of sustaining life (water, shelter, food) may be uncertain or unmet. And yet, the fact that these debates occur in countries that adhere to and have the power to shape dominant understandings of children and childhood, and the international protocols on reproductive technologies, almost inevitably will have flow on effects for children and childhood of the Global South. We have already seen that women of the Global South are variously providing gametes, gestating and giving birth to children for parents of the Global North (Gupta and Richters, 2008). What remains unexplored is the effect this is having on the existing and future children of the Global Southern women who perform the reproductive labour that makes other people's babies possible. Is the discourse around children and childhood of late modernity, in some odd inverted way, returning to early-modern ideas of child ownership, whereby the child is seen as an economic unit and valued as a commodity?

What matters most in these debates are the ways in which children are conceived of and the disparity between these visions for 'our' children and 'other' children. Even the least reproductive technological intervention, AI to rectify male infertility, has had demonstrable effects on the lived identity of the children born as a result that repeat the lived experiences of adoptees. This observation leads us to the question with which we would like to leave the reader of *Global Childhoods*. Is it not at least equally conceivable that efforts at creating perfectible children, attempts to shape ideal and idealized children, contain within them similar potential outcomes for the identities of the future children who will 'be' and 'become'?

NOTES

- 1 The first two case studies are an extended and refined reworking of material that has appeared in the *Cambridge Quarterly for Healthcare Ethics*. The authors and publishers would like to express their thanks for the following permissions:

Cregan, K. (2013) 'Who Do You Think You Are?': Childhood and Identity in Australian Healthcare Ethics', *Cambridge Quarterly of Healthcare Ethics*, 22 (3): 232–7. Copyright © 2013 Cambridge University Press. Reprinted with permission.

Cregan, K. (2014) 'Sex Definitions and Gender Practices: An Update from Australia', *Cambridge Quarterly of Healthcare Ethics*, 23 (3): in press. Copyright © 2014 Cambridge University Press. Reprinted with permission.
- 2 Laws vary from state to state on the age for consensual sexual activity from 16, to 17 and 18, although the last only applies in Queensland, and specifically for anal sex. Defences may also be made for consensual sex at younger ages for a range of reasons. See <http://www.aifs.gov.au/cfca/pubs/factsheets/a142090/index.html>, accessed 13 October 2013.
- 3 With thanks to Dr John Waugh of the University of Melbourne for clarifying the legal issues around *Re: Jamie* for me.
- 4 For more general information and a list of publications arising from the ARC funded History of Adoption Project, see <http://www.arts.monash.edu.au/historyofadoption/index.php>.
- 5 In 1978, the boyfriend of one of the authors considered donating and was offered this sum. A raft of tests is required to identify and exclude donations infected with transmissible diseases and some genetic conditions. This payment is based on one clinic that accepts up to five donations, so the total reimbursement can be AU\$1500: <http://www.spermdonorsaustralia.com.au/how-start>, Accessed 13 October 2013.
- 6 At the time of writing, legal mechanisms to enable the identification of donors prior to 1988 are being enacted, but identification will be at the discretion of the donor: in other words, it is a voluntary register.
- 7 Again, the dates of legislation vary from state to state, but formal adoption was not possible until the late 1920s. The adoption in Victoria of the father of one of the authors (Kate Cregan) was not formalized until 1930 when he was ten, under the Adoptions of Children Act 1928, although he had been with the people he believed to be his parents from the age of three. See also the History of Adoption Project, <http://www.arts.monash.edu.au/historyofadoption/index.php>.
- 8 With thanks to the anonymous reviewer for the suggestion to include both the discussion of abortion and the case of commercial surrogacy in India.
- 9 For further examples of prosecutions under this act of what appear to have been still-births, see Cregan (2009).
- 10 And Margaret Sanger in the US, whose programme was tinged with a eugenic enthusiasm.

- 11 Its prescription was restricted to married women at first, but generally made available to single women from late 1960s onwards.
- 12 Therapeutic cloning is in use in laboratories, subject to research regulation and compliance with national ethical standards (e.g. in the UK and Australia): that is, the cloning of human embryos for experimental research up to a multicellular stage, *in vitro*, whereby implantation and gestation remains illegal.

Further reading

Ettorre, E. (2002) *Reproductive Genetics, Gender and the Body*. London: Routledge.

Fukuyama, F. (2002) *Our Post-Human Future: Consequences of the Biotechnology Revolution*. London: Profile Books.

Laufer-Ukeles, P. (2013) 'Mothering for money: Regulating commercial intimacy', *Indiana Law Journal*, 88: 1223–79.

Pilnick, A. (2002) *Genetics and Society: An Introduction*. Buckingham: Open University Press.

Singer, P. (1995) *Rethinking Life and Death: The Collapse of our Traditional Ethics*. Oxford: Oxford University Press.