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Some Reflections on IVF, Emotions, and Patient Autonomy

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Finding precise analogies between new and traditional medical interventions is always a judgment call.¹ *In vitro* fertilization (IVF), it could be argued, appears to occupy a category of its own, because it is, on the one hand, a life-quality enhancing treatment that enables some otherwise potentially childless women to bear children, but one that routinely presents a risk by multiplying ova (making it different from other life-quality enhancing treatments, such as reconstructive surgery) and that, on the other hand, poses this risk while not treating a life-threatening condition.² I wish to address this question in the context of clarifying some points raised in the commentaries of Jeroen Kok and Edmund Howe regarding my analysis of the responses to the article by Abramov and colleagues.³

I was brought up short by Professor Kok's sentence about my comments possibly offending IVF patients, something I did not intend and very much wish to avoid. While he says (not quite accurately) that I refer to infertility as "merely" emotional, his comment did make me think of those patients rendered infertile because of some physical problem, such as pelvic scarring through sexually transmitted diseases or surgery, prior removal of ovaries or other reproductive organs because of cancer, or other causes. From that point of view, Professor Kok is quite right to pull me up.

By referring to infertility as a problem in the "emotional" sphere, I intended to distinguish infertility from a physical condition, even though it is often caused by one. That infertility is not life-threatening in no way diminishes its significance for the person or persons involved, but it could be argued that it imposes different questions for the caregiver, who has the responsibility of using potentially lethal drugs to address the condition. (If clients were able to obtain all the relevant clinical materials on the internet, some greater ethical onus would arguably revert to the drug companies.) I was trying therefore to draw attention to the potential for a shift in the ethical calculus on the basis of the particular nature of the intervention. The distinction I sought to make is that there might be grounds for a differential ethical reading of ovarian hyperstimulation syndrome (OHSS) because of the distinctive nature of IVF and particularly because, according to Abramov and colleagues, there seems to be room for downward adjustment in drug regimes without loss of overall benefit to clients. In this light, Professor Kok also provides heartening preliminary figures on more conservative stimulation regimes.

In relation to Dr. Howe's comments in "Taking Patients' Values Seriously," which appears at the beginning of this issue of *The Journal of Clinical Ethics*, I should also make clear that I use the term "emotional" not as a euphemism for any form of mental difficulty, such as depression, rather in reference to the emotional dimension of life, which relates to the fulfillment of hopes for oneself and one's relationships. I would never

imagine a pathology in someone seeking to have a child through the available means, nor indeed in grieving if these means do not work. Whether the stresses that can accompany fertility treatment might exacerbate a pre-existing disposition, or, if the treatment does not succeed, herald an intense emotional response, are different questions from the more straightforward one I was posing.

On the question of clinical analogies, it is important to examine the points at which the continuum might break down between assessment of the risks posed by a treatment for a physical illness (such as insertion of a coronary bypass), a treatment in response to one's own infertility, or, indeed, at one further remove, the supply of donor eggs to treat someone else's infertility, or again, the donation of eggs for experimentation. For some, there is no line to draw and the ethical questions would remain the same at every point along that scale: this would be the standard argument from autonomy. For others, there might be a different set of issues to be addressed at each point. Where the line is drawn is fundamentally a cultural choice: Abramov and colleagues, for example, make specific reference to the cultural pressure of commercial goals as potentially posing a risk in the clinical context. Yes, they do propose a "paternalistic" response to this situation,⁴ but, at the other end of the spectrum, where they identify patients at risk, lies the so-called "informative" model, that is, the view that informed consent alone shapes all the relevant ethical questions, a view that arguably might imply the abdication of a degree of clinical responsibility.⁵

There is a risk that merely asserting the priority of autonomy can also function to shut down debate. But if autonomy is to be the guiding principle, it would seem to place greater, not less, onus on the forums of medical and public debate, to open out the terms of reference for ethical discussion of the risks of IVF. In order to make informed consent truly informed, it might also put greater onus on caregivers to pursue more systematically longitudinal analysis of the physiological effects of IVF treatment.

In the end, however, the client's wishes must remain the gold standard, and in this I am ignoring, at least for present purposes, those contributions to debate that problematize the meaning of autonomy for different women in different cultural contexts.⁶ Indeed, in my article, I hoped to withdraw altogether from discussing the question of motivations for seeking IVF, as my immediate subject was the clinical culture partially represented in medical journals.⁷ For convenience, I sought to consider this culture in relation to the idea of a stable and unproblematic autonomy principle, which, if it is to stand, might reasonably be accompanied by redoubled efforts to chart the ethical landscape in ways that recognize that different types of clinical interventions can raise new questions within the caregiver culture.

I hope to have indicated here, then, that I would wish neither to trivialize nor to pathologize the emotional lives of those people who are seeking or undergoing, or who have undergone, IVF treatment.

NOTES

1. J.A. Nisker, "In quest of the perfect analogy for using in vitro fertilization patients as oocyte donors," *Women's Health Issues* 7, no. 4 (1997): 241-7.

2. S. Bateman, "When reproductive freedom encounters medical responsibility: changing conceptions of reproductive choice," in *Current Practices and Controversies in Assisted Reproduction: Report of a Meeting on "Medical, Ethical and Social Aspects of Assisted Reproduction" held at WHO Headquarters in Geneva, Switzerland, 17-21 September 2001*, ed. E. Vayena, P.J. Rowe, and P.D. Griffin (Geneva: World Health Organization, 2002), 320-32, pp. 321, 325; available at <http://www.who.int/reproductive-health/infertility/report.pdf>, accessed 4 April 2007.

3. Y. Abramov, U. Elchalal, and J.G. Schenker, "Severe OHSS: An 'Epidemic' Of Severe OHSS: A Price We Have To Pay?" *Human Reproduction* 14, no. 9 (1999): 2181-3.

4. B.M. Dickens, "Ethical issues arising from the use of assisted reproductive technologies," see note 2 above, pp. 333-48, at p. 342.

5. M.B. Mahowald, *Bioethics and Women: Across the Lifespan* (New York: Oxford University Press, 2006), 92.

6. R. Rowland, *Living Laboratories: Women and Reproductive Technologies* (Bloomington: Indiana

University Press, 1992), 277-83; E.A. Dedrick, "The Politics of Being an Egg 'Donor' and Shifting Notions of Reproductive Freedom" (Master of Arts Thesis, College of Arts and Sciences, University of South Florida, 2004).

7. Compare with, however: C. Crowe, "Women Want It: *In vitro* Fertilization and Women's Motivations for Participation," in *Made to Order: The Myth of Reproductive and Genetic Progress*, The Athene Series, ed. P. Spallone and D.L. Steinberg (Oxford: Pergamon Press, 1987), 84-93; J. Singer, *Immaculate Conceptions: Thoughts on Babies, Breeding and Boundaries* (Melbourne: Lothian Books, 2005).