

(Non-)essential treatment? Sub-fertility in the time of COVID-19 (and beyond)

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Introduction

The extremely difficult circumstances that fertility patients find themselves in force them to reconcile with acute losses and profound uncertainties. Sometimes what hurts the most is the loss of the child desired and imagined (Lesnik-Oberstein, 2008), which becomes a tangible loss in the event of a failed implantation or a miscarriage. Sometimes it is the loss of a partner due to the strain that fertility treatments can put on a relationship (Martins et al., 2014). In other instances, uncertainty about the outcome of treatment can become unbearable. The outbreak of SARS-CoV-2 in the first few months of 2020 confronted fertility patients with a new set of losses and uncertainties that came suddenly and unexpectedly. Due to the implementation of stringent social distancing measures and the suspension of ‘non-essential’ medical treatments and procedures, fertility treatments were halted in the USA, the UK and other European countries, (Ferguson, 2020; Miller, 2020). At the time of writing, many countries have slowly moved towards allowing fertility clinics to resume their activities. However, given the disruption caused, my contention in this brief commentary is that it is necessary to engage in conversations on the social value of offering fertility treatments and on whether it is justifiable to suspend them in the event of a health crisis of this proportion.

Suspending fertility treatments

Following the guidance of the British Fertility Society (British Fertility Society, 2020), the American Society for Reproductive Medicine (ASRM) (ASRM, 2020) and the European Society of Human Reproduction (ESHRE) (ESHRE, 2020), several countries issued directions to suspend fertility treatments (with the exception, for instance in the UK, of fertility preservation for cancer patients) (British Fertility Society, 2020).

This suspension has had a severe impact on fertility patients. Media outlets have been filled with stories of patients whose treatment has been suddenly halted and of how this has taken a very serious toll on their mental health. For some, the suspension has added an undefined amount of

time to the years trying to conceive before becoming eligible for treatment, and to the months on the waiting list after referral. For others, the suspension has been issued after they had undergone hormonal injections, close monitoring of one's sleep, diet, mental and physical health, and arranging life's plans around the treatment schedule. Considering that time is a key element in assisted reproduction, I believe in the importance of prioritising discussions on how to administer treatments during a health emergency over discussions on whether to administer treatments in these circumstances. While it has been reported that only a few months of delay may not necessarily affect the chances of success of fertility treatment (Romanski et al., 2020), waiting times from initial diagnosis of sub-fertility to the start of fertility treatment can be lengthy. Additionally, it is unclear whether there will be further suspensions in the event of a sustained rise in infections.

Are fertility treatments (non-)essential?

But are these really issues that should concern us, considering the unprecedented situation we are confronted with? Should we be concerned with the suspension of fertility treatments considering the large number of deaths caused by SARS-CoV-2 and the degree to which all manner of treatments and procedures have been suspended worldwide? These are tricky ethical questions. On the one hand, one could argue that fertility treatments are indeed non-essential and should be suspended to protect patients and staff and to devolve resources to more urgent and critical treatments and procedures. Trivially, contrary to the case of cancer services, no one is actually dying or missing out on life-saving diagnoses or treatments (Hiom, 2020). On the other hand – and it is here that my allegiances lie – the toll that these suspensions is taking on fertility patients would call for a more nuanced engagement with these questions.

While current circumstances are indeed exceptional, the disagreement on whether fertility treatments should be considered essential is not new. For instance, some scholars have argued against the investment of public resources to offering fertility treatments or the development of new assisted reproductive technologies (McTernan, 2015; Rulli, 2016). The idea is that these technologies would only benefit a small subset of individuals and couples who wish to have genetically related children and who are unable to do so unassisted. Considering that there are alternatives in place, such as adoption, fertility treatments and having genetically related children through IVF is often not regarded as something essential. Another argument that questions the value and the essential nature of fertility treatments focuses instead on social norms. The gist of such an argument is that social norms surrounding parenting seem to place having genetically related children as a superior parental project to other forms of family formation. For sub-fertile women and couples, these norms are likely to contribute to the negative psychological effects of their inability to have (genetically related) children, and motivate women's willingness to undergo fertility treatment, even if such a treatment is psychologically and physically taxing.

These views are relevant for the present discussion. The scale of the outbreak has put an unprecedented strain on healthcare systems. The measures enacted by the UK and other governments to mitigate the spread of the virus have had a severe economic impact, which is likely to cause the loss of significant part of people's livelihood, thus increasing their risk of falling ill. SARS-CoV-2 has had a disproportionate impact on people with low socio-economic status and from ethnic minorities groups (Bambra et al., 2020). Considering then the unprecedented health and economic crises that our societies are facing, and the burdens and costs associated with fertility treatment, one could conclude that this pandemic – and the consequent suspension of fertility treatments – might represent an opportunity to re-think the social value of genetic relatedness and fertility treatments.

Gone baby gone

It is my view that every opportunity is a good opportunity to question the social value of having genetically related children. Feminist scholars have long criticised the predominance of the genetic tie, the harms associated with undergoing fertility treatments and the justice issues associated with the fertility industry. But – and there is a 'but' to all this – for fertility patients and those longing to have (their own, genetically related) children, questioning the social value of fertility treatments, and what is, to them their preferred parenthood project, may come across as disregarding something that they feel very strongly about. This poses a dilemma: interventions aimed at questioning such social value and treating fertility treatments as 'non-essential' might benefit present and future fertility patients by lessening the pressure to conform to social norms. This is however a paternalistic approach, one that firstly assumes that their preferred parenthood project is the product of social norms and that secondly prioritises what to third parties may seem beneficial to these patients rather than what they may feel is beneficial to them.

The feminist philosopher Sally Haslanger maintains that there are two strategies to combat the negative effects of oppressive social norms. She argues: "[o]ne is to provide resources so that everyone can come as close as possible to fitting the schema, another is to combat the dominance of the schema" (Haslanger, 2012, p. 180). Following her line of argument, interventions aimed at reducing the negative impact of oppressive social norms could take two forms. The first is considering fertility treatments as essential during a pandemic and devolving resources to making them more accessible. This strategy would provide people with a means to 'come as close as possible to fitting the schema'. Suspending fertility treatments and using the SARS-CoV-2 outbreak as an opportunity to rethink the social values of offering these treatments more broadly and to promote alternative ways of achieving parenthood is instead a second strategy that would 'combat the dominance of the schema'. While I would argue that it is important to question the social value of genetic relatedness and mitigate the negative effects that social norms can have on



women and couples, I have also strong normative and conceptual views on the need to protect and promote prospective parents' reproductive freedom and enable them to satisfy their preferred parenthood project. How should these tensions be addressed?

It is true that sub-fertility has profoundly negative psychological implications, especially for women (McLeod and Ponesse, 2008). The suspension of fertility treatments during the first wave of the SARS-CoV-2 outbreak has exacerbated such implications. Framing fertility treatments as 'essential' and a priority for the state during a pandemic, and increasing funding in normal times may lend support to the view that having a genetically related child is indeed the only valuable way of becoming a parent. Despite this, people's freedom to make meaningful decisions in reproductive matters is of value (Brock, 2005). Having children and, also, having certain kinds of (genetically related) children can be for some such a core activity that thwarting the enjoyment of this possibility can have a significant impact on their sense of self and well-being.

It is my view that whilst social norms influence people's preferences and decisions to undergo fertility treatments, this does not mean that women or couples undergoing such treatments lack capacity to critically engage with these norms and formulate informed views concerning their preferred procreative projects (Cavaliere, 2020). In addition, I would resist the idea that the decision needs to be either fitting the schema or combatting its dominance.

Rather, I argue that it is necessary to operate on both levels. People's desires to have genetically related children and to undergo fertility treatments should be protected by offering such treatments and making sure that they are considered a high priority even during health emergencies. This entails for instance providing detailed and transparent information regarding the reasons why treatments ought to be suspended, and open them to scrutiny from patients and the lay public. It entails also making decisions that are proportionate and that consider the costs of suspending these treatments for patients. Lastly, it entails providing psychological support to people on the waiting list and mitigating the negative effects that suspensions may have on them. At the same time, it is important to critically engage with oppressive social norms and with the material conditions that sustain them. This cannot be done in a short period of time and on the shoulders of fertility patients. It is a long processes that entails questioning the predominance of the genetic tie and the value that it is attributed to it; promoting other ways of family formations; supporting individuals and couples who opt for these alternatives with legal, economic and social means; and counselling sub-fertile couples in ways that open up alternatives that are not necessarily medically assisted. But all this should be complementary to offering material and moral support to people who are currently experiencing sub-fertility. This truly is essential.

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