



In-vitro Fertilisation

Eligibility criteria

A Discussion Paper

**Synod Bioethics Committee
Uniting Church (Queensland Synod)**

When a mother wants to give birth to a baby in our hospitals we no longer see her marital status or sexuality as relevant to whether she is admitted. Should we still consider it relevant when assessing eligibility for IVF procedures?

Introduction and background

This paper explores the issue of eligibility criteria for in-vitro fertilisation (IVF) treatment in Uniting Church hospitals, particularly reviewing the current requirement that access to IVF is restricted to 'infertile couples within a stable married relationship'. For the purposes of promoting discussion this paper suggests a position. It does not, however, constitute recommendations or policy. Suitable recommendations will arise out of the consultation process. It is hoped that the information provided will promote further discussion from which shared understandings will emerge. Opportunity to provide feedback is given at the end of the paper.

Eligibility criteria

Eligibility criteria define whether people are entitled to IVF treatment. Whether eligibility may also determine the suitability of persons wishing to access IVF treatment is debatable. Current criteria require a relationship standard to be met--couples must be in 'a stable married relationship'. As it is currently applied, this requirement effectively excludes de facto couples, single women and lesbian couples from IVF services.

The right to create a family at the time and manner of one's choosing is a feature of liberal societies. Generally, only in extreme circumstances would any legal criteria be used to restrict the rights of persons to bear children. This does not mean, however, that other criteria do not come into play. Creating a family is a moral act through which we express our values and commitments. While some see the current variety of family practices as a symptom of moral breakdown, it could also be argued that it is a flowering expression of diverse new values and commitments. We must be careful to distinguish moral change from moral decline.

Nevertheless, it must be born in mind, in respect to both past or present family values, some people undertake parenthood in an irresponsible way. Practitioners whose assistance is necessary to create families are naturally concerned about their role, the duties that it entails and the consequences which flow from it. Usually, we rely on those creating a family to give due consideration to the responsibilities that parenthood entails and their ability to fulfil those responsibilities in their current and future circumstances. Responsible parenthood involves not only an

honest assessment of current personal desires and needs, but consideration of others in the relationship and, most importantly, the interests of any children borne into the family. However, in IVF medical practitioners are involved in assisting others to create a family. Consequently, they also have some responsibilities in regard to the children born of those procedures. Naturally, these are not parental responsibilities, but duties of care towards those seeking treatment and any children created. Creating a family through IVF is by its nature a social practice, and all involved should act with social responsibility to ensure the interests of all those involved, especially the interests and rights of children.

In assessing what eligibility criteria ought to apply to IVF treatment we might begin by observing the values and standards we apply in other areas. Currently, the Uniting Church does not apply any eligibility criteria to persons wishing to have a baby in its hospitals. Maternity services are provided irrespective of marital status, sexuality, religion, or race. By doing so, the UC does not compromise its beliefs; it gives expression to them. The provision of maternity services does not imply endorsement of the lifestyle or beliefs of all those accessing those services. The provision of services in a non-discriminatory way expresses compassion, promotes tolerance and, most importantly, is in the best interests of the child. Arguably, these values should also apply to IVF treatment. The burden of proof should be on those who would claim that these same standards ought not to be applied with respect to eligibility for IVF.

This does not mean, however, that other criteria ought not to be applied in the interests of those seeking IVF and their children. These will be canvassed below.

Current situation

In 1985 the Council of Synod approved the following policy for The Wesley Hospital. (At the time, services were provided by the Queensland Fertility Group. These services are now provided by the Wesley IVF Service):

- (i) The programme of the Queensland Fertility Group [as it was then called] shall be confined to treatment of *infertile couples within a stable marriage relationship*.
- (ii) Only the gametes produced by the partners of that relationship shall be used.

National Health and Medical Research Council (NHMRC) draft guidelines (2003) on the use of reproductive technology in clinical practice and research recommend that, 'People who wish to make use of reproductive procedures should be encouraged to do so in ways that are respectful of human life and the dignity of all human beings' (Guideline 5.2). Importantly, they continue: 'Clinical decisions about the provision of reproductive procedures should take due account of the interests of the people who may be conceived. The procedures should be carried out in ways that take account of these interests.'

The NSW Law Reform Commission's report on Human Artificial Insemination developed principles foundational for subsequent clinical decisions. Two of these principles were also used for the Commission's consideration of eligibility issues for IVF (NSW Law Reform Commission 1987). They were that:

- the paramount consideration in the practice of IVF should be the welfare of the child; and
- personal freedom, and individual autonomy should, so far as possible, be respected.

The initial recommendations for legislation regarding donor insemination asked that when applicants were considered for treatment they should include 'considerations of the welfare and interests of any child that might result, the home environment and the stability of the household in which the child would live and the physical and mental health and age of the prospective parents' (1987). The following report of the Commission, on IVF eligibility, found that these would also be appropriate criteria for IVF treatments and that any standards pertaining to suitability 'should not be based solely, or even largely, upon marital status', in that criteria 'should be the same as eligibility for any other medical treatment'(1987).

Deborah Porter (1997) argued that regulation of access to IVF treatment, and criteria established for this, was 'based on social norms and was 'discriminatory' against women on the ground of marital status. She also argued that 'while it may be necessary to regulate IVF, it is inappropriate for regulation to be based on social norms or to be discriminatory.' Instead, considerations of eligibility should 'more appropriately be based on the welfare of the child potentially born as a result of IVF'. This would include the requirement of safety for the child

born of reproductive technology and 'the right of the child to know his or her biological origin'. (These identity issues are discussed in the Synod Bioethics Committee's discussion paper on gamete donation.)

Three criteria for assessing eligibility

Currently, institutions offering IVF treatments require, in varying degrees, three criteria to be satisfied: clinical, financial and social.

Clinical/Medical

Medical recommendation for woman to undergo IVF treatment based on clinical screening--including physical, genetic and psychological--and the ability of a woman's body to accept treatment. Can also include screening for male partner (physical and blood tests).

Financial

Ability of couple accessing IVF treatment to pay for services provided.

Social

Requirement that couples accessing IVF treatment be married, or in some states in a de facto relationship for a stated period of time.

The Wesley IVF Unit requires all three criteria to be met. However, the social criteria is restricted to couples in a stable married relationship, and does not allow for single women or couples in a de facto or same sex relationship to access the treatment.

At the moment, there is no systemic inquiry into or assessment of stability. Arguably, in the current social context the mere possession of a marriage license is no guarantee of stability and security and, therefore, the current eligibility criteria would not function, in themselves, to protect the interests of the child. While it could be argued that, both practically and emotionally, being raised by two committed parents would be more secure than being raised by one, and the majority of single parent families did not set out to be that way, the suitability of couples and individuals to parent is highly contextual. Regrettably, some couplings are disasters, and the emotional and physical security of the children jeopardized. On the other hand, individual parenthood, in itself, cannot guarantee security and stability either, even though some individuals have better access to financial and emotional resources to support their parenting than some couples.

Ultimately, marital status in itself is an insufficient criteria to determine the interests of the child. At the same time, it is also arguable that neither the interests of the child, nor the interests of the prospective parents would be served by an extensive and intrusive processing of assessment and vetting, particularly if people are using IVF to create a child using their own genetic materials. (There might, however, be a case for such assessment with respect to embryo donation, where the embryo has no genetic connection to the either parent.) While there are some circumstances in which past behaviour would be an indicator of future ability to parent, it is unlikely that IVF programs would have the resources to make those inquiries, nor would it be sure that prospective parents would reveal any questionable traits or past behaviours.

The best interests of the child would be better served not by vetting people according to minimal social criteria but, instead, offering resources which will assist them in making their own responsible decisions.

As practitioners are not obligated to assist people to act irresponsibly, mandating such a process would be a reasonable requirement. Both practitioners and patients then proceed forward with shared understandings that they are pursuing a common good--the health and wellbeing of the patients and their prospective child.

Assisting people to make their own responsible decisions

Information and Counselling services

Currently, information and counselling services are provided to assist people to understand both the nature of IVF treatment and the responsibilities and the risks associated with it. Although these services do not assess suitability, they are an important educative tool which assist people to decide whether to undergo IVF treatment.

NHMRC draft ethical guidelines state: 'All potential participants in reproductive procedures should be provided with accurate and objective information about their treatment options, including all the procedures involved. The information should be presented in a way that is appropriate to, and sufficient for, informed decision making.' Information given should also include:

- an account of relevant success and failure rates
- any significant risks involved in the proposed procedures
- the likelihood and significance of potential short-term physical and psychosocial complications
- the likelihood and significance of any long-term physical and psychosocial effects of the treatment on the participants and any person conceived using reproductive procedures
- options for storage and later use and disposal of cryostored gametes and embryos
- costs involved
- counselling services supplied
- support networks
- research
- privacy policy.

NHMRC draft guidelines, 6.2-6.4

Counselling should not be offered in such a way that participation in IVF is assumed. NHMRC guidelines recommend that counselling should 'assist people in making their own decisions about their treatment', and should include:

- Provision of information and education
- Exploration of the short and long-term personal and social implications of reproductive procedures for any person who is conceived using the procedures and for the participants
- Personal and emotional support
- Help in accepting unfavourable results

NHMRC draft guidelines, (Guideline 6.7)

Counselling issues identified to the Synod Bioethics Committee by nursing practitioners in fertility clinics also include:

- Grief over unsuccessful treatment cycle
- Some people deal with the grief of an unsuccessful cycle by immediate engagement in another treatment cycle--this can lead to compounding of unresolved grief
- Limitations regarding success of treatment cycle presented to couples; many still think they will be successful

- Counsellors for IVF required to be members of Aust/NZ Fertility Council; though legal requirements for counselling vary from state to state
- Often, if there is an identified reason for the infertility, the partner identified as the 'cause' can experience guilt which is not always expressed

In the USA, the IVF and Infertility Clinic of New Jersey believes that counselling should deal with the *ethical* as well as emotional and social, moral ramifications of IVF treatment, and include:

- Issues associated with self-esteem, body image and social, emotional and financial ramifications of treatment
- Implications of conceiving a child through IVF, on the couple and the child
- Risks associated with an IVF cycle, including medication side effects, multiple births or multifoetal reduction to limit the number of pregnancies after successful embryo transfer
- Issues related to disclosure to friends and family

The UK government also sets out the types of counselling which should be available at licensed IVF clinics under the Human Fertility and Embryology Code of Practice.

- *Implications counselling*--to enable people to understand the implications of the treatment for themselves, their family, and any children born as a result. May also include genetics counselling.
- *Support counselling*--emotional support at times of particular stress; e.g., failure to achieve pregnancy.
- *Therapeutic counselling*--aims to help people cope with consequences of infertility and treatment and resolve problems that these may cause.

Human Fertility & Embryology Authority, 2004

Current local practice is to make psychological counselling available to couples undergoing IVF treatment mainly by referral. Some couples may resent the added cost and burden of counselling and argue that couples intending to create 'homegrown' families are not required to undergo such counselling. Within the vulnerable context of infertility and its treatment a counseling requirement can unnecessarily pathologise the patient. However, as indicated by the concerns expressed by practitioners in the

various guidelines above, the psychological challenges facing couples undergoing IVF are considerable. They are not pathological: nevertheless, they are *normative challenges* accompanying infertility and its treatment.

Both the fact of infertility and the treatments themselves will raise challenges for some, whether their treatment is successful or not. The best interests of the child are served by informing prospective parents for these potential challenges, so that their decision to parent is fully informed. IVF treatment needs to be embedded within a wider network where individuals and couples can explore address issues of infertility. Some couples, however will only face these issues after all options have either failed or been closed to them.

Timing and coordination of services

Anecdotal evidence presented to the Synod Bioethics Committee has raised concerns that current referral arrangements in some fertility clinics may be inadequate. There seems to be little cooperation and coordination of services. This fragmenting of professional practice does not further UC Healthcare's values of considering the 'whole person' and 'the community'. Each professional focuses on their area of expertise; yet it is the patient who must integrate these various medical, psychological, economic, social and, possibly, legal demands into a unified narrative of lived experience. Coordination ought to be aimed at helping clients to determine their own responsibilities with respect to infertility. It may be the case that after being provided information about treatment and undergoing counselling some people may decide to forgo treatment. A space in the process—even while it is under way—must be created where they are entirely free to do so.

Services not only need to be more coordinated, their timing is also important. In one clinic in the USA (Shawnee Mission Medical Centre, Shawnee Mission Kansas), for example, no patient sees a medical practitioner until they have worked through the social, psychological, and legal issues that apply to their particular treatment with the relevant members of the team. In other words, the process is sequential not, as is often the case, a parallel process. The team members claim that the interests of the child are best protected by doing it this way.

Access for women in same sex relationships or single women whether fertile or infertile

According to the principles of toleration outlined earlier there would seem to be little reason to restrict potential patients on the basis of their sexuality, or because they are single and fertile. From the anecdotal evidence, it is clear there is also a small number of women who wish to create a family but view it as immoral to have sex in order to get pregnant. They are more comfortable with the idea of sperm donation and IVF if it is required. Arguably, they ought to be assisted to make their own responsible choices in this matter and there seems little reason to deny them services so long as they are willing to undergo the same mandated educational and counselling processes as other couples. However, as these services would require the use of donor gametes, other ethical issues arise, particularly in relation to the rights of the children to information about their genetic origins. (These issues have been canvassed in the discussion paper on gamete donation).

Responding in Faith

As the Wesley Hospital is a Uniting Church hospital, criteria for accessing IVF treatment were set down in response to Christian values. In particular, the social criteria relating to couples being in a stable married relationship held to the traditional Christian view that marriage was a sacrament and the right environment within which to raise children.

Even though they may believe the Church has a qualified right to discriminate on the basis of its beliefs, there would be many in the Church today, perhaps even a majority, who would not withhold services or assistance to others on the basis of their marital status or sexual orientation. They would, perhaps, even regard it as being small-minded. As a private church hospital, demonstrably the product of the ethical decision-making of the Synod, the Wesley Hospital, for example, is entitled to some relief from the Commonwealth legislation covering anti-discrimination. The question, however, is whether it wants to do so.

- Can the virtues of the Christian marriage be promoted by policies which determine eligibility for IVF treatment? If so, what ought those policies to be?

- By simply denying access to services, what opportunities are there to promote Christian values?
- Are there more positive ways to promote Christian values than through simply denying access to services?
- We no longer consider applying discriminatory criteria to individuals giving birth in our hospitals, why would it be appropriate with respect to IVF services?
- Does the requirement that prospective couples be infertile and in a stable married relationship, by itself, even reflect Christian values? As there are no faith requirements placed on these prospective couples, does the requirement in fact merely reflect cultural conventions rather than genuine beliefs?

Role of church

The Church has a pastoral imperative to respond where possible to the needs of infertile couples and to support practices which promote the wellbeing of children and protect their interests. The Church's understanding of the nature of marriage has changed over the centuries; not doubt, it will continue to change. In part determined by the culture in which it is lives out its message of faith and hope, there currently exists a wide variety of families worshipping within the Church.

The Christian community has a strong role in promoting what have been called 'right relationships'; that is, relationships which embody important values; such as, honesty, trust, freedom, setting limits, self-control, faithfulness, equality, vulnerability, responsibility, giving and receiving affection and pleasure, communication and discovering intimacy. For the moment, the Church continues to be strongly committed to idea that right relationships are faithful relationships and require a strong commitment based on active faith and hope. The Church continues to support and promote marriage as the most appropriate public expression of this commitment.

The question of whether the Church will extend its support to other expressions of such commitments in the future is an interesting question, but setting eligibility criteria for access to IVF will not be the forum in which it can be appropriately answered. In this context, the Church's

message regarding the value of committed relationships based on faith and hope may be better served by fostering the values which undergird responsible parenthood through education and counselling services which assist clients to make responsible decisions within their own framework of beliefs.

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