Parental, Medical, and Sociological Responsibilities: “Octomom” as a Case Study in the Ethics of Fertility Treatments

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Abstract

The advent and development of various forms of fertility treatments has made the dream of parenthood concrete for many who cannot achieve it through traditional modes of conception. Yet, like many scientific advances, fertility treatments have been misused. Although still rare compared to the birth of singletons, the number of triplets, quadruplets, and other higher-order multiple births have quadrupled in the past thirty years in the United States, mostly due to the increasingly prevalent use of fertility treatments. In contrast, the number of multiple births has decreased in Europe in recent years, even though 54% of all assisted reproductive technology cycles take place in Europe, most likely because official guidelines have been implemented throughout several countries geared towards reducing the occurrence of higher-order multiple births.¹ The gestation of multiple fetuses can result in dire consequences for them. They can be miscarried, stillborn, or die shortly after birth. When they do survive, they are often born prematurely and with a low birth weight, and may suffer from a lifetime of physical or developmental impairments.

The objective of this paper is to explore the moral dimensions of certain uses of fertility treatments in light of the known dangers that may result from higher-order multiple births. I will do this by mainly focusing on the now infamous case of Nadya Suleman, also known as “Octomom.” I argue that Suleman and her fertility physician, Michael Kamrava, both violated important duties and virtues in the creation of her octuplets, but that my criticism of their actions equally applies to many other questionable uses of reproductive technology. Moreover, I will show that the responsibility for curbing the rise of high-order multiple births falls on the shoulders of not only patients and their doctors, but also the community of fertility physicians in general, insurance companies, and even the media.

Keywords: Ethics; Deontology; Virtue Ethics; Reproductive Technology; In Vitro Fertilization; Intrauterine Insemination; High-Order Multiple Births

Introduction

On January 26, 2009, Nadya Suleman, derogatorily known in the media as “Octomom,” gave birth to eight babies, all of who survived and appear, for now, to be in good health. The initial response to the birth of Suleman’s octuplets by the media and the general public was fascination and awe; that attention, however, quickly transformed into criticism and anger, including protests outside her home and even death threats, when certain revelations came to light. Suleman was a single mother, and already had six children under the age of eight, three of who suffer from disabilities of varying degrees of severity. At the time, she was relying on public assistance and student loans for their care (she has recently stated she no longer benefits from that assistance). Despite her tenuous financial situation, Suleman claims to have requested that all the leftover embryos from her previous In Vitro Fertilization (IVF) treatments be transferred into her womb.¹ When she learned she was pregnant with octuplets, she maintained that it was the result of all six embryos successfully implanting, and two of the embryos cleaving into identical twins. However, two years later, none of the octuplets appear to be identical twins, providing evidence that Suleman was implanted with more than six embryos; indeed, in another venue, Michael Kamrava, her fertility physician, admitted to implanting twelve embryos [1]. One of the most concerning aspects of this case is Suleman’s confession that in each of her six fertility treatments, she was implanted with at least six embryos [2].

Suleman’s case provides an avenue to begin an honest discussion concerning a problematic trend: the increasing instances of higher-order multiple births (a pregnancy containing three or more fetuses; hereon in HOMB) in the U.S. as a result of the use of assisted reproductive technology (ART). The United States’ 2007 National Vital Statistics Report shows that the twin birth rate increased 70% between 1980 and 2004, and that the rate of HOMBs increased 400% between 1980 and 1998; while the numbers of HOMBs have slightly decreased since, they are still rather high compared to what they were before ART was prevalently used.² Although Suleman was heavily criticized for her procreative decisions, parents of higher-order multiples are typically praised by the general public; some are the beneficiaries of charitable gifts, and some are featured on cable-network reality television shows. Indeed, media attention usually focuses on the successful aspects of HOMBs while ignoring its risks and sometimes tragic consequences. These risks will be further explored below, but one example has to do with the increased risk of cerebral palsy. One study concludes that the rate of cerebral palsy is 2.3 per 1,000 singleton births, the rate skyrocketed to 44.8 per 1,000 in pregnancies involving higher-order

¹Suleman’s scarred fallopian tubes precluded any other kind of fertility treatment – all fourteen of her children are products of IVF.

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In 1997, the McCaughey septuplets were born in Des Moines, Iowa after their mother was prescribed the fertility drug Metrodin. Because of their Christian faith, they declined selective abortion. Two of their seven children, Alexis and Nathan, now suffer from cerebral palsy and are mentally disabled. Despite these consequences, the Frustacis family have not deterred from using fertility drugs again; in 1990, Patti gave birth to healthy twins after using Pergonal once more. The Morrison sextuplets were born in Minneapolis, Minnesota in 2007. They too were products of fertility drugs and were born prematurely at twenty-three weeks gestational age. Five of the six children died within two months of their birth. Most recently, in August 2009, the Stansel sextuplets were born in Houston, Texas as a result of ovulation induction and intrauterine insemination (IUI). Against the advice of their doctor, the Stansels refused to selectively abort any of the fetuses. Only two of the six remain alive, both little girls. One baby died as a result of bleeding in his lungs due to an open heart valve, another baby died because of a tracheal infection, yet another of kidney failure, and the fourth died after battling yeast pneumonia.

Multiple conceptions are not an isolated phenomenon. The advent and development of various forms of fertility treatments has made parenthood a reality for those who cannot achieve it by traditional modes of conception. Yet, like most scientific advances, fertility treatments have been misused, and the United States has not, as of yet, adopted any official guidelines concerning acceptable uses of ART. The above cases are some of the most well-known concerning HOMBs that have resulted in tragic consequences, but more cases surely exist. Because of the increasing use of fertility treatments, and the consequent augmenting of HOMBs that has the potential to result in devastating consequences, it is time that we discuss the ethical dimensions of the wanton use of fertility treatments. By “wanton” I mean deliberately using fertility treatments in a way that increases the probability of a HOMB, even though one is aware of the risks and possible harm that could come to the resulting infants, in order to expedite pregnancy. While there is nothing wrong with having procreative interests, like all our other interests and goals this does not bestow a carte blanche to act in any way we desire to satisfy those interests, especially if it can lead to potentially devastating consequences.

In this paper I will mainly discuss Suleman’s case, however mostly everything I conclude about her equally applies to any case in which fertility treatments are wantonly used. Although I will spend some time discussing the moral dimensions of Suleman’s actions (and, by extension, any parent who acts in a similar manner) through the lens of two moral theories (deontology and virtue ethics), Suleman alone is not to blame. In addition, there is her fertility physician, Michael Kamrava, who indulged her desire to implant many embryos. More broadly speaking, others are also indirectly to blame for the rise in multiple births. For example, most insurance companies refuse to cover fertility treatments, thereby forcing couples to pay for the procedures themselves which, in turn, aggravates their desperation to become pregnant, since they cannot afford repeated attempts. The media is also partially to blame, for they focus on and celebrate the rare success stories without highlighting the more common tragic ones. Then there are the fertility clinics themselves who compete for business by preying on the anxieties of infertile couples by promising high pregnancy rates that are often achieved using unsafe practices. In other words, a shared responsibility exists, and this paper will address all of these concerns.

The medical, social, and emotional consequences of HOMBs

The two types of fertility treatments most likely to lead to HOMBs are IVF and IUI. As the name indicates, in IVF the embryos are conceived outside the woman’s body by combining oocytes (typically the gestating woman’s, but sometimes donor eggs may be used) and spermatozoa (typically her partner’s, but donor sperm may also be used), and then returning the embryos back into the womb for implantation. HOMBs could be avoided by opting for single embryo transfer (SET) or double embryo transfer (DET). However, because this decreases the chances of the woman becoming pregnant, patients often request that multiple embryos be transferred; this increases the odds of a singleton pregnancy as well as a multiple one. In IUI, ovarian induction is achieved by either the use of Clomiphene, or, if that fails, an injection of gonadotropin, in order to bring multiple follicles into maturity. A thin catheter is inserted through the cervix in order to introduce washed sperm into the uterus. When multiple ova are released, the sperm may fertilize more than one of them, thereby increasing the chances of a multiple pregnancy. Although still rare compared to the birth of singletons, the number of triplets, quadruplets, and other HOMBs in the U.S. have quadrupled in the past thirty years, mostly due to the increasingly prevalent use of fertility treatments [3,4].

In contrast, the number of multiple births has decreased in Europe in recent years, even though 54% of all assistant reproductive technology cycles take place in Europe, most likely because official ART guidelines have been implemented throughout several countries that serve to decrease the chances of a HOMB.

The consequences of a HOMB can be devastating to the resulting infants and to the gestating woman. The more fetuses occupy a womb with finite space and resources, the more they compete for those resources and the less they each receive. This may preclude them from getting adequate amounts of nutrition and limits the space they have to grow and develop. Consequently, the fetuses can be miscarried, be
stillborn, or die shortly after birth. When they do survive, they are often born prematurely and with a low birth weight [5]. Because of their prematurity, these infants can suffer from a plethora of physical impairments, such as cerebral palsy, chronic lung disease, strokes, blindness, anencephaly, hydrocephaly, mental retardation, respiratory distress syndrome, intracranial hemorrhage, hyaline membrane disease, bronchopulmonary dysplasia, and intraventricular hemorrhage [5]. In some cases, the infants may be spared from these afflictions (e.g., the Gosselin and Masche sextuplets are all healthy), but more often than not, serious complications ensue. Approximately 78% of higher-order multiples require prolonged care in the Neonatal Intensive Care Unit, compared to 48% of twins and 15% of singletons [6].

Gestating multiple infants also poses dangers to the pregnant woman, who is more likely to suffer gestational health problems, often resulting in prolonged periods of bed rest. She is also more likely to suffer from high blood pressure and blood clots. Because of the increased probability of preterm labor, a woman who gestates multiples will be subjected to labor-arresting drugs that can cause respiratory distress [7]. She is also more likely to experience hypertension, preeclampsia, gestational diabetes, anemia, postpartum hemorrhage, and will typically have to undergo a cesarean section rather than a vaginal delivery [7].

In addition to all these health risks, there are social consequences for the families that end up caring for multiple infants. Parents of multiples experience far higher incidences of stress than parents of singletons. Mothers of multiples are also more likely to suffer from postpartum depression [8] and more likely to report dysfunctional interaction with their children [9]. The stress of caring for multiple children is, of course, compounded if they suffer from disabilities. One woman comments that while she loves her children, she “didn’t plan on having four kids at once and needing overnight nurses for children with special needs like quadriplegia, feeding tubes, blindness, and permanent brain shunts” [10]. Because of the added demands of caring for multiples, women are more likely to leave their work in order to stay at home, which often results in a loss of identity and independence [11]. A higher divorce rate has also been reported for parents of multiples [12].

Finally, there is the economic impact that comes with the care of sickly and impaired infants. One study found that the average charge for delivering healthy twins is four times higher than delivering healthy singletons, and eleven times higher for healthy triplets. The costs of a quadruplet birth can exceed $1 million [13]. One 1994 study estimated that if every HOMB at one hospital would have been a singleton birth instead, “the savings would have been more than $3 million in this one hospital for one year” [14]. A 1999 study found that the cost to keep a baby alive in an incubator who was born at 24 weeks gestational age or less was about $2,346 per day. The daily median ancillary cost for these liveborn infants who were not harmed by being brought into existence; indeed, this would remain the case even if the children had been afflicted with some disability as a result of being a higher-order multiple so long as that defect was not severe enough to render nonexistence preferable.

This is a version of Derek Parfit’s nonidentity problem. If harm is defined as making someone worse off than they otherwise would have been, then children born of ART’s cannot claim to be harmed, even if they are born with some sort of defect, because the alternative to being born with that defect is not to have been born at all. Because there was no harm done onto the children, there is tenuous bases for curbing artificers autonomy in cases like Suleman’s or any like situation in which ART is used in a manner that knowingly increases the chances of a HOMB. John Robertson, a strong defender of procreative autonomy, argues along these lines: “If the couple is committed to rearing the resulting children and has no reasonably available alternative way of having genetic offspring, they would appear to be seeking the ordinary goods of reproduction. They should not be stopped from doing so because of unavoidable risks of offspring...the children unavoidably born with the condition of concern have not been harmed or wronged” [22]. Robertson concedes that people may react negatively towards individuals who deliberately risk bringing a child into the world with a disability, however, this distaste alone does not provide “a sufficient basis for restricting [an infertile person’s] reproduction” [23].

Couples like the Stansels may be more easily excused than Suleman with this line of reasoning, since they were childless and had no other method of procreation, whereas Suleman already had existing children. Nevertheless, because we do not restrict coital reproduction for couples who already have a large number of children, Robertson would most likely argue that the fact Suleman had existing children has no bearing on her right to continue having more. Moreover, because we do not
restrict coital reproduction for couples who stand a risk of having children with congenital abnormalities, we cannot restrict anyone from using fertility treatments in a manner that raises the probability that the children would be born with certain afflictions. In other words, because infertility is legally classified as a disease, we cannot treat the infertile in a different manner than we treat the fertile; we cannot restrict the procreative autonomy of the former in a manner we are not willing to do for the latter. Robertson is surely correct that all persons have a legal right to procreative autonomy, and this has been supported in multiple state and Supreme Court cases. Moreover, although the nonidentity problem has its share of supporters and detractors, it is admittedly difficult to point to a clear consequentialist reason for maintaining that the resulting children of HOMBs have been harmed, even if they are born with certain defects, if the only alternative to being born as a multiple was not being born at all.

Because of these complications, I will grant, for the sake of argument, that Suleman, and by extension any prospective parent who uses ART, has the right to utilize these treatments, even if doing so can lead to the birth of children with certain afflictions. Nevertheless, I do believe that there is merit to the general public’s disfavor against Suleman’s and Kamrava’s actions, and to the medical community’s criticism of the use of ART that is likely to increase the incidence of a HOMB. Individuals who wish to hold Suleman and Kamrava responsible for their actions are unlikely to be deterred if they were made aware of the nonidentity problem and its conclusion, and such a reaction is not necessarily an irrational one. Indeed, many may, when pushed, even concede that Suleman acted within her rights, and that Kamrava was doing nothing more than respecting her procreative liberty. Yet, conceding that someone has a right to act a certain way does not exhaust the moral dimensions of her actions; there can be ways of exercising one’s rights that are morally questionable.

Suleman initially stated that she had six embryos implanted, all of them left over from her previous IVF treatments, because she did not want them destroyed. “I couldn’t live with the fact that I didn’t allow these little embryos to live. Or give them an opportunity to grow” [24]. Yet, it was later revealed that Suleman underwent fresh cycles for all her reproductive treatments even though she had cryogenically preserved embryos [25]. When asked whether she was aware of the possibility of a multiple pregnancy, she admitted she was but thought it unlikely that all her embryos would successfully implant [24]. Yet, in another venue, where she touted Kamrava’s services after giving birth to her first four children, she complimented his unique IVF tactic, which allows him to see inside a patient’s uterus as he directly implants the embryo, rather than transferring them and allowing them to implant themselves, and credited it for raising the odds of successfully attaining a pregnancy (although some of Kamrava’s colleagues have claimed that his methods do not increase these odds) [21]. She also acknowledged that she was fully aware of the dangers that could come to her and her fetuses as a result of a HOMB.

Why would Suleman take this chance? Her reasons for wanting a large family betray a sense of personal emptiness she wanted fulfilled. In her own words:

[Her children provide a] feeling of self and identity. Reflecting back on my childhood, I know it wasn’t functional. It was pretty - pretty dysfunctional, and whose isn’t? I was very unconditionally loved and accepted, I felt, by my father. My mom, we had a relationship. I knew she loved me. I always knew she loved me. But she didn’t, openly or overtly, express, you know, affection and love… I wanted that huge family, just to surround me, to be surrounded by connections, the bond that I lacked. And I personally believe that need to fill something inside that’s not there, the void, the feeling of emptiness. I think everyone has that [24].

More often than not, most individuals who seek to bear or raise children do so because it constitutes, for them, a fulfilling life. This is, of course, a perfectly legitimate reason for procreating; however this does not grant us license to act in any way we desire, even if, in the end, we may have a right to act that way. The question, then, is the following: Did Suleman act in a morally dubious, if not reprehensible, way by putting her own desires for a large family before the welfare of her existing and resulting children? Let’s begin by assessing her actions from a deontological perspective, which holds that moral agents are bound by duties and obligations towards others; to violate a moral duty, therefore, is to act in a morally impermissible manner. When multiple duties conflict, one must perform the most stringent one, which involves determining which duty supervenes. Thus, we need to consider whether there are any duties or obligations Suleman failed to meet in this case. I propose that there were two duties in conflict. Given the importance Suleman placed on childrearing, it can be argued her duty of self-improvement (as deontologist W.D. Ross calls it) entailed that she bear and raise children. This means, therefore, that her interests in procreation were legitimate ones, and this alone is not the subject of censure. The issue is whether possessing this legitimate interest entitles one to act in any way (s)he desires to satisfy that interest. I argue that it does not – especially if one has other duties and obligations (s)he is required to meet. When deciding whether to have multiple embryos implanted, knowing the risks that come with a HOMB, Suleman’s duty of self-improvement was in conflict with another duty that relates to any preconception choice - what Bonnie Steinbock and Ron McClamrock call the duty of parental responsibility. They write:

A principle of parental responsibility should require of individuals that they attempt to refrain from having children unless certain minimal conditions can be satisfied. This principle maintains that in deciding whether to have children, people should not be concerned only with their own interests in reproducing. They must think also, and perhaps primarily, of the welfare of the children they will bear…. where there is no child at all, the question facing the prospective parent is not, what does my child want? nor, What is best for my child? It’s rather a question of whether to create a child who is likely to have a life marked by pain and severe limitations. It seems to us that the answer to this question must be no. What reason could be offered in justification of an affirmative answer? That the child’s life, while miserable, is not to awful that he or she will long for death? That is not the kind of answer a loving parent could give. Anyone willing to subject a child to a miserable life when this could have been avoided would seem to fail to live up to a minimal ideal of parenting [26].

A few caveats must be mentioned. First, Steinbock and McClamrock do not develop what is meant by the term “minimal,” and this can pose a problem for adhering to the principle. For example, would deliberately conceiving a child who may be at risk for diabetes violate this principle? What about deliberately conceiving a child who runs the risk of inheriting his parents’ dwarfism? Indeed, without a careful delineation of what is meant by “minimal condition,” an appeal to this principle could potentially justify condemning poor people
for procreating if they cannot provide a certain kind of lifestyle for their children. Determining what is meant by “minimal conditions,” however, is beyond the scope of this paper; moreover, considering all the dangers listed above that may come to mothers and fetuses as a result of a HOMB, it seems reasonable to hold that these dangers, if realized, fall below commonsensical minimal standards of health.

It can be argued, then, that Suleman experienced a conflict of duties: her duty of self-improvement qua procreation conflicted with her duty of parental responsibility towards her future children (and her existing ones, as will be discussed below). This conflict, however, was only superficial, for she had other avenues open to her she did not opt for that would have satisfied her desire to have more children without the accompanying risks (i.e., SET or DET). Instead she requested that a large number of embryos be implanted with a method she believed to have a higher success rate. This illustrates she was willing to deliberately increase the chances of a HOMB, even though she was aware of all the risks that come with it. Therefore, it very much seems as if she was “concerned only with [her] own interests in reproducing” rather than being concerned for the “welfare of the children” she wanted to bear.

But the resulting octuplets are not the only ones affected by Suleman’s actions; one must also consider her older six children. As abovementioned, three of her older children suffer from disabilities of varying degrees of severity; properly caring for six children, half of who are disabled, takes an immense amount of time and commitment. Having more children will only serve to further restrict the time one can spend with each child, in addition to stretching already limited resources. In the interview cited above where Suleman defends her procreative decisions, not once she considers whether she has violated the interests of her older children. When pressed to answer whether her actions were fair to them, she answered: “I think there are a lot of things in life that are not fair. It is going to be hard for them. But life, I believe, isn’t always perfect and idealistic” [24]. In other words, the older children should simply “deal with it”; the fact of her time would be severely stretched in trying to care for fourteen children, that three of those children already require more time and care because of their disabilities, and that financial resources were already scarce for six children, seemed irrelevant to Suleman. A strong case can be made that she violated a duty of nonmalfeasance in reference to her older children, in addition to violating her duty of parental responsibility towards them, for she seemed to prioritize her interests in reproducing above their needs.

In addition to a deontic approach, one can also analyze Suleman’s actions through a virtue ethics perspective. Consider Aristotle’s functionality argument in his Nicomachean Ethics: in order to be a good x, x must perform its function well. So, for example, a good clock is one that tells time well. Part of the function of a parent is mentioned by Steinbock and McClamrock: a good parent is loving. A good parent, therefore, is one who performs his function as a parent well, which includes practicing the appropriate virtues. Although Robertson and Suleman would contend that she acted within her procreative rights, from a virtue ethics perspective, asserting that one has a right to something does not immediately end the moral assessment of the action. There is a further, much more complex, question concerning whether one is using a right well; whether one is using a right in a manner that illustrates a virtuous character. As philosopher Rosalind Hursthouse writes:

…in exercising a moral right I can do something cruel or callous, or selfish, light-minded, self-righteous, stupid, inconsiderate, disloyal, dishonest - that is, act viciously. Love and friendship do not survive their parties’ constantly insisting on their rights, nor do people live well when they think that getting what they have a right to is of preeminent importance; they harm others, and they harm themselves [27].

For example, although we have a right to free speech, hate speech would be considered an unvirtuous exercise of such a right. Although we have a right to use our earnings in any (legal) manner we see fit, it would not be virtuous to taunt a homeless person with our excess cash. There is more to the moral dimensions of an action than whether it was an exercise of a certain right; we must also consider whether that right was used well. This is especially the case when a nonvirtuous exercise of a right affects others, especially those who are vulnerable and to whom one has special duties of care.

If a moral agent were to implement virtue ethics in order to navigate a moral dilemma, Hursthouse maintains that the appropriate question the person should ask herself is: “If I were to do such and such, would I be acting justly or unjustly (or neither), kindly or unkindly [and so on]” [28]. That is, it is important to determine whether one’s actions were manifesting a virtue or a vice. One of the strengths of virtue ethics is that it allows one to take into account the salient particulars of a situation, and the answer as to what constitutes a virtuous or vicious action in one situation may not be so considered in another. For example, Aristotle argues that what constitutes a healthy amount of food for an athlete may not be considered healthy for a nonathlete; the former certainly requires far more than the latter for optimal health [29]. Suleman’s case contains many unique circumstances: her pre-existing children (half of who were disabled), her lack of financial stability, and her limited resources and time availability given her status as a single mother. All of this count as reasons against using fertility treatments in a manner that increases the chances of multiples, which, in turn, increases the chances those children will be sick or disabled. Because of all these reasons, a charge of irresponsibility certainly seems to apply in Suleman’s case. Moreover, her decision to place her procreative interests above the interests of her older children and her resulting children can certainly be classified as selfish.

Because the circumstances that accompany each individual situation may alter which actions count as morally virtuous or vicious, the upshot of this is that every situation in which prospective parents wish to use ART would need to be assessed on its own merits. The salient particulars from a virtue ethics perspective may include, but need not be limited to, the following considerations:

1. Were the prospective parents sufficiently informed, i.e., were they aware that a certain procedure may increase the odds of a HOMB, and the inherent risks involved in gestating higher-order multiples?
2. If they were so aware, did they disregard those dangers and, instead, deliberately act in a manner that increases the chances of a HOMB?
3. Were there other people whose interests and welfare they were required to consider who may have been adversely affected by the introduction of higher-order multiples in their lives?

4. Did they possess the resources (e.g., financial, emotional, and mental support) necessary to care for any resulting children, including disabled ones?

5. Were they able to fulfill their desire to have genetically related children in a way less likely to lead to a HOMB? That is, were other, less dangerous, avenues available to them?

Again, it is worth stressing that these considerations are not meant to challenge the procreative rights of infertile couples who desire biological children. Rather, they are meant to outline relevant considerations for exercising those rights in a responsible, judicious, and virtuous manner.∗

The decision to engage in aggressive fertility treatments needs to be considered in light of all these questions; such considerations are pivotal for determining whether a particular couple acted responsibly and dutifully in their decision to bring children in the world through the use of fertility treatments. While my discussion has focused mainly on Suleman, my analysis equally applies to anyone who acted in a similar manner. For example, a woman who knows she is experiencing ovarian hyperstimulation and is aware that the introduction of sperm could result in a HOMB would be acting in a morally dubious fashion by requesting IUI or engaging in unprotected sexual intercourse (and any physician who would concede to IUI knowing his patient was experiencing hyperstimulation would also be acting in a morally dubious fashion). When prospective parents are so consumed with their procreative goals, to the extent that they are deliberately willing to engage in actions that increase the chances their children may be born with afflictions, this illustrates they have put their interests above the interests of their would-be children. They have also put those interests above the interests of any dependents (if they exist), and are willing to subject society to the immense amount of expense that it would take to care for premature, possibly disabled, infants. The willingness to deliberately bring a child into the world by any means necessary, even if it increases the odds of having children with potentially devastating disabilities, is a state of mind that lends itself to being negatively evaluated.

An analysis of Kamrava’s actions

The fact that Michael Kamrava defended his actions by citing Suleman’s procreative and ownership rights indicates that he felt obligations only to her, and that he simply acted in a way that respected her autonomy and desires. In 2009, Michael Kamrava was expelled from the American Society of Reproductive Medicine (ASRM) for repeatedly violating standard (yet unofficial) guidelines concerning the number of embryos that ought to be transferred in any single IVF cycle. Depending upon a woman’s age and her prognosis for pregnancy, the Society for Assisted Reproductive Technology (SART) advocates that the number of embryos implanted in Suleman were far in excess of the recommendation and beyond the reasonable judgment of any treating physician… [31].

Yet, not all of Kamrava’s colleagues chastised his decision. Jeffery Steinberg, a fertility specialist, defended Kamrava’s actions on the same grounds Kamrava defended himself: the patient’s wishes for the embryos, which are under her ownership, are definitive: “In our eyes, those embryos belong to the patients and they have to make decisions about them” [1]. Accordingly, although the physician may offer advice to a patient, council against implanting too many embryos, or even suggest selectively aborting some of the fetuses in order to render the pregnancy safer, ultimately the physician’s responsibility is to acquiesce to the patient’s decision. Because embryos are, legally, considered the property of the genetic parents, the parents have the ultimate say as to what is done with them.

If Kamrava is to be condemned for following Suleman’s wishes concerning her treatment, then it must be the case that, at times, a patient’s autonomy may be overridden by other concerns; that sometimes physician paternalism is justified. Within the medical community there has long existed a tension between patient autonomy and what is called “medical beneficence” or “medical paternalism.” Comparing the official statements of the American Medical Association between 1847 and 1990 illustrates a shift in attitude away from medical paternalism and towards patient autonomy.

The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them. A failure in one particular may render an otherwise judicious treatment dangerous, and even fatal (1847).

The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatments (1990).

As Dr. J.J. Chin notes, the current ethos in medicine almost always became pregnant with quadruplets (after Kamrava transferred seven embryos) and consequently suffered some complications, including the death of one fetus and an infant born with developmental delays, a 42-year-old woman who was undergoing fertility treatments even though she suffered from advanced ovarian cancer, and a couple who sued him after he overmedicated the woman in order to hypostimulate her ovaries (Kamrava settled the last case out of court). Because of all these and other questionable cases Kamrava’s medical license was revoked in 2011 [1,31].

Kamrava has been accused of gross negligence by some of his colleagues. For example, endocrinologist John Jain criticized him for not looking after the interests of his patients; discussing Kamrava’s 49-year-old patient, he remarked: “Not only are there risks to the unborn babies, pre-term delivery and all that goes with it as we learned from the octuplets, but to a 49-year-old woman the risks mostly relate to her cardiovascular system and these risks are serious, such as stroke and heart attack and even death” [32]. The California Medical Aboard (CMA) accused Kamrava of failing to adhere to his medical duties when it came to Suleman’s case:

When [Suleman] returned to [Kamrava] in July 2005 following the birth of her fourth child and again in January 2007, following the birth of her twins—her fifth and sixth children—[Kamrava] failed to exercise appropriate judgment and question whether there would be harm to her living children and any future offspring should she continue to conceive… [the number of embryos implanted in Suleman were] far in excess of the recommendation and beyond the reasonable judgment of any treating physician… [31].

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∗This is not meant to single out the infertile. Couples who can procreate through traditional means also have an imperative to procreate in a responsible manner, which may preclude, for example, deliberately bringing a child into an abusive home, or having a child when one lacks the resources to care for it.
favors patient autonomy rather than medical paternalism; indeed, as of late, "paternalism is almost always perceived in a negative light, regardless of intention and outcome" [33]. Suleman very clearly desired to have more children, and she openly admits to requesting that Kamrava implant multiple embryos. Given that, first, embryos are legally the property of the genetic parents and, second, that patient autonomy is considered primary, what basis could there be for claiming that Kamrava acted inappropriately? Suleman seemed well informed by Kamrava of the risks involved in HOMBs, and Kamrava even suggested fetal reduction, which Suleman vehemently rejected. What, then, could Kamrava have done differently?

Although it is the case that a patient’s autonomy must be prima facie respected, that autonomy cannot extend to engaging in actions that may harm others (indeed, almost all of our rights are subject to restriction on this basis). If Suleman’s older and resulting children are regarded as appropriate subjects of moral concern whom Kamrava was required to consider, then it would not be impermissible to restrict her autonomy in certain ways in order to avoid inflicting harm upon them. In other words, it can be argued that the duty to avoid harming the children, in this case, trumped Suleman’s right to practice her reproductive autonomy in the precise manner she wished. The italicized part is important; Suleman’s procreative autonomy simpliciter would not have been violated had Kamrava refused to implant more than two embryos. What would have been violated is a particular exercise of her procreative autonomy, one that had the potential to result in enormous suffering for her future and existing children.

Given his role as a fertility doctor, there are certain duties of care to which Kamrava was expected to adhere. Most obviously, he violated his obligations to act responsibly when he implanted far more embryos than is recommended, given the known health risks to his patient and the potential children. Second, he conceded to fresh cycles for every single instance of Suleman’s treatment, despite the fact that there existed frozen embryos and that ovarian hyperstimulation and egg retrieval also carries with it health risks for the woman (again, the existence of preserved embryos means that Suleman’s procreative liberty simpliciter would not be violated by refusing to initiate fresh cycles). Third, Suleman repeatedly returned for a new round of treatment within a short amount of time after giving birth, and this was “outside the norm and her conduct [placed] her offspring at risk for potential harm” [34]. This created a duty for Kamrava, according to the CMA, to refer Suleman for psychiatric evaluation.

Kamrava cannot be condemned on consequentialist grounds. Had he adhered to the standards of his profession and only implanted two embryos, no one would have condemned him had they both cleaved into triplets, resulting in a sextuplet pregnancy; this would have been an unforeseen accident, but not one for which he could have been held responsible given that he sought to create, at most, two fetuses. Similarly, he is rightly subject to censure even if only a single embryo had successfully implanted out of the multiple ones he transferred, and even though the octuplets appear to be in good health and Suleman appears to not have been harmed by gestating eight fetuses. But from a deontological perspective, the consequences of an action are not as relevant for assessing whether a moral agent acted rightly or wrongly; it is nature of an action that matters, and any action that violates a duty or obligation is rendered prima facie impermissible even if no actual harm came of it. Appealing to Suleman’s procreative liberty or a derision of medical paternalism, then, does not adequately defend Kamrava’s actions. There were reasonable alternatives available to him; ones that would have simultaneously respected Suleman’s reproductive rights and were less likely to lead to a dangerous condition for her and the resulting children. Chin writes that patients are best served when “efforts are directed... to finding ways of minimizing... paternalism without too great a compromise on patient’s freedom... [medical] beneficence and autonomy are therefore not conflicting, but congruent principles... an approach that serves the patient best is probably one that promotes a harmonious marriage of beneficence and autonomy” [35]. There were ways of attaining this marriage that Kamrava did not appear to seek, and this, in conjunction with repeatedly violating the accepted practices and obligations for his profession, render his actions appropriate for censure. The same censure would apply against any physician who acted in a similarly negligent manner.

From liability to social connection: Sharing the responsibility

When detailing her ethics of responsibility, Iris Marion Young distinguishes between attributing blame to moral agents for their actions versus attributing responsibility. In order to properly attribute blame, Young argues we ought to appeal to what she calls the liability model of assessing blame, which “assigns responsibility to a particular agent (or agents) whose actions can be shown to be causally connected to the circumstances for which responsibility is sought” [36]. Noteworthy for the purposes of this paper is Young’s comment that the liability model for assessing blame “holds an agent liable for harm even if the agent did not intend or was unable to control the outcome” of the state of affairs in question [36]. One could argue that it was neither Suleman’s nor Kamrava’s intent to create an octuplet pregnancy, especially since Suleman’s history did illustrate she had difficulties getting pregnant and required multiple cycles in order to have her children. Moreover, the odds of so many embryos successfully attaching to the uterine wall and gestating to viability were extremely low. Nevertheless, Suleman and Kamrava are appropriate subjects of blame because they are both directly casually responsible for the octuplet pregnancy, for all the reasons stated above.

However, the problematic proliferation of multiple births extends beyond the immediate parties involved; there is a certain amount of shared responsibility. Certain structures, from insurance companies to the media, have also contributed. While it is perhaps inappropriate to directly blame these structures for the rise of HOMBs, as Young argues, “it is also inappropriate... to allow them (us) to say that they (we) have nothing to do with it. Thus, I suggest that we need a different conception of responsibility to refer to the obligations that agents who participate in structural social process with unjust [or harmful] outcomes have” [37]. Young calls this conception of responsibility (rather than blame) the social connection model. According to Young, those who participate in, or benefit from, some unjust or harmful outcome are responsible for taking steps to rectify the wrong and help ensure it will not reoccur. Young’s particular concern is the unjust conditions of sweatshop workers, and she argues that, because we all benefit from what they produce, we all contribute to the demand that keeps sweatshop workers in inhumane conditions. Consequently, although we may not be blameworthy for their condition, we are nevertheless responsible to rectify it because “those who contribute by their actions to the structural process producing injustice [or harm] share a responsibility for such injustice [or harm]” [38]. The extent to which we are responsible depends on four factors: power, privilege, interest, and collective ability [39].

First, we must take into account the position each moral agent has in society, for that position will influence the opportunities, capacities, and resources at the agent’s disposal. Second, whether an agent has a privileged status in society is also relevant. Young argues...
that, for example, when it comes to making a statement concerning the
swathwork practices of companies such as Wal-Mart, “lower-income
clothing consumers, whether in the developing or developed world,
may be less able than more affluent consumers to spend more for
clothing in order to ensure that the workers who make it are treated
fairly” [40]. Third, those who actually have a vested interest in improved
circumstances have a special responsibility to work toward attaining
that goal (e.g., swathwork workers themselves). Finally, although there
are times that a single person or two can do very little to prevent a
future harm or injustice, “a coincidence of interest, power, and existing
organization enables people to act collectively to influence processes
more easily…” [41]. That is, if, collectively, a group of individuals
can easily work together to remedy a harm or an injustice, then this
presents a strong prima facie reason for engaging in such a collective
activity (one example Young mentions concerns university students
collectively rallying against clothing made in swathshops at their
campus’ bookstores; consequently this results in breaking ties with a
particular brand or company because of their use of swathwork labor).

In what follows I will discuss three groups, in order of influence and
power, I believe possess a moral responsibility to help curb HOMBs
under Young’s model: fertility physicians, insurance companies, and
the media.

**Fertility Physicians**

In general, the community of fertility physicians did not regard
Kamrava’s actions favorably. A physician is often regarded as a healer
and also as “a wise friend, and a caring partner in the journey towards
healing and comfort” [35]. Because of the trust patients have in their
physicians, this puts them in a position of power and influence over the
decisions patients make about treatments. Because of such influence,
according to the social connection model, all fertility physicians have
a responsibility to take steps to curb the uses of ARTs that can lead to
HOMBs. The first step physicians can take is to ensure that patients
seeking fertility treatments are fully informed of the risks and dangers
of a multiple pregnancy. They also need to be informed of the long-
term costs and consequences of caring for children who may develop
disabilities or other afflictions because of premature birth. Indeed,
one study found that as little as 35% of the public understand the
effects of prematurity or see it as a serious public health problem
[42]. Patients undergoing fertility treatments often regard the idea of
a multiple pregnancy as a success, and the desire for a multiple
pregnancy increases in proportion with the length of time the couple
has been using ART [43]. However, when patients are well informed
about the fetal and maternal risks that accompany HOMBs, they “were
significantly less likely to want this outcome” [44]. The correlation
between increased desire for a multiple pregnancy with the length of
time a couple has undergone treatment reflects the desperation many
infertile couples feel and their desire for an “instant family” [43]. In
order to mitigate this desperation, physicians and counselors should be
on hand to help patients through their journey, and remind them that
the ultimate goal of a round of treatment is a single healthy pregnancy
and child. Ultimately, “patient education may play an important
role in assisting physicians in the quest to reduce the contribution of
assisted reproductive treatment to multiple births and their attending
complications” [45].

Fertility physicians also have a responsibility to self-legislate
amongst themselves and establish official, firm guidelines concerning the
number of embryos that ought to be implanted during IVF treatments.
Several countries have adopted federal regulations designed to decrease
HOMBs. For example, the U.K.’s Human Fertilization and Embryology
Act limits the amount of embryos transferred per IVF cycle to two. In 2003,
Belgium introduced a policy that reimburses laboratory costs for
IVF and artificial insemination (for up to six treatment cycles) if couples
elect to use SET. This policy has lead to a sharp decline in multiple
pregnancies, from 29.1% to 9.5%, within three years [46]. American
doctors are hesitant to embrace federal regulations [47]. Consequently,
SART self-regulates ARTs, determining the number of embryos
that ought to be implanted in IVF with a woman’s prognosis for a
successful pregnancy; as abovementioned, implanting five embryos is
the upper limit. However, none of these standards are official, and there
are no set consequences for physicians who do not adhere to these
recommendations, although an overtly grievous violation like that of
Kamrava’s did result in his expulsion from the ASRM.

Moreover, there are little guidelines concerning what constitutes
appropriate limits for IUI. Perhaps lower doses of stimulation drugs
may be administered, a policy suspending insemination when too
many follicles have matured may be implemented, or “if too many eggs
are likely to be released, then a subsequent injection to release the eggs
should not be administered, and the couple should be advised against
attempting pregnancy in that cycle...” [48]. That is, in terms of IUI
regulations, “several studies have shown that the number of multiple-
gestation pregnancies can be decreased by the more judicious use of
ovulation-induction agents and by increased monitoring” [49]. If they
reject federal regulations, it is the responsibility of fertility physicians
to monitor themselves, establish clear and enforceable guidelines
for responsible administration of treatment, and also implement
consequences strong enough to deter any physician who is tempted to
stray from these guidelines.

One worry is that establishing parameters that limit certain uses of
fertility treatments unfairly penalizes infertile couples and limits their
procreative autonomy. John Robertson expresses this concern. He argues that policies that intend to reduce multiple gestations may
diminish the chances a patient may become pregnant in any given
cycle; such policies, therefore, directly conflict with “the interest of a
woman/couple in having offspring in a particular cycle.” Robertson
is particularly critical of a SET policy because it “may unduly limit the
ability to get pregnant” [50]. Physician David Adamson echoes
Robertson’s concern: “the reproductive rights of infertile patients must
also be considered… at what point is it acceptable to place societal
or professional limitations on personal reproductive choice?” [51].
However, if adopting certain regulations decreases the chance an
infertile couple may successfully conceive in a particular treatment
cycle, this does not necessarily impede their procreative autonomy
so long as their general capacity to procreate by seeking additional
treatment cycles is not compromised. That is, decreasing the chances
of successful reproduction in a particular instance is distinct from robbing
an infertile couple of their general capacity to procreate; the latter is
retained if the infertile couple is able to repeatedly access treatment.

There are two important concerns however. First, repeated ART
cycles may not be financially feasible for many couples, and this very
genuine concern is addressed below when I discuss the responsibilities
medical insurance companies have in this area. In order to justifiability
implement restrictions on ART that may lead to decreased chances of
pregnancy in a particular cycle, it is necessary to provide couples
with the means to try again if the previous cycle is unsuccessful as a
way to protect their procreative liberty. Second, repeated exposure to
treatment cycles may be invasive for the woman (e.g., repeated ovarian
hyperstimulation or egg retrievals carries with it certain risks). This
is certainly a very valid concern, but it can be mitigated by, for example,
freezing procured eggs so as to limit retrievals, or decreasing the potency of ovulation-inducing hormones. A balance can be achieved between respecting the procreative rights of the infertile, protecting the health of the woman undergoing multiple fertility treatments, and implementing restrictions to curb HOMBs.

There is growing evidence that SET and DET have increasing pregnancy success rates. One study found that “transferring one fresh embryo, followed if necessary by the transfer of one frozen-and-thawed embryo, did not result in a substantially lower rate of pregnancy resulting in at least one live birth than did transferring two fresh embryos on a single occasion” [52]. Other studies have indicated that if a healthy embryo exists, along with a healthy woman with an overall good prognosis for pregnancy, SET provides a good chance at a successful pregnancy and birth [53]. Some studies have even found that transferring a “top quality embryo is equally effective as, but substantially cheaper than, double embryo transfer in women less than 38 years of age in their first IVF cycle” [54, 55] when taking into account the costs saved by decreasing multiple pregnancies. There is even increased knowledge as to how to create a “top quality embryo”; research has shown that “shorter exposure of oocytes to spermatozoa... may have a favorable effect on implantation rates by improving embryo quality” [56]. Further research concerning how to create quality embryos in order to increase the success of IVF is vital. Therefore, there are ways of implementing SET that do not significantly cripple a couple’s chances of successful procreation in a particular cycle. It should also be emphasized that, in order to fully respect an infertile couple’s procreative autonomy and rights, ART only needs to yield a pregnancy rate comparable with coital reproduction rates, and the latter are not very high in any given cycle, between 20% to 30%.

Insurance Companies

Having a child is an important, life-altering, and identity-altering decision. This is one of the main reasons why procreative liberty is so sacrosanct; because of the profound impact having a child has on someone’s life, it is a decision that cannot be made by anyone else other than the prospective parents. Indeed, becoming a parent is so vitally important to many people that remaining childless sometimes negatively impacts a marriage and one’s quality of life. Because of this, couples with modest financial means who seek fertility treatments are understandably eager to successfully achieve pregnancy with as few rounds of treatment as possible. This is often exploited by fertility clinics; they promote themselves as having high pregnancy success rates, and mostly achieve these rates by implanting more embryos than recommended when conducting IVF, or subjecting a woman to extreme ovarian hyperstimulation and insemination. The often prohibitive costs of fertility treatments, and the lack of coverage for these treatments by medical insurance companies, therefore, influence behavior that leads to a heightened probability of a HOMB. Prospective parents are more likely to “put all their eggs in one basket” in a single round or two of treatment and, therefore, will likely pressure physicians to either implant a large number of embryos if utilizing IVF or to proceed with insemination despite hyperstimulation and the maturing of several follicles if utilizing IUI. Consequently, according to the social connection model, medical insurance companies share in the responsibility of reducing the occurrence of HOMBs because their policies play a vital role in patients’ decisions concerning treatment.

Because of the inability to control how many embryos are released and fertilized, IUI is the major cause of HOMBs. However, because IUI is cheaper it is used twice as frequently as IVF by patients who have to pay for fertility treatments out-of-pocket [18]. Many studies have confirmed that when insurance covers fertility treatments, resulting in patients largely relieved of the financial pressures, they are less likely to engage in drastic measures aimed at achieving pregnancy expediently. For example, patients whose insurance covers IVF cycles are less likely to implant multiple embryos in a single cycle, since multiple attempts are financially feasible [57]. Another possible impact of insurance coverage for fertility treatments is that women undergoing IUI would be more willing to cancel insemination in the event too many follicles develop [58]. One study found that in the U.S., states that do not mandate medical coverage of fertility treatments have the highest number of embryos transferred per IVF cycle and a higher percentage of live HOMBs than states that require partial or complete coverage [59]. However, some have cautioned against thinking of insurance coverage as the magical solution to HOMBs, arguing that increased insurance coverage alone is “not likely to address the... multiple birth problem sufficiently, unless they limit number of embryos transferred in a given procedure” [60].

There is the concern that expanding insurance programs to cover fertility treatments would cost the companies too much money which, in turn, would be disseminated amongst the other beneficiaries, or result in the complete loss of coverage for some because of rising costs. However, some studies have concluded that, even factoring in the rising costs of expenditures if more people utilize fertility treatments because of increased coverage, the annual cost per beneficiary would be approximately $3 [61]. As abovementioned, the cost to care for multiple gestation pregnancies can be high if the infants and mother are relatively healthy, extravagant if they are not. If the infants survive and are subsequently disabled, their care would continue to cost insurance companies, not to mention the emotional and psychological toll on the families that must raise these children. One study showed that “the direct (perinatal) costs related to multiple births after IVF outweigh the costs of IVF itself. Indirect lifelong expenses attributable to disabilities will add even further to overall costs in relation to multiple births. Hence, reduction of the multiple birth rate after ART would greatly increase the overall cost-effectiveness of IUI and IVF treatments...” [62]. Ultimately, then, expanding insurance to cover ART can lead to overall positive results at a relatively low cost.

Because there is evidence that lack of insurance coverage for ART influences infertile couples to utilize these treatments in more risky ways, and that providing insurance coverage is correlated with using such technology in safer ways, insurance companies have quite a bit of power to influence change in the incidences of HOMBs. They can even expand coverage of fertility treatments with certain restrictions designed to ensure more judicious behavior on behalf of their beneficiaries. For example, in Sweden IVF treatments are covered an unlimited number of times if SET is used, but only four times if more than one embryo is transferred [50]. The upshot, then, is that insurance companies and their policies partially contribute to the incidences of HOMBs and therefore have a moral responsibility, according to Young’s social connection model, to take steps to curb the rise of multiple pregnancies by offering expanded medical coverage of fertility treatments.

The Media

Within the past decade, television shows about higher-order multiples have permeated cable television. Although a few of these shows
have featured children who suffer from disabilities due to being part of a multiple gestation, most of them feature perfectly healthy multiples. Although the families on these shows often discuss the financial burdens of caring for many children, they are typically showered with charity, and are paid well for their appearance on television. In other words, these shows portray multiples as an exhausting, often expensive, but a generally happy, experience. But these cases are the minority, “women who have gone through large multiple pregnancies with poorer results say the shows give viewers a misleading picture by failing to present the wreckage left behind in many cases — babies who are stillborn, spend months in the hospital undergoing painful procedures that require morphine or suffer from long-term disabilities” [18]. In addition to television shows that romanticize multiple births, these families are often featured in news outlets, and the infants are praised as “miracles.” While the decision to gestate and birth all the infants is considered heroic, very few individuals question the wisdom of engaging in the treatments in the first place. While Suleman and Kamrava are derided, the McCaughey family is praised and showed with gifts and positive attention.

Of course, those in media can do very little to directly curb the rising frequency of multiple births, so they are not as responsible as fertility doctors or insurance companies. Yet, the media importantly shapes public opinion and is the source of so many people’s “knowledge” about the world. It is plausible to conclude that many infertile couples seek fertility treatments with the idealized images of three, four, five, six healthy children firmly in mind; images they have derived from continual coverage of families like the McCaugheys, and reality shows such as Jon and Kate Plus 8, Raising Sextuplets, and Make Room for Multiples. They are not exposed to the trauma of the Stansel multiples. They do not watch infants die one by one due to painful afflictions, the parents burying each child while hoping that the others live, the struggles that come with continual twenty-four hour care for those who do survive, the women who almost die due to cardiac arrest or high blood pressure, and the consequent millions of dollars in hospital bills. If the media wants to honestly cover multiple births, it is imperative that they equally document families like the Stansels alongside of families with healthy multiples. While they cannot directly influence the use of fertility treatments or multiple births, they can present fair, honest, and accurate coverage about these families in the hopes that it will contribute to the informed consent necessary to ensure that those who seek fertility treatments do so in the most responsible manner possible.

Conclusion

This paper have covered many bases, and it presents what I hope is an honest and fair moral assessment of the growing use of ART that leads to HOMBs. I have focused on Nadya Suleman and Michael Kamrava because it seems that the “Octomom” case has opened the eyes of many individuals in regards to the wanton use of fertility treatments and the rise of HOMBs, and discussing this case opens the door to asking more fundamental questions concerning the ethical uses of ART. Moreover, any assessment I have made of Suleman and Kamrava equally applies to any person who acts in a similar manner, and we cannot consistently simultaneously deride them but praise others for their “miracles.” I suspect one reason Suleman received so much negative attention was because of her reliance on public assistance, and therefore the animosity aimed at her may be partially fueled by the general hostility we have towards “welfare mothers” in American society. While this reason for chastising Suleman is indicative of the dubious manner we regard the poor in this country, Suleman is worthy of admonishment for the reasons I have detailed in this paper. But she is no less guilty than any other person who acts in a similar manner, regardless of whether (s)he relies on public assistance.

I am sympathetic to Robertson’s defense of procreative liberty, but, like all our rights, we must learn to use them in responsible, judicious, virtuous ways. Therefore, not every exercise of procreative liberty will be a morally acceptable one. Procreative liberty must be balanced with the interests families and society in general share in curbing the proliferation of HOMBs. The final goal, therefore, should be to “limit the economic burden to society and the medical risk to future offspring while offering patients a realistic hope for a child” [63].

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