Access to IVF
Norman Fost, MD MPH*

TOPICS FOR DISCUSSION
1. Should all health-care services, including IVF, be equally available to all?
2. Do parents act immorally by creating a child at high risk of major disability or suffering?

Introduction
I am in substantial agreement with most of the central points made in "The Ethics of In Vitro Fertilization (IVF)." Therefore, I will address two issues that were not addressed: who should have access to IVF and what policies would follow if those who disagreed were correct. Before getting to those points, however, I would like to buttress one key point on which I think Goldworth yielded ground unnecessarily; that is, the implications of considering the embryo as a person in the full sense of the word.

What If an Embryo Were a Person?
As Goldworth points out, the definition of personhood is unavoidably a social construct. Reasonable people, religious and secular, always will disagree on the various available definitions. It is most certainly not a scientific question that can be resolved by experiment.

When a definition is constructed for a social purpose, it is helpful to determine the purpose. In this case, "personhood" is shorthand for the position that an embryo should be entitled to the same privileges and protections as all other entities who generally are included in that category. At one level, such a proposal seems silly. Even the most ardent proponent of the embryo-as-person view would not suggest that an embryo is entitled to the same level of health care as other persons. Although the United States lags behind most countries in positing a right to health care, there are advocates who argue that every person should be entitled to some decent minimum of health care. Someone who makes that claim presumably would not assert that a sick or dying embryo was entitled, for example, to emergency services, including ambulance or helicopter transport, to get it to the closest available laboratory for stabilization and possible transfer to a human uterus.

A more serious claim made by the embryo-as-person advocate is that it would be wrong to kill such a person, and Goldworth concedes this point. I do not think it is so clear. It does not follow that just because an entity is a person, it is wrong to kill that person. Further, if it is wrong to kill an embryo, the wrongness is of such a different order as to suggest that the embryo's status is of some very restricted sense of personhood.

Killing persons can be justified in some circumstances, such as self-defense, just wars, and perhaps in special cases of active voluntary euthanasia. Even ardent "pro-life" advocates agree with the first two examples. Moreover, deliberate ending of a life can be passive as well as active, and many who oppose killing of embryos support withholding and withdrawing of life-sustaining medical treatment with the clear and primary intent that the person will die as a consequence.

Few among those who would consider the embryo to be a person advocate the same penalties for embryo killers as they do for other person-killers. President Bush was caught off guard during his re-election campaign when asked why he didn't support the death penalty for those who kill unborn children. He acknowledged that he did think there should be a double standard, though he could not say exactly why. Like most "pro-life" advocates, he also opposed violence against those who performed abortion, but this too is inconsistent with our attitude toward those who kill persons. There is widespread support for the use of force, even lethal force if necessary, to stop someone who is killing hundreds of persons annually.

In a time of apparently imminent human cloning, this question will become even more difficult for the embryo-as-person advocate because the number of potential persons will multiply a billion-fold as differentiated cells assume the status of potential (or is it actual?) persons. The claim that these cells are not persons because they are not genetically unique will not avoid the problem; a twin, whether born minutes or decades after his sibling, is no less a person. We assume the embryo-as-person advocate will not argue for criminal proceedings against those who deliberately destroy clonable cells.

Who Should Have Access to IVF?
Goldworth concludes by acknowledging that if IVF is considered generally morally permissible, we must address and answer questions of access, such as inclusion in the benefit package for privately and publicly funded insurance systems. As with other reproductive technologies, there are also questions of access for full-pay or insured single women, lesbians, or couples who are considered poor candidates for parenthood by the physicians who control access to the technology.

A full review of these questions would need to be based on a general theory of access to health care, which clearly is beyond the scope of this discussion. I will only make three observations.

First, our longstanding respect for procreative privacy involves recognition of a negative right (or immunity), not a positive right (or entitlement). The United States Supreme
Court's decisions, including Roe v Wade, recognize the consensus that the state generally may not interfere in a woman's procreative decisions, absent a compelling purpose. There is no implication in such a claim that the state has an affirmative obligation to provide procreative services to its citizens. Apart from the general question of whether there is a right to health care, there is no recognized positive entitlement to have a child.

Second, if there is no entitlement to such a service, then inequality based on ability to pay is not inherently problematic. We might conclude that access to technologic reproductive services such as IVF is or should be an entitlement. However, without a strong claim or consensus about such a right, the ability of some persons to purchase IVF with discretionary funds is no more problematic than the purchase of other discretionary benefits.

Third, a physician or health plan that offers such a service does have an obligation to treat candidates fairly, meaning they must avoid discrimination on grounds that have no medical or moral basis. There could be a prima facie claim of unfairness if an insured couple were labeled as unfit potential parents without some evidence for the claim as well as a process for evaluating all clients for their fitness as parents. Good ethics starts with good facts, and claims that certain classes of people are unfit should be based on evidence. This, of course, assumes that physicians should be making moral judgments about whether some future possible children face prospects so dismal that they would be better off not being brought into the world.

What Policies Follow From Moral Opposition to IVF?

The claim that an embryo is a person in the full sense of the word is suspect when the claimant shrinks from enforcing criminal statutes against those who kill. However, what of the concern about harm, not to embryos, but to future children who will be persons in everyone's social and psychological deficits from inadequate parenting in such circumstances. These cases more commonly are due to hyperovulation followed by natural insemination than to IVF. However, the couple who asks for three, four, or five embryos to be implanted takes a substantial risk that the resulting children will be damaged.

Although the woman also is at risk for medical complications, Goldworth correctly notes that this is a decision that a competent person generally should be allowed to make. The far more likely and serious risk is imposed on the nonconsenting future child. To be more precise, the parents are transferring the cost of multiple IVF cycles with a smaller number of embryos from themselves to the children. A couple could choose to implant only one or two embryos. They also could agree to fetal reduction if three or more embryos are implanted. The number of cycles required to produce a single-term pregnancy would be increased, as would the financial and psychological costs of multiple IVF attempts. There also would be a risk of never having a child. The implantation of multiple embryos transfers the costs from the parents to the children.

Goldworth correctly points out that there is no bright line separating a reasonable from an unreasonable burden or risk to impose on a future child. However, that is not a reason to pretend that there is no moral issue or to shield parents from reflecting on the moral dimensions of what they are doing. Some obstetricians have criticized colleagues who facilitate the development of octuplets as irresponsible, arguing they should not cooperate with a couple who requests reproductive services but refuses to take measures that would avoid the potential damage associated with multiple births. Implanting three, four, or five embryos is not as hazardous to the children involved as implanting seven or eight embryos, but the risk is high enough to warrant discussion as a serious moral issue.
Access to IVF
Norman Fost
Pediatrics in Review 1999;20;e36
DOI: 10.1542/pir.20-8-e36

Updated Information & Services including high resolution figures, can be found at:
http://pedsinreview.aappublications.org/content/20/8/e36

Permissions & Licensing Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
https://shop.aap.org/licensing-permissions/

Reprints Information about ordering reprints can be found online:
http://classic.pedsinreview.aappublications.org/content/reprints
Access to IVF
Norman Fost
Pediatrics in Review 1999;20;e36
DOI: 10.1542/pir.20-8-e36

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pedsinreview.aappublications.org/content/20/8/e36