

# BIOETHICS NOTES

*a newsletter from the Bioethics Review & Advisory Committee*



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**"Do not do unto others as you would they should do unto you. Their tastes may not be the same."**

George Bernard Shaw (1856–1950)

## Social Support and Reproductive Rights

By Jeremy Bennett

**Was it unethical for Nadia Sulaiman to seek giving birth to more children, considering that she already has 6 young children, and that two of them have special health needs?**

In America, systems of government-run social support – Social Security and Medicare among them – have always seemed less comfortably situated in the public eye than in the more liberal democracies of western Europe. An investigation of the history of welfare in Ellen Reese's book, *Backlash Against Welfare Mothers*, describes a series of public debates about the costs, benefits, and fairness of social support networks, each catalyzed by anecdotal claims of their inappropriate use. The American foundation of welfare has always included components of justice and individualism: "The government may spend my taxes to help this unfortunate person, as long as it does not spend an unreasonable amount, and as long as that person is already struggling to the limit of their energy and abilities to help themselves."

Bioethics touches upon these sensitive debates. In the recent past, the latest anecdote of contention is the story of Nadya Suleiman, a single mother of six who was already partially dependent on welfare. She paid privately for a single course of IVF treatment; was implanted with six embryos; chose not to selectively reduce her fetuses; and successfully delivered eight premature babies owing to unintentional twinning of two of those embryos.

The costs of the delivery and NICU care are expected to approach \$1 million, with additional expected costs to welfare for proper care of Ms. Suleiman's 14 children in the future.

From the perspective of a health care professional, was Ms. Suleiman's management appropriate? All four basic principles of bioethical decision making – patient autonomy, beneficence, nonmaleficence, and social justice – are involved here. Medical beneficence and nonmaleficence apply specifically to whether her IVF and decision not to selectively reduce was medically safe for Ms. Suleiman and her eight fetuses, and it is true that many fertility experts debate whether she was allowed to transfer too many embryos at one time, and whether the risks she chose for herself and her fetuses were too great to be allowed to other patients in the future. The point of contention that has caught the public eye, however, is the conflict between Ms. Suleiman's choice to have more children in the first place (her autonomy) and the government's responsibility to fund that choice at a time when health care resources are scarce (our social justice). Were Ms. Suleiman's doctors, nurses, and support staff acting ethically when they assisted her choice?

Considerations of social justice most commonly come into play when there are specific, non-negotiable resource shortages that impact the medical care of many patients. The classic example would be organ transplants, where the limited supply of organs for transplant means doctors must choose which patients are most likely to benefit from these procedures. This decision is made entirely on the basis of expected years of survival with good quality of life, taking into consideration other chronic medical illnesses and the procedure's

chances of success. Social evaluations of the patient do come into play in this evaluation – for instance, a history of IV drug abuse that could threaten a newly transplanted liver with hepatitis – but the patient's economic status is excluded. As a utilitarian measure, systems like this balance the medical needs of patients against other patients in as fair and outcome-based manner as possible.

Ms. Suleiman's decision makes a poor parallel to this sort of organized and necessary system of resource distribution. There were no specific resource shortages to be managed, and hence she had no competition with other patients for her treatment. There were no public funds spent “inappropriately” on Ms. Suleiman and her family – she paid for her actual IVF course herself, addressing the one truly optional cost of her care. Following its success, she required the same management for a high-risk pregnancy that many other mothers do, and her children required the same level of care that many other premature babies do. Applying conventional utilitarian standards of social justice to this case brings up a surprising amount of nothing to discuss, and hardly anything sufficient to justify interference with a patient's autonomy in making a medical choice for themselves.

This chain of logic might seem thin, and it is because all of the accepted and appropriate health care costs that Ms. Suleiman and her family incurred would not have ever happened had she chosen not to have more children. Additionally, one can always argue that health care dollars are a limited resource in the grand picture, and Ms. Suleiman's choice effectively spent money that could have been used to fund less intensive medical care for many other families. These points are true, but also unfair. There is no utilitarian distinction to be made between Ms. Suleiman receiving IVF in order to bear eight children, and the choice of a fertile woman to naturally bear eight children under similar circumstances. All human beings possess the exact same reproductive rights, male or female, fertile or infertile, and the mechanics of biology – age, illness - are a purely accidental limitation imposed on those rights. It may only be the sudden and artificial nature of Ms. Suleiman's choice that has drawn such intense scrutiny, but it is likely that whether IVF were involved or not, a welfare-

dependent mother choosing to continue to bear children would face public criticism.

Where we are left with regard to this puzzle is an appeal to broader systems of ethics to help settle the question. A comparison of the widely accepted human rights of reproduction and property ownership would be required, and the bottom line of that discussion would be whether our community should draw a line beyond which it actively discourages additional reproduction in any case, medically assisted or not. Until then, the ethically sound choice for health care professionals is to respect the decisions of their patients, and to continue to use their medical knowledge to allow others to exercise reproductive rights unfairly denied to them by accident or by disease.

Respectfully Submitted,  
*Jeremy Bennett*