Child interests in assisted reproductive technology: how is the welfare principle applied in practice?

Sheryl L. de Lacey1,*, Karen Peterson1, and John McMillan2

1School of Nursing and Midwifery, Flinders University, GPO Box 2100, Adelaide 5001, South Australia, Australia 2Bioethics Centre, Division of Health Sciences, University of Otago, PO Box 56, Dunedin 9054, New Zealand

*Correspondence address. Tel: +61-402424208; E-mail: sheryl.delacey@flinders.edu.au

Submitted on August 19, 2014; resubmitted on October 19, 2014; accepted on November 25, 2014

STUDY QUESTION: How is the welfare principle interpreted and practised and what meaning does it hold for health professionals who must apply it in assisted reproductive technology (ART)?

SUMMARY ANSWER: The welfare of a child is a meaningful concept to ART counsellors but it is also impractical when applied preconception.

WHAT IS KNOWN ALREADY: Policy which promotes the interests of a child to be born is inconsistent between and within countries, and has been widely criticized as meaningless, as an unfair imposition and for its lack of clarity and inconsistent translation to ART practice.

STUDY DESIGN, SIZE, DURATION: We conducted a qualitative study of ART counsellors in Australia and New Zealand in 2012. This study took an inductive approach.

PARTICIPANTS/MATERIALS, SETTING AND METHODS: Thirty-two counsellors (15 psychologists and 17 social workers) participated in 6 focus groups. Vignettes were used to focus and stimulate discussion of how the welfare of all participants but especially the interests of a non-existent child were interpreted and operationalized in practice. Qualitative descriptive content analysis was used to analyse the data into themes.

MAIN RESULTS AND THE ROLE OF CHANCE: Five themes emerged in the data: giving presence to the child that could be, balancing welfare interests, welfare concerns, balancing values and making a decision and screening and legal presumptions against treatment. Themes were validated according to qualitative research standards. The study showed that counsellors take the child welfare principle seriously but that the concept is indeed slippery and difficult to operationalize. Counsellors denied a role in screening patients for parenting fitness but were engaged in health care assessment of patients and these roles need further differentiation, clarity and research. Health care practitioners would benefit from a process that reviews decisions and clarifies professional values.

LIMITATIONS, REASONS FOR CAUTION: Participants were drawn from only two of the six Australian states and two territories.

WIDER IMPLICATIONS OF THE FINDINGS: The study provides insight and deeper understanding of how welfare principles play out in counselling practice, what gives them meaning and the difficulties of balancing various interests and values. Our findings have shown that the welfare of a child can be a meaningful concept to ART counsellors but that it can also be impractical and unclear. Despite differences in legislation among countries, our study contributes to the growing data and debate emerging from the USA and the UK.

STUDY FUNDING/COMPETING INTERESTS: This study was funded by a Flinders University Faculty of Health Sciences Grant. There are no conflicts of interest.

TRIAL REGISTRATION NUMBER: Not applicable.

Key words: assisted reproductive technology / child welfare / counselling / ethics

Introduction

The welfare of children who might exist as a result of infertility treatments is a key ethical consideration for assisted reproductive technology (ART) policy. In many countries, legislation pays attention to the welfare of the not-yet-conceived; however, the emphasis placed upon it differs. In some jurisdictions, the interests of the child who could be born of the procedure are “paramount” (Government of South Australia, 1988;
Government of Victoria, 2008) or ‘given priority’ (Parliament of Canada, 2004). However, in other jurisdictions, child interests are said to require ‘proper consideration’ (Government of Western Australia, 1991), or that ‘treatment should not be provided unless account has been taken of the welfare of any child’ (Government of United Kingdom, 2008).

In Australia, legislation that regulates ART exists in some states but not in others, however, those not affected by state legislation are required to practice within the NHMRC Ethical Guidelines on the Use of Assisted Reproduction in Clinical Practice and Research (National Health & Medical Research Council, 2007) and to comply with accreditation standards set and monitored by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia (Fertility Society of Australia Reproductive Technology Accreditation Committee, 2014). The NHMRC guidelines discuss broad ethical principles for the clinical practice of ART and in reference to respect of all participants, advise that the interests and welfare of children who may be born must be considered ‘primarily’ in clinical decisions. In contrast, clinicians in New Zealand are advised that the health and well-being of children born as a result of an ART procedure ‘should be an important consideration’ in clinical decisions. However, the health and welfare of children is promoted as equally important to the health, safety and dignity of future generations; to the health and well-being of women; to the needs, values and beliefs of Maori and the different ethical, spiritual and cultural perspectives in society (New Zealand Parliamentary Counsel Office, 2004). Neither national guidelines in Australia nor legislation in New Zealand elaborate how the welfare of children to be born should be interpreted in the clinical practice of ART.

The notion that the interests of a child who does not yet exist should be paramount, given priority or considered primarily in a health care setting raises questions about its application and practicality (Dickey, 2011). The child welfare principle has been argued to be rhetorical rather than pragmatic (Blyth and Cameron, 1998), and driven by ideologies (Blyth et al., 2008).

Some philosophers have argued that at preconception, child welfare should be interpreted as a ‘best interests test’ (Harris, 2000; McCarthy, 2001) while others have argued that it should involve a judgement about parental plans to provide a child with a good life (Archard, 2004). Emily Jackson (2002) questioned the relevance of a child protection approach in ART legislation and concluded that it is: ‘incoherent, disingenuous and illegitimate’ in this context. In contrast McMillan argues that a preconception welfare principle is not necessarily unjust and may indeed be meaningful if focused on an assumption that those wishing to exercise their procreative liberty should have a reasonable plan to care for and nurture any resulting child (McMillan, 2014).

Although consideration of a child’s interests at the point of preconception is for many an unfamiliar thought, the welfare of children is not a new concept in a health care setting. Health Care Practitioners in Australia are legally mandated to observe and report suspected child abuse and neglect according to various state-based child protection legislation (Atkins et al., 2014). New Zealand does not have mandatory reporting for suspected child abuse and addressing child vulnerability, although it is clear that health professionals can report it and that there are professional and ethical expectations that they are subject to (New Zealand Government, 2014). Although familiar with their responsibility to protect vulnerable children, ART clinicians and counsellors may be less clear about their role in judging child welfare and how to make fair, reasonable and ethically consistent decisions in cases where a child does not yet but could exist.

The child welfare principle has been interpreted as implying the parents should be screened in a similar manner to how they are for adoption and fostering. However, the implication of screening patients for parenting fitness and making decisions about access to, or the denial of, medical treatment is contentious. Some ART physicians and patient advocacy groups have publicly rejected parental screening as unfair (Baker and McBain, 2005; Dill, 2009–10). Critics have also been raised regarding the scope of practice of counsellors and clinicians. Daniels et al. (2000) argued that policy empowers health care professionals but relies on their subjective judgement. Questions have also been raised about the scope of screening that is authorized and the limit of discretion that clinicians should be allowed (Mumford et al., 1998). This is unsurprising given the claim that child welfare has been used for illegitimate and discriminatory activities such as excluding some social groups or prohibiting some treatments (Blyth and Cameron, 1998). Similar arguments have been advanced about the mandatory reporting of child abuse (Levi and Loeben, 2004; Levi and Portwood, 2011).

Further criticisms are related to the consistency and fairness of screening practices. For instance, Pennings (1999) observed a troubled practice in that whilst ‘everyone agrees on the fundamental importance of the welfare of the child of new reproductive technologies … this is as far as consensus goes’. Two studies of clinicians in the USA regarding screening practices and determining access to ART showed substantial variation in assessment practices and a high risk of inappropriate denial of treatment (Stern et al., 2001, 2002; Gurmankin et al., 2005). Substantial variation was also reported between clinician practices and decisions, and clinic policy regarding access to treatment (Stern et al., 2001). A study of clinicians and regulators in three Australian states showed that approaches to child welfare are contradictory and disparate, and that there is potential for the interests of children to be undermined (Thorpe et al., 2012).

The Human Fertilisation & Embryology Authority (2005) in the UK reports that during a consultation about the welfare principle they received a strong message from both clinicians and patients that there was considerable uncertainty and anxiety about the application of a child welfare principle and a desire for clearer guidance from Governance bodies.

There is clearly a need to understand how the welfare principle is to be interpreted and practised, and what meaning it holds for health professionals who must apply it. In 2012, we ran focus groups in the Australian states of Victoria and South Australia, and New Zealand in order to gain a deeper understanding of how the welfare principle is operationalized. Whilst the welfare principle underscores the professional practice of clinicians, nurses, scientists and counsellors in ART clinics across Australia and New Zealand, we focused our attention on ART counsellors, often characterized as the profession most familiar with welfare principles and child protection practices.

**Methodology**

The study was approved by the Social and Behavioural Research Ethics Committee at Flinders University. Permission to contact practising counsellors in ART in Australia and New Zealand was sought and granted from Australian and New Zealand Infertility Counsellors Association (ANZICA) which is a subgroup within the Fertility Society of Australia. Invitations to participate...
in a focus group were sent to all ANZICA members who were currently employed as a counsellor in an ART clinic in the Australian states of Victoria and South Australia, and New Zealand.

The sample
Members of ANZICA in Victoria, South Australia and New Zealand who were not actively practicing within an ART clinic as a counsellor were excluded. All remaining members were contacted by email and invited to take part in a focus group. Thirty-four counsellors in Victoria, 4 in South Australia and 10 in New Zealand were contacted (n = 48).

Participants expressed a preference for a focus group to be conducted within a specific clinic setting. The managers of counselling services in two ART clinics in Victoria formed their own group comprising counselling staff who were available and willing to participate, and researchers conducted the focus group on site. Similarly, in New Zealand managers of counselling services in two ART clinics formed their own groups and focus groups were conducted on site. In contrast in South Australia, one focus group included three counsellors from two different clinics. A further focus group was conducted during the Fertility Society of Australia annual scientific meeting in New Zealand later in 2012 and comprised counsellors who had not been available to participate before the meeting. This group included counsellors from a variety of clinics and locations in New Zealand and was conducted at the conference in a private room. In total, 32 counsellors participated in 6 focus groups of whom 15 were psychologists and 17 were social workers. Other than the disciplinary qualification of the counsellors, no other demographic data were specifically gathered.

The focus groups
The focus groups ranged in size from 3 to 12 participants. Three vignettes were developed which presented typical cases or situations that could be expected to invoke an application of the welfare principle of the best interests of the child to be born in ART provision. Following presentation of the vignette, participants were asked to reflect on their response to the situation simulated in the vignette and then discuss what their state or country required them to do in this situation. Questions were then posed about specific areas of interest: how they managed the interests of a non-existent child, how they weighed the interests of the child with those of the woman or couple, how they managed doubt and dubious characters, and communication and decision making within the multidisciplinary team.

They were also prompted to identify the strategies, tools or resources they were likely to employ to achieve the welfare principles. Lastly, they were invited to discuss the ethical and legal issues they faced in responding to the policy requirements in their practice.

The group discussions were digitally recorded and transcribed by a professional transcription service who signed a confidentiality agreement. Each transcript was checked for accuracy and participants voices were coded by number and location. Any identifying features were removed or changed. The transcripts were then subjected to a process of qualitative analysis.

Data analysis
Qualitative descriptive content analysis was used to analyse the data (Sandelowski, 2000; Neergaard et al., 2009). The transcripts were read by S.L.deL and K.P. to obtain a general impression of the responses and issues raised by participants. Similarities and differences were then identified and transcripts were coded taking specific account of the areas of interest above. The initial coding was performed by K.P. and emerging codes and categories were validated by S.L.deL and further refined. Insights and reflections on the data were shared and themes were validated (Milne and Oberie, 2005). As the analysis proceeded the transcripts were read and reread to ensure that the context and meaning of participants views was preserved.

Results
Legislation in Victoria requires every patient entering an ART treatment process regardless of the treatment programme to have at least one session with an ANZICA approved counsellor. In contrast, counselling is not legally mandated in South Australia or New Zealand and counsellors in these sites described seeing only patients who were contemplating third party reproduction (i.e. the use of a donated gamete) as a matter of routine, an estimated 20% of the patient population. In addition to routine practices, all counsellors described also seeing patients who were distressed and through a process of self-referral or referral of patients from other professionals in the team.

Giving presence to the child that could be
Participants described the interests of a child as an important concept in their management of infertility and its treatments . . .

[S]I have to tell you it’s [child interests] well and truly out of the filing cabinet in my considerations.

However, welfare was described as being a collection of different interests and a fluid concept that was always present to some extent but foregrounded in some situations and foregrounded in others. For instance, when the purpose of counselling concerned the use of a donated gamete the non-existent but intended child to be born was perceived as having a strong presence and was foregrounded in the counselling session:

[NZ] Participant 1: That person [the child that could be], well to me, is in the room, yeah.

Participant 2: I always feel they’re on my shoulder.

Participant 1: For me, it sort of feels like I’m the voice of that child because that child is not . . . we’re talking about someone that isn’t here at the moment.

Foregrounding the interests of the non-existent child and advocating their interests was described by all counsellors as a process of taking the woman, and her partner if she has one, forward in time to a hypothetical scenario in which they must imagine themselves as parents. Patients are then encouraged to consider practices in parenting after the use of a donated gamete; such as openness, honesty and the practices of disclosure of origins to their child.

Despite a belief that this process was necessary to the interests of the child and also the family, counsellors perceived it as incurring well-being costs for the woman and her partner. Infertile women and men typically protect themselves from distress and repeated disappointment by blocking out the child that could be but has not yet been born. Foregrounding the interests of a possible child in the counselling process was a counselling intervention that was perceived as conflicting with a professional value of support. The process was generally described as uncomfortable but as an ‘ethical dilemma’ by one counsellor.

[NZ] [the interests of a child] is a perspective that sometimes may be hard for them to look at that point in their journey.

[Vic] and that’s [discussing the child to be born] also very confronting for them because they’ve had usually years and years of maybe reproductive loss, and it’s also painful to be talking about a child that isn’t here yet. So you also have to walk a line there as well, and that makes it so hard.
Balancing welfare interests

Several participants described cases where tension mounted in the room as they pursued their primary goal of foregrounding the perceived interests of a child. In one clinic-specific focus group, the following conversation took place:

[NZ3] Participant 1: it’s not always easy is it, to be the one to present that perspective [of the child’s interests]?

Participant 2: No, certainly not. You become the bogey in the room in a way.

Participant 3: I had a situation recently where I was saying ‘well what about …’ and that didn’t work and ‘well have you considered …’; because it was a donor couple and they weren’t going to tell. Then it really got quite kind of defensive, or pursuant – avoidant. It was yeah, difficult.

When a couple appears to reject the notion of openness and disclosure to their child a counsellor may then feel that there is a need to emphasize this style of parenting in the child’s interests. However, as described here, the counselling session then has a confrontational edge.

In another (non-specific) focus group, the exchange was similar however a different perspective was offered:

[NZ3] Participant 1: the one [situation in practice] that I take to supervision the most is that situation of a couple who will not tell. In the counselling room I find that the hardest to work with because I feel so uneasy about it myself when I get that total resistance. ‘We’ve thought about it. We’re not going to do it. We’re absolutely clear we don’t want to even have our awareness raised and we’re not going there. Don’t even go there!’ I come out of that feeling very uneasy.

Participant 2: But do you think that’s reflective of attitudinal change in any setting where someone has a fixed opinion about something? Attitudinal change takes time so people might come in with a view [of] ‘I’m not going to tell’ but they haven’t got a child – they don’t know what they’re going to do until they’re in that situation I think. They might have a view now like I don’t want my awareness raised but it has been raised. So I think it’s going to be like the process of disclosure, it’s over time.

Participant 1: I just give them as much information as I can and leave them with some [hypothetical] examples such as the child doing science and finding out blood groups or Granny get Alzheimer’s and starts talking about things. That’s all you can do. But it does feel uncomfortable.

In this discussion, a couple was not viewed as rejecting the concept of disclosure but as beginning a process of cognitive development to parenthood resulting from discussions about the use of a donor.

Participants clearly perceived the interests of a child as important and meaningful where a particular treatment, such as the use of a donated gamete, was known to hold potential harms to children/adults and families if secrecy and non-disclosure were practiced in parenting. Such counselling practice is based on evidence arising from research in the fields of both adoption and third party reproduction. The interests of the non-existent child were perceived to be present and advocated in counselling practice. However, the participants raised the ethical question of how to proceed when they had misgivings about the couple’s plan to care for and nurture a child born from the use of a donated gamete where non-disclosure was planned. As one participant pointed out:

[Vic] So sometimes there’s a bit of tension between trying to do what I believe is right in terms of how I interpret legislation [about the child interests] and there’s no criteria which measures that [what’s right].

Several participants clearly struggled with the question of whether treatment should be denied to couples who resist the dominant construction of child interests and best parenting practice regarding third party reproduction. When a couple firmly resisted what is professionally considered to be best parenting practice the participants described feeling uneasy if not seriously concerned. However, an ART counsellor has no legal authority in Australia or New Zealand to refuse treatment and may receive no support from a clinician should he/she propose this. Participants described the policy as ‘falling short’ since the notion of child interests lacks definition about how far to go, what plans for parenting are acceptable and when to refuse treatment. The different views put forward in discussion raise the question about whether resistance by the couple should be considered a permanent or transient state. Clearly, some participants perceived the couple as being unable to process the concept of openness and disclosure in such a brief period and during a time of distressing treatments. A view was also promoted that child interests should be translated to practice differently. As one participant pointed out:

[Vic2] [when the patients aren’t parents and aren’t in that space] it becomes quite surreal and loses some of its meaning. I often feel that the conversation would be better had afterwards [after parenthood is achieved].

In other words, this participant proposes that screening for parenting that would meet perceived child interests is fraught with difficulty whereas post-natal support for good parenting practice would be more appropriate and effective.

Welfare concerns

Participants were adamant that their role in counselling was one of support rather than screening and gatekeeping. Formal assessment was viewed to be fraught with difficulty as patients were perceived to become wary and defensive when this was invoked. Nonetheless, they described situations in which patients were referred to them because they presented unusual characteristics or because their medical or social history or approach to parenting ‘rang alarm bells’.

[Vic] I think the bigger concern for me is the group of patients that are somewhere on the fence, that are presenting with concerns that don’t really – we have no real right to stop them from having treatment. We might have
guesses, we might have assumptions, we might have gut feelings or intuition, or a little bit of information. But most of our patients know not to give us too much information, or if they do, they quickly gobble it back up.

[NZ3] [for] 99 per cent of people it’s fine. You know that they’re going to do the very best in the interest of their child. But we always encounter, every year you encounter someone who you’re less convinced about.

[S]A... our alarm bells will go off from time to time, and then we will take some steps.

Alarm bells or what one counsellor referred to as ‘neon issues’ were described as situations that were quite rare but nonetheless ‘disturbing’ and ‘frustrating’. Cases were referred to in which patients who did not have custody of existing children, or did not have access to existing children, or who were only allowed supervised access to existing children were an example. Other examples given were single women with a history of mental illness and concerns about their ability to cope alone, concerns about the impact of pregnancy and treatment on the psychological or physical health of the woman, unsubstantiated reports that children had been removed from care, suspicions of domestic violence, a history of alcohol or recreational drug abuse and medical histories of infections such as human immunodeficiency virus.

In their description of these situations and their responses to the vignettes, the application of the best interests of a child was far less clear. The welfare interests of the child and concerns for the health and welfare of the woman seemed to be equal weight and to be synonymous.

The metaphorical hearing of alarm bells was described as triggering a process but not necessarily a refusal. Participants described ‘putting treatment on hold’, ‘delaying treatment’ or ‘imposing a cooling off period’ in which further assessment or therapeutic counselling took place.

[Vic3] We made them come back and back - we had to see them about four times. So that was just to see what happened, like ‘let’s just see what happens and really talk about [the issues]’

[NZ3] Twice I’ve done that in the last year and a half. I’ve taken the client and me back with the doctor and expressed my concerns in front of the doctor with the client there and said, ‘we need to talk about this’. [The clinician] I’ll make them a review appointment for a couple of weeks and he’ll sometimes say, ‘I need to talk to my clinical colleagues about it’. It’s nothing hidden. If we go ahead we can say to the clients we’ve done everything we can to make sure that this is an okay scenario but yeah it is a delay tactic. It gives you time just to take a breath and think, actually, what are all the factors? Why am I reacting to this particular issue? What does someone else think about this?

[Vic1] In situations where there’s been mental health issues I might make a recommendation that things - we do need to slow down. There will be anger, there will be resistance, and often what I will say to that person it’s our ultimate priority to help you achieve your goal. We want you to have a healthy baby, and we want you to be healthy and functional at the end of this. It’s not that it’s going to be ‘no’ forever, it’s there are some important concerns and the risks are X, Y and Z in your current state.

The welfare clause in policy was described as a ‘tool’ or ‘lever’ for setting goals about cognitive or behavioural change to ensure a safe environment for the child and/or the woman or couple. For instance, in cases where a history of domestic violence was indicated or there was evident relationship instability the welfare principle was used to invoke a ‘pause’ in treatment and purposeful counselling.

[Vic2] We do from time-to-time use that concept of the best interests of the child (and the fact that it’s enshrined in the legislation [gives it strength]) with our clients and patients when we’re talking them through concerns we might have. So we’ll say: ‘we were putting this on hold and we need to look after your safety and all the rest of it, and of course we are obliged to consider the interests of the child and I’m sure you do as well, have the best interests of any unborn child at heart’. So we can use that best interests of the child to motivate them to maybe make some change or to agree to a delay or whatever.

In this way, then the welfare clause is occasionally employed meaningfully to induce change, raise awareness of a child’s need for a stable environment or for the safety of the woman and to promote a positive plan for parenting.

On occasion the imposed delay in commencing treatment allowed the uncertain situation to resolve itself. Patients stopped attending or refused to provide the requisite information or merely grew too old for the treatment to be successful.

[NZ3] The one we had recently was a couple and neither had custody of their children [from previous relationships]... they gave information but nothing made sense in the stories that they were telling us. They weren’t prepared to give any more information or permission for us to speak to anybody else. We [referred the case to a social worker] and they decided not to go ahead with treatment. So we never knew the full story but everybody had a lot of alarm bells going off.

[NZ3] We had a case of a woman who was 39 with mental health issues and other social issues. [Clinician] was concerned about her ability to care for the child. We got an assessment from Maternal Mental Health. They didn’t say that she couldn’t be a fit parent they said that they would be able to provide support for her, should she become pregnant. [Treatment was delayed for assessment and various reasons] and what happened was she got older and her [indicator of menopause] went up and treatment wasn’t offered.

When suspicions were raised, counsellors in collaboration with the multidisciplinary team tried to acquire enough information through assessment and consultation to underpin their decision regarding access to treatment. It is unusual that external agencies would be familiar with the concept of preconception child welfare and they were described as unhelpful. The clinic therefore was left with the decision to deny or allow treatment to proceed and this decision also lacked policy guidance or any professional parameters for the predicted welfare of a child. In addition, there are other avenues for women and their partners to pursue in order to challenge a decision to deny treatment. A different participant describes a similar case

[NZ2] So we refused treatment on those grounds and concern about the safety of the child given the way she was talking within the counselling session. She’s taken this to the Human Rights Commission.

Balancing values and making a decision

Counsellors described different experiences regarding values held within the multidisciplinary team about the threshold at which the treatment of clients should be slowed down or reviewed. One clinic-specific focus group described a collaborative approach in the team and a ‘united front’ in determining risks. Another described a collaborative process of team meetings and consensus decision making saying: ‘If we have concerns we will not treat’. However, another clinic-specific group described (and supported) an ‘unspoken attitude that people
coming the interests of patients (and companies) over the conflicting tension between privatized medicine and business models that promoted the interests of patients (and companies) over the conflicting interests of a [non-existent] child.

Screening and legal presumptions against treatment

In Victoria, the Assisted Reproductive Treatment Act (2008) clearly lays out the conditions under which a woman and her partner would be regarded as meeting the criteria for a presumption against treatment (see Section 14, p. 13). According to Victorian legislation, a woman must not be provided treatment if charges have been proven against her or her partner for a sexual offense, or the woman or her partner has been convicted of a violent offense or a child protection check reveals that a child protection order has been issued involving a child removed from the custody or guardianship of the women or her partner (Government of Victoria, 2008, 2011, p. 13). The legislation describes a process by which each patient must provide a criminal record check that is sighted by the counsellor and must provide permission for a child protection check. A process is also included about how an application for review can be made to a patient review panel (PRP).

While clearly associated with Child protection legislation, Sections 11, 12 and 14 in particular of this Act have created tensions for counsellors in Victoria.

[Vic2] With the police checks we’ve been invited into a world we just don’t want to be part of.

Nonetheless counsellors described the process where a woman met the criteria for a presumption against treatment as straightforward. Because the legislation is clear about the criteria, the counsellor is able to inform a couple that treatment could not be offered and provide support to the woman and her partner in making an application to the PRP. This fitted with their role in the provision of information and support and caused little professional tension.

[Vic1] Where there is a criminal conviction, we have to make the phone calls to the patients, and often we’ll get quite an abusive response on the other end of the telephone. But generally, we can calm them down because we say ‘your charge reads X, Y and Z. The ART Act specifies, specifically, A, B and C. It’s the legislation’. So they then [appreciate] it’s the government, it’s the legislation [and not] that terrible counsellor who made the phone call. That takes a little bit of counselling and rapport building with them too, to bring them down to a level where they do calm down. Because the majority of them are actually quite angry and quite abusive, particularly if they feel that they’ve been convicted and they’ve paid their price. Whether they’ve served time or paid their fines, but they’re still angry. So you’ve got two pages of offenses that don’t need to go to the PRP . . . but they’re still there in front of you.

When concerned a counsellor could make a report to the PRP themselves requesting a presumption against treatment. However, this situation created considerable professional conflict for them.

[Vic1] Some of the police checks that I personally have seen are incredibly colourful. They might be several pages long; manufacturing amphetamines, drug trafficking, breaking and entering, assault, so on and so forth. So in this case it’s not the legislation that stops that person, it’s not an anonymous body behind [the clinic] it’s [counsellor’s name] personally. The application will go before a review panel and I will be named as the person [reporting] so they know my name, they know where I work, and it [the refusal] becomes between myself and the patient.

The clarity of legislation in Victoria about who should be excluded from access to treatment was generally described as helpful to practice even if considered discriminatory. However, mandatory police checks exposed other activities which while not the subject of exclusion criteria raised welfare concerns about a child, the interests of adults and also issues about a counsellor’s welfare and safety.

Discussion

This study aimed to understand how the welfare principle is interpreted and practised, and what meaning it holds for health professionals. Our findings have shown that the principle of the best interests of a child to be born is a meaningful concept to ART counsellors and a principle that guides their practice. Our data indicate that counsellors are striving to meet policy requirements regarding the best interests of potential (or existing) children and to do so in ways that are sensitive, fair and free from discrimination. This is, however, clearly easier said than done due to existing constraints. First, the child welfare principle is largely interpreted in practice as parenting assessment but is impractical in application because in the majority of cases neither a child nor parents exist. Secondly, policy dictates its paramountcy yet fails to clarify the scope of its application in ART treatment.

In a study of health professionals in the UK, Lee et al. (2014) noted a widespread misconception that there is a legal requirement to treat patients using donor gametes differently. In the present study, no matter which state or country, patients using donated gametes routinely received implications counselling. In contrast to the UK legislation, which mandates the provision of counselling, the state of Victoria requires that all patients receive counselling prior to treatment. Whilst not mandated in other Australian states or New Zealand, counsellors practice according to professional standards laid out by the RTAC of the Fertility Society of Australia and contained within ANZICA standards of practice (Australia and New Zealand Infertility Counsellors Association, 2003). These standards require that a counsellor engages patients before treatment with donor gametes in a discussion of a range of psychosocial issues including . . .

exploration of the acknowledged importance that donor information be accessible for any donor conceived person and the future availability of donors for information about identity [and] attitudes to telling others and plans to disclose donor conception to children (Australia and New Zealand Infertility Counsellors Association, 2003).
These standards reflect current opinion that it is better for children conceived with donor gametes to be informed about their conception by their parents (Victorian Law Reform Commission, 2005). This does indeed create a difference in the way in which patients are treated but one which may be justified within the social context of growing emphasis on transparency and openness, and access to information contained in national registers (Legal & Constitutional Affairs Legislation Committee, 2011; Blyth, 2012; Blyth et al., 2012; Hammarberg et al., 2014).

Applied in this way, the child welfare principle was operationalized by participants in this study in varying ways. Participants described counseling practices focused on enhancing patient autonomy by facilitating an exploration of the disclosure issues to inform and enhance valid consent, even where this caused some discomfort. However, others extended this role to educate patients and promote good parenting practice. This created the expectation that patients would ‘get’ the importance of disclosure and the child welfare principle was constructed as having achieved patient agreement to tell a child of their origins. The practice of South Australia, 2010; Lee et al., 2014). Whereas welfare concerns in Lee’s study led staff to consider ‘checks and filters beyond those currently required’ (p. 509) participants in this study found police checks to be of limited value. Police checks evidently identify those violent and sexual offenders who have a conviction; however, the process is not failsafe. Unfortunately, they also raise new welfare concerns that, like other alarm bells, are not supported by professional guidelines or policy. Whilst preventing or avoiding harm to a child is morally good, it has been argued that the practice of criminal record checks is unlikely to meet this aim. Nor does the identification of an offender indicate absolute risk to a child (Allan, 2012). In the context of these issues and a lack of similar policy in other Australian states (where offenders may travel for treatment), participants in this study considered routine police checks as unfair and discriminatory.

The use of treatment deferral where welfare concerns are raised needs further exploration, professional discussion and policy clarification, especially in relation to its use as a tool or lever. The withholding of treatment whilst requiring certain behavioural changes or conditions to be met may arguably constitute ‘nudging’ through the use of treatment as an incentive for change (Blumenthal-Barby and Burroughs, 2012). The use of nudge in health care raises ethical issues beyond the scope of this paper but which are nevertheless important to consider.

While denial of treatment can lead to childlessness (and may be ethically justified), too can protracted deferral of treatment in the context of women seeking treatment at an advanced reproductive age. Counsellors in this study expressed uncertainty about their welfare literacy and their ability to predict whether a particular impairment or condition would mean a child would be at risk. More information is required about child welfare outcomes across a range of parental situations. When transposed to the infertility health care setting, the child welfare principle conflicts with other ethical considerations such as patient privacy, confidentiality, patient choice and the fiduciary relationship between patients and professionals. This is made especially problematic where the child welfare principle is given legal paramountcy. However, ART professionals are not isolated as the experience of suspicion, uncertainty, lack of confirmation and lack of clarity on how to proceed raised by participants in this study bears striking similarity to the issues reported in...

Even where policy provides a ‘risk assessment’ process and guidance on the interpretation of ‘the need for supportive parenting’ (Human Fertilisation & Embryology Authority, 2009; Lee et al., 2012) some welfare concerns were difficult to resolve satisfactorily (Lee et al., 2014). As Lee points out, ART professionals are influenced by the spectre of child abuse and this apparently forms a powerful rationale for pre-emptive action, however, pre-emptive action may not always be fair and effective (Allan, 2012).

Differences in interpretations and applications of the child welfare principle were evident among participants in this study. In addition, participants described varying degrees of agreement, support and collaborative processes within clinics. Previous studies also report variation between health professionals (Stern et al., 2003; Gurmankin et al., 2005). Like mandatory reporting of child abuse, there are varying degrees of agreement as to what to do when alarm bells ring, and to what extent harm to a potential child can be predicted (Levi and Loeben, 2004; Levi and Portwood, 2011). This is supported by the findings of Lee’s study which found that while views differed about welfare assessment these turned largely on whether it is possible to reliably assess the welfare of a child at preconception rather than on the value of assessment per se (Lee et al., 2014).

Indeed Blythe points out that neither the European Society of Human Reproduction and Embryology Task Force on Law & Ethics nor the ASRM Ethics Committee have clearly delineated responsibilities for decisions about access to treatment, despite both reinforcing the legitimacy of evaluations of parenting fitness (Blyth, 2012).

**Clinical implications**

This study has shown that counsellors take the child welfare principle seriously and make the concept meaningful in their practice. That said, this study has also shown that the concept is indeed slippery (Brewaeys, 1998) and difficult to operationalize. In the absence of guidelines for ethical practice, explicit criteria for making welfare judgements and further specific training in welfare issues, health professionals may constitute the welfare principle in ways that are unjust and subject to legal challenge. While participants in this study emphatically denied a role in screening patients for parenting fitness they were indeed engaged in health care assessment and these roles need further differentiation, clarity and research.

That said, this does not appear to be an aspect of ART practice that lends itself to the application of a set of objective criteria, although in the UK practitioners found a checklist to be helpful (Lee et al., 2014). Each case must be considered on its own merit. Nonetheless, health care practitioners need the support of professional development and a process of auditing and peer review of practices and decisions concerned with the child welfare principle, in order to clarify professional values, make fair decisions and promote consistency.

**Limitations to the study**

This study reflects the perspectives of psychologists and social workers employed as counsellors in ART clinics in only two of the six states and two territories in Australia where ART legislation variously exists. However, the majority of counsellors in New Zealand were able to be recruited.

**Acknowledgements**

The authors wish to thank Kate Bourne, ANZICA, for assistance in conducting this study and all individual counsellors who participated in the study and shared invaluable insights.

**Authors’ roles**

S.L.deL designed the study, conducted the data collection, analysed the data and drafted the manuscript. K.P. analysed the data and assisted in drafting the manuscript. J.M. assisted data collection and critical discussion of findings and commented on the manuscript.

**Funding**

This study was funded by a Flinders University Faculty of Health Sciences Grant.

**Conflict of interest**

The authors have no conflicts of interest to declare.

**References**

Allan S. Gatekeeping parenthood: should the state play a role in determining eligibility criteria for assisted reproductive treatment? *Family Law Rev* 2012; 149:149–163.


Blyth E. Guidelines for infertility counselling in different countries: is there an emerging trend? *Hum Reprod* 2012;27:2046–2057.


