

Child-rearing ability and the provision of fertility services: a committee opinion

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Fertility programs may withhold services when there are reasonable grounds for thinking that patients will not provide adequate child-rearing to offspring. This document was reviewed and updated and this version replaces the previous version of this document, reviewed in June 2009 (Fertil Steril 2009;92:864–7). (Fertil Steril® 2013;100:50–3. ©2013 by American Society for Reproductive Medicine.)

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KEY POINTS

- Fertility programs may withhold services from prospective patients on the basis of well-substantiated judgments that those patients will be unable to provide minimally adequate or safe care for offspring.
- 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.
- A program's assessment of a patient's inability to care for a child or potential to cause harm to a child should be made jointly among members of the program. A home study is not required.
- Persons with disabilities should not be denied fertility services solely on the basis of disability.

Providers of infertility services are sometimes faced with patients who do not appear to be well-situated to pro-

vide safe or adequate 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 who present other risks to the well-being of the child. Accurate 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 able to provide adequate parental care, 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 child-rearing may be taken into account in appropriately deciding whether to accept a patient for infertility treatment.

THE NATURE OF THE DILEMMA

Fertility specialists provide services that treat or bypass medical and nonmedical problems that interfere with the ability to have children. Fertility specialists ordinarily focus on medical aspects of the situation. While some psychological 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, a wide variety of individuals now seek infertility treatment, including subcategories of

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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 or current evidence of uncontrolled or untreated psychiatric illness, substance abuse, violent or criminal behavior, and child abuse; previous loss of parental rights; or ongoing partner abuse in their relationship. These factors and others may lead fertility programs to question whether such patients 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, questions about child-rearing ability of persons with severe disabilities could reasonably arise in some situations.

This presents a dilemma for fertility programs. As providers of medical services, programs 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 the 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. Programs may obtain social or psychological history information from patients. Programs may require patients to spend time with a counselor to provide support for the stresses of treatment. Such counseling has become routine for patients using donor gametes or surrogacy. Even though fertility programs do not seek to assess specifically parenting adequacy, pretreatment evaluation of patients might reveal potential problems, such as uncontrolled psychiatric illness, a history of child or spousal abuse, or substance abuse. In such situations, some programs and providers may be reluctant to proceed with treatments, either out of concern over their role in helping patients become parents who may be potentially harmful to their child or because of fears of legal liability. At the same time, programs may feel that they are not competent to make such predictions and should not be required to do so. Programs also may 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 with the provider's own sense of moral responsibility in deciding which 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 the potential for serious child-rearing deficiencies in their patients. 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 only after investigation shows that there is a substantial basis for such judgments. In reaching such conclusions, it is imperative that programs not engage in prohibited or unjust discrimination. Given the great importance of procreation, infertile persons should not be denied services without a thorough assessment and determination jointly made by members of the treatment team. However, we do not believe that fertility providers are morally obligated to refuse services in all cases in which there might be a question about inadequate child-rearing. It is very difficult to make such complex judgments about potential future risk to offspring. Some will prefer to proceed with treatment, giving greater weight to the parents' desire to reproduce. Also, 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 provision of reproductive technologies, however, sometimes presents questions of risks or harm to offspring from being born to a particular set of parents.

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.

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 potential harm to the child alone is sufficient to justify this conclusion. Others might point to the significant costs and burdens that parental unfitness imposes on the larger society.

Denying fertility services to those who might harm a child is not an easy judgment to make, and providers or policy-makers should be very cautious in making them. A wide range of parenting approaches or homes is 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, the parents’ prospective child-rearing would have to raise child protection concerns and represent a very large deviation from a “good enough” home. Such assessment should be thorough and defensible 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, but such protections usually don’t extend to the behavior of 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 also is 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. Many 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 become 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 there is a strong presumption in favor of an obligation 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 that prohibit discrimination on the grounds of race, religion, ethnicity, sexual orientation, marital status, 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 deny treatment solely 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 assess a patient’s child-rearing abilities or other child welfare concerns. 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 raised by these parents. 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 accepting 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 presence of a serious disability automatically disqualifies someone from being a capable rearing parent.

Assessments of patients who raise child protection concerns 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 or untreated psychiatric illness, substance abuse, on-going physical or emotional abuse, or a history of perpetrating physical or emotional abuse). Programs also should establish a procedure for making such assessments when questions about the child-rearing adequacy of potential parents arise. This might involve evaluation by a mental health professional and consultation with other experts culminating in a group assessment or review prior to a final determination.

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