

Child-rearing ability and the provision of fertility services

The Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

Fertility programs may withhold services when there are reasonable grounds for thinking that patients will not provide adequate child-rearing to offspring but are not obligated to do so. This document was reviewed in June 2009 and while no changes were made, this version does replace the previous version of this document, published in September 2004. (Fertil Steril® 2009;92:864–7. ©2009 by American Society for Reproductive Medicine.)

1. Fertility programs may withhold services from prospective patients on the basis of well-substantiated judgments that those patients will be unable to provide or have others provide adequate child-rearing for offspring.
2. Fertility programs may—except in clear cases of significant harm to offspring—provide services to all persons who medically qualify.
3. Fertility programs should develop written policies and procedures for making determinations to withhold services on the basis of concerns about the child-rearing capacities of prospective patients.
4. A program's assessment of a patient's child-rearing ability should be made jointly among members of the program. A home study is not required.
5. Persons with disabilities should not be denied fertility services except in rare cases when a well-substantiated basis exists for thinking that they cannot provide or have others provide adequate child-rearing for offspring. Providers of infertility services are sometimes faced with patients who do not appear to be well-situated to provide good care for children. Treating them may lead to the birth of a child who is reared by parents who are psychologically unstable, who abuse drugs, who may abuse the child or the other parent, or present other risks to the well-being of the child. Predictions about parental child-rearing ability, however, are not easily made, and personnel in fertility programs may not be well-situated to make them. This poses an ethical dilemma in which clinicians must weigh the potential interests of offspring against the needs and desires of infertile patients. The aim of this statement is to provide guidance to fertility programs in such circumstances. It addresses the question of whether clinicians may—or must—provide services to persons whom they suspect may not be good child-rearers, or whether they have an ethical obligation not to provide these services. It also discusses the extent

to which a physician's own moral views of minimally acceptable childrearing may appropriately be taken into account in deciding whether to accept a patient for infertility treatment.

THE NATURE OF THE DILEMMA

Fertility specialists provide services that treat or bypass physical problems interfering with fertility. They are sought by persons whose efforts to have children coitally have failed and they ordinarily focus on medical aspects of the situation. While some psychological or social screening may occur in determining whether a person or couple will be able to understand, tolerate, and comply with the demands of infertility treatment, much less attention ordinarily is focused on the home or rearing situation of children born as a result of treatment.

As with persons who reproduce coitally, no systematic screening of their ability or competency in rearing children has traditionally occurred or been thought to be appropriate, as would ordinarily occur in adoption. With the growth of fertility programs and increased access for many people in the population, a wide variety of individuals now seek infertility treatment, including subcategories of patients for whom questions of child-rearing ability might legitimately arise. Many programs have had treatment requests from patients that raise such questions, for example, from persons who have a history of psychiatric illness, substance abuse, or ongoing physical or emotional abuse in relationships. Some patients or their partners may also have a history of perpetrating child or spousal abuse, or they present other factors that lead fertility programs to question whether they are likely to cause significant harm to a future child. In addition, persons with disabilities are increasingly seeking fertility services. While most disabilities do not impair child-rearing ability, there are some situations in which questions about child-rearing ability of persons with severe disabilities could reasonably arise.

Reviewed June 2009; published online August 5, 2009.

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This presents a dilemma for fertility programs. As providers of medical services, they are not equipped to evaluate the child-rearing ability of their patients or conduct home studies as adoption agencies do, nor has it been thought their role to do so. There is no existing child to be placed for adoption and thus no need for the home studies and extensive scrutiny that occur in adoption. Medical factors have been the key determinant of whether treatment will be provided. Indeed, some physicians argue that that should be the only factor in deciding whether to provide services.

Fertility programs, however, are not totally removed from social and psychological assessment of patients. Many programs require patients to spend time with a counselor to ensure that patients can handle the stresses of treatment. They may also ask patients for a social or psychological history. Such assessments have become routine for IVF and for procedures involving the use of donor gametes or surrogacy. Even though fertility programs do not seek specifically to assess parenting ability, pre-treatment evaluation of patients might reveal potential problems, such as uncontrolled psychiatric illness, a history of child or spousal abuse, or drug abuse. In such situations some programs and providers may be reluctant to proceed with treatments, either out of concern about their role in bringing about a situation that is not beneficial to the child or because of fears of legal liability. At the same time they may feel that they are not competent to make such predictions and should not be required to do so. They may also feel that it is necessary to respect the right of persons to have children if they choose and to avoid charges of unlawful or improper discrimination in withholding services from them.

The problem is complicated because many interests are implicated in such dilemmas. The interest of future children in having a healthy home environment and minimally competent rearing parents must be reconciled with the interest of infertile persons in receiving the treatment services they need to reproduce and the provider's own sense of moral responsibility in deciding what patients to treat.

RECONCILING THE INTERESTS

We analyze below the interests of offspring, infertile persons, and providers of fertility services. Recognizing that it is difficult to reach optimal solutions for all situations, we believe that fertility programs should be attentive to serious child-rearing deficiencies in their patients, and if they have a substantial, non-arbitrary basis for thinking that parents will provide inadequate child-rearing, they should be free to refuse to provide treatment services to such patients. Because of the difficulty of making such judgments reliably, however, clinicians should deny services on the basis of inadequate child-rearing abilities only after investigation shows that there is a substantial basis for such judgments. In reaching such conclusions, it is imperative that they not engage in unjustified discrimination. However,

we do not believe that fertility providers are morally obligated to refuse services in all cases in which questions of inadequate child-rearing arise. Such judgments may be very difficult to make reliably. Also, given the great importance of procreation, infertile persons should not be denied services without good reason after an assessment jointly made by members of the treatment team. Programs may adopt a policy that they will provide fertility services to all persons who medically qualify except when significant harm to future children is likely.

The Welfare of Offspring

Questions about the child-rearing ability of fertility patients raise questions about the welfare of future offspring and the duty of prospective parents and those aiding them to avoid situations in which that welfare may be brought into jeopardy. Ordinarily the birth of a child is deemed a good in itself, and helping the parents achieve that goal is a morally worthwhile endeavor. The use of reproductive technologies, however, sometimes presents questions of risks or effects on offspring from the social situations in which resulting children are born.

Many persons have argued that the well-being of offspring should be the primary consideration in determining whether medical services should be provided to treat infertility. Indeed, the Human Fertilisation and Embryology Act setting up a regulatory authority for assisted reproductive technology in the United Kingdom made this consideration explicit. It stated that treatment services should not be provided, unless account has been taken of the welfare of any child who may be born as a result of treatment (1).

The Ethics Committee believes that the well-being of offspring is an overriding ethical concern that should be taken into account in determining whether to provide infertility services. Respecting the interests of children in the context of infertility, however, poses an ethical paradox. In most instances decisions about whether to provide a treatment will determine whether a child will be born at all, not whether the child will be born more or less healthy. In such cases the only way to protect the child from the risks of concern would be to avoid its birth altogether. This is true even if the feared harm is caused by inadequate childrearing, because such harm might occur even if other child-rearers theoretically could be provided.

A large body of philosophical and bioethical literature discusses the issue of harm to offspring from the very conditions of their conception or birth (2–10). Some commentators have concluded that unavoidable “harm” to a child from assisted reproduction can never be a valid reason to withhold services (2, 10). However, we think that such a judgment takes too narrow a view of the relevance of offspring welfare in determining ethical conduct. Although a child may not strictly speaking be “harmed” as a result of fertility procedures that made its birth possible, we think that concerns about future harm to offspring validly may be taken into account in

making ethical assessments about those treatments. For some persons the diminished welfare of the child alone is sufficient to justify this conclusion. Others might point to the significant costs and burdens that children with greatly diminished welfare impose on others. In addition, it is difficult to understand how a person's interest in reproducing and rearing offspring is rationally served in cases in which there is a high risk of injury to a prospective child from conception or the rearing situation into which the child will be born.

These are not easy judgments to make, and providers or policy-makers should be very cautious in making them. A wide range of social situations are compatible with a child thriving and having a meaningful life and persons having a rich and responsible parenting experience. For concerns about the welfare of offspring to be relevant to ethical assessment or policy choice, they would have to be very large deviations from normal health and social situations, with such assessment made only after careful consideration of relevant factors.

The Interests of Infertile Persons

Another important consideration in assessing this issue is the interest of infertile patients in receiving services that will enable them to reproduce. Fertile persons have constitutional rights to have and rear children that the state cannot restrict except in extreme cases of harm. Indeed, persons with severe mental illness or developmental disability are protected against compulsory sterilization or contraception even when reproductive decisions may be rightly regarded as irresponsible or wrong. Infertile persons have the same rights and interests in reproducing as do fertile persons, and they should not be denied services merely because they are infertile. Reproductive rights protected under the United States and state constitutions are rights *against* state interference, not rights *to have* physicians or the state provide requested services. In addition, constitutional rights protect individuals against interference or discrimination *by government* or governmental entities, not against persons in private practice. Federal and state anti-discrimination laws, however, do ban certain kinds of private sector discrimination in accepting patients that, because they are private actors, would not violate their constitutional rights (11). As long as the private sector physician does not impermissibly discriminate under these laws, he or she may choose not to accept a fertility patient without violating that person's constitutional rights. It is also important to recognize that constitutional rights to reproduce are, like all rights, not absolute and they can be restricted or limited for good cause. While there is great dispute about what will count as a sufficient justification for *state* restrictions on reproduction, physicians in private practice might legitimately, when a clear case of a substantial risk of harm to offspring is shown, choose not to provide services that make such a birth or rearing situation possible.

As noted, such judgments may be difficult to make or support except in the clearest cases. Because of the importance of reproduction to persons, judgments to deny treatment should

be made only when there is a strong and substantial basis for doing so. In making them, providers should pay special attention to treating equally persons with disabilities who request fertility services. Most persons with disabilities are able and well-qualified to rear children, and should not be disqualified from doing so merely because of their disability. Indeed, the federal Americans with Disabilities Act, which applies to private fertility clinics, prohibits denying persons with disabilities access to infertility services if the denial is based on ill-founded doubts or stereotypes about their ability to rear and parent.

Provider Autonomy

An important difference between reproduction by fertile and infertile persons is that fertile individuals do not need the help of physicians to conceive or get pregnant. Persons who seek the assistance of a physician to reproduce necessarily implicate the physician in the outcome that they seek. Requests for reproductive assistance thus also raise the question of whether physicians are obligated to treat all patients who seek their services. Although a strong ethic urges physicians to treat all persons in need, physician and professional autonomy is also an important value. Ordinarily, physicians are free to decide whether to enter into a doctor-patient relationship with a patient, and once in it, whether, with adequate notice to the patients, to terminate that relation. Unless the conditions of their employment require otherwise, physicians providing fertility services are generally free not to provide those services to individuals as they choose, subject only to federal and state laws against unjustified discrimination on the grounds of race, religion, ethnicity, or disability. Physicians faced with individuals or couples whom they have strong reasons to believe may be seriously deficient child-rearers may have very good reasons for choosing not to treat them. Precisely because fertility services could produce a child, physicians may reasonably believe that they have a moral responsibility for the situation of the resulting child and choose not to help bring about such an outcome. If they take that view and do not discriminate on the basis of disability or other impermissible factor, they may take the welfare of resulting children into account in deciding whether to provide services.

By the same token, some providers may believe that they have an obligation to treat all patients who would benefit from medical treatment and should not be required to make assessments of a patient's child-rearing abilities or other child welfare issues. This too is a reasonable position, except when significant harm to a future child is likely. Physicians and providers with this treatment philosophy should be free to accept persons for treatment as long as they have a reasonable basis for thinking that the child will not suffer significant harm from being born in those circumstances. Professional autonomy thus has two aspects. It entitles physicians to choose *not to treat* persons whom they think will be inadequate child-rearers (as long as they comply with anti-discrimination

laws). It also generally entitles them *to treat* such patients if they choose.

RECOMMENDATIONS

Offspring welfare is a valid consideration that fertility programs may take into account in selecting patients and providing services as long as they do not discriminate on the basis of disability or other impermissible factor. However, it does not follow that they are morally obligated to withhold such services, except when significant harm to future children is likely. Physician autonomy entitles physicians to provide medical services if they choose, but they are not usually obligated to do so. While practitioners and clinics may—except in the case of impermissible discrimination—make their own moral decisions about whether to accept individuals as patients, their decisions should be based on empirical evidence, not stereotype or prejudice. For example, they should not assume that a history of social or psychological problems or serious disability automatically disqualifies someone from being a capable rearing parent.

Such assessments need careful inquiry and should be dependent on empirical facts. To aid in the process fertility programs should develop explicit policies and procedures for handling such situations. Written policies might address such matters as the information and evaluation that will be required of potential patients and what conditions would preclude medical treatment for infertility (e.g., uncontrolled psychiatric illness, substance abuse, on-going physical or emotional abuse, or a history of perpetrating physical or emotional abuse). Programs should also establish a procedure for making such assessments when questions about the child-rearing adequacy of prospective parents arise. This might involve evaluation by a mental health worker and consideration by psychological or other consultants culminating in a group assessment or review prior to a final determination.

Acknowledgments: This report was developed by the Ethics Committee of the American Society for Reproductive Medicine as a service to its members and

other practicing clinicians. While this document reflects the views of members of that Committee, it is not intended to be the only approved standard of practice or to dictate an exclusive course of treatment in all cases. This report was approved by the Ethics Committee of the American Society for Reproductive Medicine and the Board of Directors of the American Society for Reproductive Medicine.

The members of the ASRM Ethics Committee have the following potential conflicts of interest: Robert Brzyski, M.D., Ph.D., Chair, has nothing to disclose. Andrea Braverman, Ph.D., has nothing to disclose. Andrea Stein, M.D., has nothing to disclose. Bonnie Steinbock, Ph.D., has nothing to disclose. Bruce Wilder, M.D., M.P.H., J.D., has nothing to disclose. G. David Adamson, M.D., has nothing to disclose. John Robertson, J.D., has nothing to disclose. Judith Daar, J.D., has nothing to disclose. Leslie Francis, J.D., Ph.D., has nothing to disclose. Mark Gibson, M.D., has nothing to disclose. Robert Rebar, M.D., has nothing to disclose. Rosamond Rhodes, Ph.D., has nothing to disclose. Sean Tipton, M.A., has nothing to disclose. Senait Fisseha, M.D., J.D., has nothing to disclose. Steven Ralston, M.D., has nothing to disclose.

REFERENCES

1. Human Fertilisation and Embryology Act of 1990. Human Fertilisation and Embryology Act of 1990. In: Morgan D, Lee RG, eds. Blackstone's guide to the Human Fertilisation & Embryology Act 1990. London: Blackstone Press Limited, 1991:194.
2. Heyd D. Genethics: moral issues in the creation of people. Berkeley, CA: University of California Press, 1992.
3. Coleman CH. Conceiving harm: disability discrimination in assisted reproductivetechnologies. 50 U.C.L.A.L. Rev. 17 (2002).
4. Peters PG Jr. Protecting the unconceived: nonexistence, avoidability, and reproductive technology. 31 Ariz. L. Rev. 487–558 (1989).
5. Brock D. The non-identity problem and genetic harms—the case of wrongful handicaps. Bioethics 1995;9:269.
6. Parfit D. On doing the best for our children. In: Bayles MD, ed. Ethics and population. Cambridge, MA: Schenkman, 1976.
7. Green RM. Parental autonomy and the obligation not to harm one's child genetically. J Law Med Ethics 1997;25(5):10.
8. Steinbock B, McClamrock R. When is birth unfair to the child? Hastings Cent Rep 1994;24(Nov–Dec):15.
9. Cohen CB. The morality of knowingly conceiving children with serious conditions: an expanded “wrongful life” standard. In: Fotion N, Heller JC, eds. Contingent future persons. Boston: Kluwer Academic Publishers, 1997:33.
10. Roberts M. Child versus childmaker: future persons and present duties in ethics and the law. Lanham, MD: Rowman & Littlefield, 1998.
11. Robertson JA. Procreative liberty, harm to offspring, and assisted reproduction. Am J Law Med 2004;30(2):7–40.