

Virtual Mentor

American Medical Association Journal of Ethics
September 2007, Volume 9, Number 9: 635-640.

Medicine and Society

Is Restricting Access to Assisted Reproductive Technology an Infringement of Reproductive Rights?

Andrew M. Courtwright, MA, and Mia Wechsler Doron, MTS, MD

The United Nations Universal Declaration of Human Rights includes the right to “found a family” [1]. While families may be established through “social” means—for example, adoption—this statement is often interpreted as conferring a right to reproduce [2].

Rights are expressions of our dignity and shared humanity. When we assert a right, we create corresponding duties not to interfere with us—and possibly to assist—in certain ways [3]. If a right to parenthood exists, what obligation, if any, does it impose on physicians to provide assisted reproductive technology (ART) services, given the uncertain promise of benefit and the potential expense and risk? And when, if ever, can physicians infringe that right?

Rights are not freestanding moral imperatives, nor are they absolutely inviolable. They exist within a network of social relationships and moral and legal principles that both ground them and establish the conditions under which they may be abridged. Potential sources for a right to parenthood include appeals to the value of family, the basic human desire for and interest in having a child, normal human biological and social functioning, a presumptive principle of equal freedom of action (including procreation), and existing laws that support the right. We will not argue the validity of these principles here, but will focus instead on physicians’ role in fulfilling (or limiting) individuals’ exercise of their *assumed* right to parenthood [4].

Negative and Positive Rights

All rights, and the duties they entail, can be interpreted negatively or positively. Negative rights obligate others not to interfere without justification; in this case, not to restrict a person’s ability to become a parent. For physicians, the law and professional practice standards already uphold this liberty. Physicians have a duty to warn patients about the potential fertility-altering effects of procedures or treatments and to avoid damaging patients’ reproductive capacity when possible. Hence, sterilization without consent is morally and legally repudiated except in extraordinary circumstances [5].

A positive right to parenthood, however, would go further, obligating others to support a person’s attempt to become a parent. It is here that questions about the use of ART are likely to arise. Do physicians have a duty to assist their patients’

procreative efforts, and if so, in what ways [6]? Although we believe that physicians who are not trained to provide ART services have a duty to refer their infertile patients to specialists for further work-up and evaluation, we think this duty arises not from any right to parenthood, but from broader professional obligations within the patient-doctor relationship.

When a patient is trying unsuccessfully to conceive a child, adequate health care includes assessment and possible treatment of infertility, and certainly a physician with expertise in ART who commits to providing the technology to a patient under his or her care has a professional duty to do so. The obligation to use ART comes, not from the right to parenthood, but from the right to have a commitment fulfilled. The real test of a positive right to parenthood, then, is whether specialists with expertise in ART *must* accept as patients those who require their services to become parents and if the kind(s) of ART provided must be those most likely to result in parenthood [7].

In virtue of their training, skills, and sanctioned role as professional caregivers, physicians are thought to be under strong obligations to provide assistance to patients with medical needs when it is in their power to do so. Although the strength of this duty may vary with the need in question—obligations to assist in a life-threatening emergency are stronger than those in less serious cases—a patient's medical needs can, with certain restrictions, create a right to have that need fulfilled. We suggest, therefore, that specialists with expertise in infertility and ART do have a duty to take on patients pursuing parenthood and should commit to providing them with appropriate services. We will have more to say about the extent of this obligation, which, we believe, comes from the right to parenthood.

Can Procreative Rights be Restricted?

We first turn to the general question of whether and when procreative rights can be restricted. In general, negative rights are more stringent than positive rights; stronger arguments are needed to abridge or override them. In practice, physicians tend to ground abridgement of a patient's procreative rights in appeals to that patient's benefit or autonomy or both. For example, such interference may be permissible when it is an unavoidable consequence of medical treatment that is otherwise in the patient's best interest and when the risks or harms to procreation have been agreed to in advance [8].

Positive rights, on the other hand, are, justifiably, more subject to the tempering influences of competing moral and social considerations. It is important to note in this regard that ART is not monolithic; it consists of various particular services that can be provided in different ways. The obligation to assist others in the pursuit of parenthood by providing ART, therefore, need not translate into a duty to assist using *all* possible means under *any* circumstances.

Considerations that might justify physicians in not assisting a patient to achieve parenthood through ART include: ART's potential to produce multiple gestation pregnancies, which increase the risk for maternal and infant morbidity and mortality

and involve significant financial and opportunity costs for couples and society [9, 10]; the competing rights of others who might otherwise have access to the resources used to care for these pregnant women and offspring [11]; and the potential negative impact ART may have on social values such as supporting nonbiological families [12]. It is also legitimate for physicians to consider the availability of alternative ways to found a family (such as adoption), the uncertainty that any of the hoped-for or feared consequences of the use of ART will actually occur, and their own willingness or reluctance to participate in the possible creation of these medical and social consequences.

We believe that the existence of these strong countervailing considerations provide sufficient grounds for physicians to impose some restrictions on access to ART. In doing so, however, they must also be cognizant of the moral problems they might *cause* as a result of these limitations. For example, one common suggestion is to withhold ART from potential parents who refuse to commit in advance to reducing the number of fetuses if a multiple gestation pregnancy occurs. We believe this is not an appropriate restriction for a couple of reasons [13]. First, the positions of the parties in the negotiation for access to ART is unequal. While the physician stands only to lose a patient if someone refuses to accept ART under such conditions, the value and investment that potential patients place on achieving biological parenthood provides a strong motivation to access ART, even under conditions they might later come to regret [14]. Given this disparity, physicians have a responsibility to avoid imposing restrictions to which patients would not agree, were it not for their desperation to achieve their goal.

Second, we cannot endorse the idea that an appropriate mechanism for avoiding a possible moral harm—be it bad consequences, the violation of rights, or the undermining of a value—is to create conditions in which a patient might be forced to choose between a prior commitment and a new-found relationship with her potential children. While physicians do have responsibilities to future patients and society, their first obligation is to avoid harming their current patients by, for example, placing them in situations like this [15].

More justified restrictions on access to ART might include offering only technology that has less chance of multiple gestations; prescribing medications at lower doses, even if doing so is more expensive or less effective; frequent ultrasound monitoring of the number of developing follicles, with cancellation of insemination cycles and the requirement that patients commit to refraining from intercourse or using condoms when the number of developing follicles reaches a certain threshold.

In the case of in vitro fertilization, justified restrictions include agreeing to implant only a certain number of embryos and, in general, more conservative medical judgments about thresholds for escalating therapy to achieve a pregnancy [16]. These restrictions are likely to minimize medical and social harms and burdens while still allowing physicians to assist patients in their pursuit of parenthood. Furthermore, such restriction on ART does not undermine the central responsibilities of

nonmaleficence and beneficence in the patient-doctor relationship. As long as both the physician and the individual or couple understand these limitations, there seems to be little basis to claim that the right to parenthood has been violated [17].

Notes and References

1. United Nations General Assembly. Universal Declaration of Human Rights, adopted under Resolution 217 A (III), UN Doc A/810 at 71 (1948). December 10, 1948. <http://www.un.org/Overview/rights.html>. Accessed August 7, 2007.
2. Office of the High Commissioner for Human Rights. General Comment No. 19: Protection of the family, the right to marriage and equality of the spouses (Art. 23). 39th session (1990). For a discussion of the right to procreate in United States law, see *Carey v Population Serv Int'l*. 431 US 678, 685; 97 SCt 2010, 2016 (1977); *Stanley v Illinois*, 405 US 645, 651; 92 SCt 1208, 1212 (1972); Wu L. family planning through human cloning: Is there a fundamental right? *Colum L Rev*. 1998:1410.
3. Feinberg J. The nature and value of rights. *J Value Inq*. 1970;4:243-257.
4. For a broader discussion of the justification for procreative rights and the use of ART see Warren MA. Does distributive justice require universal access to assisted reproduction? In: Rhodes R, Battin BP, Silvers A, eds. *Medicine and Social Justice: Essays on the Distribution of Health Care*. New York, NY: Oxford University Press; 2002:426-437; and Harris J. Rights and reproductive choice. In: Harris J, Holm S, eds. *The Future of Human Reproduction: Ethics, Choice, and Regulation*. Oxford: Clarendon Press; 1998:5-37.
5. The history of eugenic programs in the United States and abroad suggests that the right to reproduce has not always received such strong endorsement from medical professionals or the general public. Some guidelines regarding nonconsenting sterilization include: American Academy of Pediatrics Committee on Bioethics. Sterilization of minors with developmental disabilities. *Pediatrics*. 1999;104(2 Pt 1):337-340; and ACOG Committee Opinion. Sterilization of women, including those with mental disabilities. *Obstet Gynecol*. 2007;110(1):217-220.
6. We will not consider whether physicians should restrict access to ART from couples who would refuse selective reduction out of an obligation to give some fetus or other the best possible chance of a normal gestation. See Evans MI, Johnson MP, Quintero RA, Fletcher JC. Ethical issues surrounding multifetal pregnancy reduction and selective termination. *Clin Perinatol*. 1996;23(3):437-451. We will also set aside questions regarding the physician's role in assisting adoptive and other "social" efforts to become a parent. Finally, we will not consider what demands the right to parenthood might make on the general public including whether part of the yearly tax revenue should be put aside to help pay for access to ART.
7. Our focus here will not be on physicians who refuse to provide ART based on social judgments about who should be a parent—like single women, gay couples, or older individuals. These objections center on who has a positive

right to parenthood in our society rather than the conditions under which such a right could be limited.

8. A recent case involving a developmentally disabled girl whose parents requested that her growth be attenuated and her reproductive organs removed so that they could more easily care for her may represent a rare exception to this rule, although in this case the patient's best interests are equated with the ability of her parents to care for her. See Verhovek SH. A radical treatment to stunt a 9-year-old disabled girl's growth stirs a deep ethical debate; What about Ashley's dignity? *Houston Chronicle*. January 5, 2007:A4.
9. Callahan TL, Hall JE, Ettner SL, Christiansen CL, Greene MF, Crowley WF Jr. The economic impact of multiple-gestation pregnancies and the contribution of assisted-reproduction techniques to their incidence. *N Engl J Med*. 1994;331(4):244-249.
10. Glazebrook C, Sheard C, Cox S, Oates M, Ndukwe G. Parenting stress in first-time mothers of twins and triplets conceived after in vitro fertilization. *Fertil Steril*. 2004;81(3):505-511.
11. Scholz T, Bartholomaeus S, Grimmer I, Kentenich H, Obladen M. Problems of multiple births after ART: medical, psychological, social and financial aspects. *Hum Reprod*. 1999;14(12):2932-2937.
12. Petersen TS. The claim from adoption. *Bioethics*. 2002;16(4):353-375.
13. We also have reservations about extracting a commitment in a situation where there is no mechanism in place for enforcing the terms of the commitment or even the intention to enforce it (i.e., the decision whether or not to reduce will ultimately be left to the mother while the physician presumably has no intention of taking that choice from her regardless of their previous agreement).
14. Although specialists can be under significant pressure to maximize the number of successful pregnancies and thereby attract new patients, we do not believe that this is sufficient to place the parties on equal ground in negotiating access to ART. For a discussion of what information should be available to the public regarding individual physician's "success" rates with ART, see Schieve LA, Reynolds MA. What is the most relevant standard of success in assisted reproduction? Challenges in measuring and reporting success rates for assisted reproductive technology treatments: What is optimal? *Hum Reprod*. 2004;19(4):778-782.
15. In cases where there are other physicians who are easily accessible and are willing to provide ART without requiring a commitment to reduce in advance, then, all else being equal, the availability of this alternative may make it permissible for a physician to adopt the agree-to-reduce-in-advance restriction.
16. Other recommendations are noted in Wilson EE. Assisted reproductive technologies and multiple gestations. *Clin Perinatol*. 2005;32(2):315-328. While we do not believe physicians are required to adopt these measures, we do support the idea that specialists have some responsibility to self-police when using ART, where that may include reasonable efforts to reduce

multiple gestations. Alternatively, regulatory boards or societies within the specialty may help play this role.

17. For more on this point see Chester R. Double trouble: Legal solutions to the medical problems of unconsented sperm harvesting and drug-induced multiple pregnancies. *St Louis U Law J.* 2000;44:451-485.

Andrew M. Courtwright, MA, is a teaching fellow in the Department of Philosophy at the University of North Carolina Chapel Hill and a fourth-year student in the UNC School of Medicine. His research focuses on the relationships between justice, socioeconomic status, and health disparities.

Mia Wechsler Doron, MTS, MD, is an associate professor of pediatrics and adjunct associate professor of social medicine at the University of North Carolina School of Medicine in Chapel Hill. She is a neonatologist in UNC Hospitals' Newborn Critical Care Center and serves on the Hospitals' Reproductive Therapy Ethics Committee and Fetal Therapy Advisory Board. Dr. Doron's research focuses on applied ethics and medical decision making.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2007 American Medical Association. All rights reserved.