

## ARTICLE

# A study of the experience of Norwegian IVF physicians in evaluating the parenting capacity of patients



## BIOGRAPHY

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## KEY MESSAGE

Should applicants for assisted reproduction be assessed for parenting capacity? This is a requirement in the Nordic countries. In this interview study, Norwegian fertility doctors thought that such assessments are important and that they themselves were capable of performing them. In cases of doubt, there is scope for individual discernment.

## ABSTRACT

**Research question:** How do Norwegian fertility doctors assess the parenting capacity of applicants, and how do they experience and evaluate the assessment practice?

**Design:** Qualitative interview study with 14 Norwegian fertility doctors. Interviews were analysed with systematic text condensation, a qualitative analysis framework.

**Results:** Norwegian fertility doctors deem parenting capacity assessments of applicants to be straightforward and simple in most cases. Yet, some cases of doubt pose difficulties. Physicians can then draw on resources such as colleagues, physicians from other specialties who know the patient and patient records. All the participating physicians agreed with the principle of parenting capacity assessment for patients seeking fertility treatment. The assessment enabled physicians to refuse patients whom they thought should definitely not have responsibility for children. The physicians' main argument was their own felt responsibility for the future child. Even though assessments could be challenging, the participants all thought of themselves as competent to perform them. Indeed, some thought that delegating the assessments would imply abdicating a responsibility that was properly theirs. Although national guidelines might aid decision-making, the physicians would not want guidelines to curtail the significant discretion that they exercised.

**Conclusions:** Whether societies should assess applicants' capacity for parenthood before fertility treatment is an ethical and political question. Although sometimes a difficult task, Norwegian fertility doctors see it as important, and as something they are competent and suited to undertake.

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## KEYWORDS

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## INTRODUCTION

Some countries require that infertile patients undergo an evaluation of their parenting capacity (their ability to be good parents who take good and proper care of their child) before starting treatment by assisted reproductive technology (ART). This includes the Nordic countries, although procedure and legal framework varies between countries (*NordForsk, 2022*). In the present study, the perspective of Norwegian ART physicians was examined. Analysis was undertaken of their descriptions of how they performed these complex evaluations, how they rated their own ability to carry them out, and what they saw as the major difficulties in performing this task. This undertaking diverges in scope, prerequisites, and potentially, skill set, from their other duties in the fertility clinic. It is a duty that is both important and potentially demanding because it may present dilemmas for the physician.

### Previous research

Previous studies have examined the attitudes of healthcare professionals towards parenting capacity evaluations, how such evaluations are conducted and the ethical questions that the evaluations raise. In general, most healthcare professionals working in ART support such evaluations because of a perceived responsibility for the welfare of the future child (*Sperling and Simon, 2010; Lee et al., 2014; Lind, 2020*). In an Israeli study, however, existing guidelines were often perceived as vague or not followed (*Sperling and Simon, 2010*). A Swedish study found that concerns for proper stewardship of public resources was appealed to alongside concern for the child's welfare to justify denial of treatment (*Lind 2020*).

A UK study found that a more thorough investigation of parenting capacity would typically be carried out when an initial assessment found mental illness, transmissible or inherited illness, physical illness or disability, or substance abuse (*Lee et al., 2014*). Clinics would, however, practice in accordance with a presumption to provide treatment, and rejections would be rare. A Swedish study of two publicly funded clinics found that 7.5% of evaluated patients were denied ART treatment either for medical reasons or because of unfavourable evaluation of parenting capacities (*Elenis et al., 2020*).

Studies have also examined the question of whether there *ought* to be assessments of parenting capacity. Several accept such a requirement; however, several authors have argued that such a requirement is unjust and discriminatory, in particular concerning patients' past criminal records (*Thompson and McDougall, 2015; Tonkens, 2018*).

As argued by *Budd (2005)*, an assessment of parenting capacity should involve three key features: it should focus on the person's capacity and deficits as a parent and for establishing an adequate parent–child relationship; it should have a functional approach with everyday functioning in mind; and it should apply a minimal, as opposed to an optimal, standard of parenting. Research on parenting capacity in other health and welfare service contexts suggests that professionals may face challenges in conducting valid assessments of parental capacity (*Carr et al., 2005*). Some suggest that professionals would require specialized training and guidelines (*Houston, 2016; Rutherford and Keeley, 2009*).

### Assisted reproductive technology in Norway

The legal framework for ART in Norway recently underwent changes that put focus on the evaluation by ART physicians of the parenting capacities of patients. Since 2003, according to the Norwegian Biotechnology Act 2–6 (*Norwegian Biotechnology Act, 2021*), the decision to offer ART treatment to an infertile patient or couple must include a 'medical and psychosocial evaluation' of the woman and any partner and take into account their 'capacity for care and the child's best interests'. The evaluation must be conducted by the ART physician, who can involve a psychologist or counsellor, but is not required to do so. The evaluation is a requirement for IVF and insemination and applies regardless of whether gametes are the patients' own or donated. At the time of this study, no national guidelines were available to aid Norwegian ART physicians in carrying out such evaluations. As a result of changes to the Biotechnology Act just before the present study was conducted in (May 2020) (*NordForsk 2022*), public attention and debate concerning the availability of ART had increased, particularly as single women were granted access to ART treatment by this change in the law.

In 2020, the Norwegian parliament also decided that prospective ART parents must submit to a criminal background check before entering treatment. The background check includes a statement from the police on previous criminal offences committed against laws deemed relevant for the best interest of the child, such as child abuse or physical violence. Some drug-related offences are also included. If the prospective parent has a criminal record that contains breaches of these laws, it is nevertheless left to the ART physician's discretion to deny or approve fertility treatment. Physicians at public clinics will have access to the clinical ethics committee (CEC) of the health trust to which the clinic is affiliated. It is entirely up to the physician whether or not to consult the CEC, and any advice would not be binding.

If a patient or couple is denied treatment in one Norwegian fertility clinic, they can appeal to the County Governor, but are also free to seek help at another clinic, with no obligation to disclose the previous medical and psychosocial evaluation. In Norway, the publicly funded healthcare system and private clinics offer ART treatment, with the number of treatment cycles evenly split between the two sectors. Both sectors must abide by the Biotechnology Act, and certain additional restrictions apply on access to treatment in the public sector, in particular an upper age-limit on women of 40 years of age, an upper limit on body mass index for women and an upper limit of two live children born to the couple seeking treatment. In the public sector, ART treatment is subsidized yet not free of charge. The cost to the patient of ART in the public sector in Norway is not considered a relevant obstacle for treatment (*Goisis et al., 2020*), although in the private sector it is.

### The distinctive role of the fertility physician

The aim of the present study was to explore the practice of ART physicians of evaluating parenting capacity of prospective patients. Our preconception was that this is an important and demanding role for the physician, potentially involving conflicting loyalties to both patients, society and the prospective child. Such diverse loyalties might lead to what has been termed 'intra-role conflicts' (*Hertogs et al., 2021*). The gatekeeping role of physicians means that they act as what Lipsky has termed 'street-level bureaucrats' in that they interpret and

enforce laws (the Norwegian Biotechnology Act), regulations and public policies in direct contact with the public (Lipsky, 2010). ‘Street-level bureaucracy’ refers to discretionary actions of individuals who, in their professional role, effectively determine access to public rights and benefits.

As physicians are gatekeepers who decide which infertile patients are fit to become parents, it is a controversial role. This is especially true in countries that have not legally formalized this aspect of the physician’s role. The normative question of whether there *ought* to be evaluations of infertile patients’ parenting capacity has been examined by other authors (Sperling and Simon, 2010; Lee et al., 2014; Thompson and McDougall, 2015; Tonkens, 2018, Couture et al., 2021), and will not be covered in the present study.

## MATERIALS AND METHODS

The aim of the present study was to understand how physicians assess the parenting capacity of applicants, and how they experience and evaluate this assessment practice. To this end, we formulated three more specific research questions: what characterizes situations in which the physicians are in doubt, and what dilemmas do they encounter? Which resources, broadly conceived, do physicians use when in doubt? Finally, do physicians believe that capacity assessments fit appropriately within the ambit of their responsibility?

Qualitative research interviews were chosen as an appropriate method for a detailed investigation of practices and experiences. Individual interviews were preferred over group interviews because the former was thought to allow participants to speak more freely. Although a quantitative study might give the prevalence of certain attitudes and practices, a qualitative study generates ‘thick descriptions’ of a phenomenon or practice, including, for instance, illuminating examples, lines of argument or ambivalence on the part of participants.

### Recruitment and data collection

All 30 physicians who worked with assisted reproduction in Norway were invited by email to participate in the project. Fourteen volunteered to be interviewed, nine women and five men. Eight worked privately and six worked in the public

sector. Of those who worked privately, several had worked in the public sector previously. Experience and age varied greatly; some were relatively new to the field, and some had worked in the field for many years. To preserve participants’ anonymity, only sex and sector (private versus public) will be stated.

The first interviews were held in the participant’s workplace; subsequently, the format of interviews changed to a combination of telephone, Zoom and physical interviews during the COVID-19 pandemic. We do not think that this affected the depth of the interview data. Interviews took place between November 2020 and January 2021. Each interview lasted 30–60 min and were conducted by the first and second authors. Interviews were aided by a semi-structured interview guide, covering such topics as how assessments are made, physicians’ competence to conduct assessments, characteristics of cases of doubt and how these are handled, and physician–patient relationships. Audio recordings were transcribed by the first and second authors. Transcripts were stored on a secure server.

### Analysis

Transcripts were analysed with systematic text condensation, a qualitative analysis framework (Malterud, 2012). Analysis proceeded in four steps. First, the transcripts were read to form an overall impression. Then, units of meaning were identified and coded according to topic. Third, each coded group was condensed and summarized in so-called artificial quotations. Until this point, the first, second and last authors had analysed the data independently. At this stage, the different analyses were reconciled through discussions. Several topics were made explicit, and these were grouped into five main topics and several sub-topics. Finally, the artificial quotations provided the basis for the development of the analytic text from which the final text of the article stems. Quotes from the interviews were translated from Norwegian to English during the writing of this paper.

### Research ethics

In line with the requirements of the Norwegian system, the project was evaluated and recommended by the Data Protection Official at the Norwegian Centre for Research Data on 8 October 2020 (reference 480140). Participation required informed consent.

## RESULTS

The analytical process generated five main themes: public regulation of parenting capacity assessment; when in doubt; differences between public and private clinics; effect on physician–patient relationships; and the effect of the new offer for single patients. The first two themes also have sub-themes.

### Public regulation of parenting capacity assessment

#### A capacity assessment is required

All the participating physicians agreed with the principle of parenting capacity assessment for patients seeking fertility treatment. The physicians wanted the assessment so that they could potentially refuse patients whom they thought should not have responsibility for children. Their main argument was that they had a responsibility towards the future child. One physician put it this way:

‘I think it’s a bit in the Norwegian mentality that you then have a responsibility for the unborn life.’ (Participant number 9, female, public clinic).

Others pointed to the responsibility for stewarding public resources:

‘We shouldn’t use public resources to help people who later need public resources to take care of their children, I think.’ (Participant number 7, female, public clinic).

Some participants claimed that, without a capacity assessment, there would be more of a free market and that children could become more of a ‘commodity’.

Participants did not, however, consider the idea of a national registry of patients who had been found to be unsuitable a good idea:

‘No, I’ve never thought so. That thing about a registry is always dangerous. We are after all no court of justice. With cases handled in a court the defendant always has the right to appeal. That’s the way it has to be here also if one has a registry; who has given the rejection and on what basis? Then you’ll rather have to make a new evaluation.’ (Participant number 2, female, public clinic).

It was thought that patients should not be judged unsuitable once and for all based on one clinician’s discernment. Another

problem mentioned with a national registry would be issues of confidentiality.

### **Physicians deem themselves competent**

Even though parental capacity assessment could be challenging, the participants all thought of themselves as competent to conduct it. The views of this participant were representative:

‘Throughout a long life, generally through qualifying to become a doctor and having been in the clinic a lot, I think you develop a clinical judgment. I can't see that there is anyone else who necessarily should [do it] (...) I'm not trying to put doctors above anyone else, that's not what I mean, but we are equally competent as other professions that potentially could do it.’ (Participant number 12, male, public clinic).

Although some participants thought that having another professional conduct the assessments would relieve them of a burden, the general view was that the responsibility for carrying out the assessments belonged to them as the physicians responsible for fertility treatment. Indeed, some thought that delegating the assessments would imply abdicating a responsibility that was properly theirs. None of the physicians thought of the parental capacity assessments as a significantly negative aspect of the job.

### **Pros and cons of detailed guidelines**

Participants reflected on the pros and cons of having more specific guidelines for conducting capacity assessments. On the one hand, guidelines can make assessments more uniform and less dependent on discretion. On the other hand, guidelines would not be able to take into account all the different variables that might sometimes be relevant:

‘I think that in many ways [the current system] is good enough, because I think it is hard. Once you create guidelines you either fall into this sack or you fall into that sack.’ (Participant number 4, male, private clinic)

Several physicians agreed with the above participant that current regulations were sufficient and that guidelines would decrease the space for necessary discernment. Very few criteria ought to lead to an automatic rejection; instead, a comprehensive assessment was needed in each case.

When asked whether changes to current guidelines were warranted, two potential

changes were mentioned, both relating to the age of applicants. First, the Biotechnology Act today has an upper age limit of 46 years for women; however, none of the clinics represented practiced such a high upper age limit, owing to the significantly lower probability of treatment success with increasing age. Many, therefore, wanted to lower the legal upper age limit for women. Second, some participants were concerned about couples in whom the male was considered to be old. In one case, a physician consulted the CEC because the physician considered the age difference to be too large. The CEC, however, found no basis for rejecting the couple because of their age and they thus received treatment.

### **The role of the police certificate**

Since 2020, applicants have been required to submit a police certificate as part of the parental capacity assessment. Most participants considered this certificate as a potentially valuable resource, which can bring to light past events in the life of applicants that otherwise might go undetected. Physicians, however, were uncertain about how much weight should be given to the certificate. Interviews also revealed that few of the physicians had in-depth knowledge of what the certificate entails and covers. For instance, few knew that not all potentially relevant, previous offenses would be included on the certificate; for instance, offenses that occurred 10 years previously would normally not be listed.

### **When in doubt**

Participants were in agreement that most cases were clear-cut: applicants were ‘normal’ or ‘average’ people and there was no reason to suspect a lack of parenting abilities. Rarely, the judgment that an applicant was unsuitable was also easy to make. This left a final set of cases in which the physicians were in doubt. The interviews, therefore, concentrated on these cases.

### **What characterizes cases of doubt**

‘We don't have good guidelines on what constitutes unsuitability.’ (Participant number 2, female, public clinic)  
This doctor's quote shows why cases of doubt can easily arise in parenting capacity assessment. How often the doctors were in doubt varied and depended on how they themselves defined a case of doubt. The doubtful cases formed a heterogeneous group, but similar concerns were mentioned by most physicians. Important characteristics of cases of doubt were as

follows: alcohol and drug abuse; mental illness; previous crime or violence; unemployment; disability; inadequate care for previous children; language difficulties; chronic diseases (myalgic encephalomyelitis/chronic fatigue syndrome was mentioned as a specific example by several); using several prescription drugs; and age of the father.

However, as several argued, the most difficult cases were those where one could not identify specific, tangible concerns:

‘But I think it's the most difficult, not the medical diagnoses or the psychiatric diagnoses, but more vague things.’ (Participant number 5, female, private clinic).

Here, patients who were doubted were described as ‘nervous’, ‘hesitating’, ‘unsure’, ‘childish’, ‘strange’, ‘unruly’, ‘immature’, or as having poor self-awareness, or poor couple dynamics, yet having no specific diagnosis.

What the cases of doubt had in common was that several individual factors came into play. They were difficult to compare with other cases and had to be assessed individually. Several of the doubtful cases were characterized by a previous medical history or crime, i.e. drug abuse and mental illness back in time. Several expressed that a history of such factors did not always align well with their current impression of the patient, as a physician here put into words:

‘Then you have these drug addicts who are, in a way, fully treated and doing well. How long should we let them go before we let them reintegrate into society again?’ (Participant number 4, male, private clinic).

### **What physicians do in cases of doubt**

When in doubt, physicians obtain more information, confer with colleagues, or both. All doctors mentioned colleagues as a great resource in cases of doubt. Several clinics have regular meetings at which difficult cases are discussed:

‘[We] take difficult cases and discuss what we think is reasonable, and what we should do. We use each other and each other's experience.’ (Participant number 3, female, private clinic).

In these cases, they usually reach an agreement, which is important considering that several of the colleagues would be

involved in the treatment of the same patients.

When supplementary information about patients is needed, physicians most often turn to the patient's general practitioner, psychiatrist or other physicians familiar with the patient. The in-depth information they then receive can also include the consulted physician's specific advice as to whether the patient should receive fertility treatment. All the participants said that they then would follow the advice they receive.

In more exceptional cases, physicians pass the case on to the state-run 'Children, Youth and Family Agency' or the hospital CEC. Interestingly, all the cases mentioned in the interviews that were sent to the agency or hospital CEC ended up being approved for treatment. Several physicians also pointed out that they see themselves as more restrictive than both the external agencies mentioned. For example, one case was referred to in which one of the physicians had severe doubts about a patient. The CEC, however, saw no substantial reason not to treat the patient, and the doctor decided to approve the patient. In this case, however, the child protection agency had to take over custody right after the child was born. In the aftermath, the physician regretted this and wished they had rejected the patient straight away.

### **Differences between public and private clinics**

On several points, practices among public and private clinics differed. Importantly, in public clinics, all patients are referred from a general practitioner or a gynaecologist. Although the decision of whether or not to provide treatment lies with the fertility doctor, the referring physician is expected to comment on whether the couple or patient are assessed as suitable for treatment, and the referral should contain relevant medical and psychosocial information. The participants considered this information to be valuable. In contrast, a physician from a private clinic commented:

'When you work privately, the patients come directly to the office without a referral, so we have very little background information about the couple.' (Participant number 8, male, private clinic).

A second difference is that the public clinics have access to patient records that

might be relevant. Public clinics have access to records from other departments in the local health trust. Access to psychiatric records, however, is limited and they do not have access to records from elsewhere in the country. Access to patient records, and psychiatric records in particular, was thought to be helpful. Physicians working in private clinics, however, did not have such access:

'[Working] privately you have nothing [i.e., no access to patient records]. So, I don't discount that some of those I have refused, based on information I have found when I worked at the hospital, may have received treatment elsewhere later, because it is not always that [the cause for concern] is visible on them [i.e., the patients].' (Participant number 8, male, private clinic).

A third difference, according to several participants, was that, although patients differ widely in both types of clinics, the most demanding psychosocial issues are typically encountered in public clinics. According to some participants, this might be because such patients might have poorer economy and thus could only afford treatment at public clinics.

### **The requirement of a parental capacity assessment can affect physician–patient relationships differently**

When asked about the effect of parental capacity assessments on relationships with patients, participants thought their own relationships were affected differently compared with those of physicians who referred or who were consulted in the process. Several participants thought that, if anything, the requirement for a capacity assessment would strengthen their relationship with patients because it led to openness and exchange of information, and that patients understood the need for it.

On the other hand, physicians who referred patients or were consulted by fertility doctors were often thought to be reluctant to comment on patients' capacity:

'(...) they are often in a close treatment relationship with the patient, so it is difficult for them to write especially that they do not vouch for them, then. Because they are afraid that it will damage the treatment relationship. (Participant number 7, female, public clinic).

For this reason, psychiatrists and general practitioners would often rather provide

their views by telephone instead of in writing. Significantly, compared with fertility doctors, these doctors typically will continue a physician–patient relationship regardless of the outcome of the assessment at the fertility clinic.

### **The new offer for single patients affects capacity assessments**

All the clinics that undertook treatment of single women experienced a high number of patients in this category. The impression of participants was that these patients were typically resourceful and had given the choice to seek fertility treatment much thought.

Several participants considered that the new offer for single women challenges conventional ways of carrying out parental capacity assessment and was about to lead to a significant shift concerning which factors were given weight in the assessment:

'In the past, we have had it as a criterion that if one [prospective parent] is not expected to survive more than a certain number of years, this has been reason for refusal because the child ought to have two parents. These have been refused until now. And, actually, the guidelines have not changed when it comes to couples. But now the law has been changed so that single people can receive treatment, and then it becomes a paradox to have to refuse these who are on the verge of death. (Participant number 2, female, public clinic).

When being a single parent now had become sufficient to be deemed capable, it would be paradoxical to keep refusing couples in which there was doubt about one partner's capacity. To participants it followed logically that when single women can receive treatment after their partner's death, they must also be eligible as long as their partner lives. Therefore, the introduction of assisted reproduction for single women was thought to require a shift in how couples were assessed.

Participants were not in agreement on whether singles or couples should be assessed similarly. Some participants thought that being a single parent was a more vulnerable situation, and that, therefore, the threshold for being assessed as suitable should be higher. Others, however, thought it could sometimes be more difficult for two people to be deemed capable, as concerns about the capability

of the one might be disqualifying for the couple in sum.

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## DISCUSSION

The study has shown that Norwegian ART physicians deem parental capacity assessments of applicants to be straightforward and simple in most cases, but that some cases of doubt pose difficulties. Here, physicians have a significant scope for discernment. They can then draw on resources such as colleagues, physicians from other specialties who know the patient, and patient records.

### Fertility physicians as ‘street-level bureaucrats’

Significantly, all participants in the study wanted there to be a form of parenting capacity assessment. This is in line with previous international research (*Sperling and Simon, 2010; Lee et al., 2014; Lind, 2020*). In general, they were comfortable with the responsibility for such assessments. The parental capacity assessment can be seen as a ‘safety valve’ for the physician to be able to refrain from providing fertility treatment when having significant concerns about a prospective child’s best interests. Some participants also invoked the concern of stewardship of societal resources, which has also been used as an argument by colleagues in Sweden – like neighbouring Norway a well-developed welfare state (*Lind, 2020*).

Arguably, the physicians’ perception of their roles and obligations are in line with pervasive ideals of professional ethics in the Nordic countries (*Bringedal et al., 2017*). The physicians are not private entrepreneurs peddling a product to customers, but professionals mindful of their responsibilities to society (*Emanuel and Emanuel, 1992*). Therefore, in their gatekeeping role, they function as what in sociology is termed ‘street-level bureaucrats’, a concept introduced above (*Lipsky, 2010*). Their considerable capacity for discernment implies both power and responsibility vis-à-vis patients and the community. This is potentially an ‘intra-role conflict’ (*Hertogs et al., 2021*) (yet as we have seen, the physicians do not perceive the role as an undue burden). It might, however, be asked whether society should contend with having ‘delegated’ this power to physicians or whether other arrangements should be explored (*Thompson and McDougall, 2015; Tonkens, 2018*).

### Are physicians suited to assess parental capacity?

The participants felt themselves able to assess applicants’ capacity as parents. It is worth probing, however, whether making such assessments is something that society should see as properly the responsibility of physicians (*Tonkens, 2018*). On the one hand, the task might be seen as diverging from the core responsibilities of physicians. Whether a person is suited to become a parent is arguably not a question that medical science can answer. It is certainly not an assessment that physicians have been prepared for in medical school. It could be asked whether it is not presumptuous of physicians to deem themselves and their own discernment as equally or more competent than a potential professional body with specific expertise concerning parenting.

On the other hand, parallels exist with the work of other physicians because the physician is considered the highest authority in decisions concerning patient care and because physicians are expected to use discernment and to make decisions under uncertainty. In the Norwegian welfare state and healthcare system, responsibility is often delegated to physicians for tasks such as referrals and ‘gatekeeping’ to specialized care and recommending the allocation of welfare benefits (*Carlsen and Norheim, 2003*).

### Guidelines or laws?

Previous studies on other aspects of parental capacity assessment typically call for either ‘policy guidelines that should regulate the provision of treatment in an objective and evidence-based manner’ (*de Lacey et al., 2015; Elenis et al., 2020*), or at least point out that the current guidelines offered by professional bodies, such as those of the American Society for Reproductive Medicine, ‘can be interpreted loosely enough to satisfy each and every party involved’ (*Sperling and Simon, 2010*). Yet, creating guidelines for an issue as complex as predicting future parental capacity is of course not straightforward, leading some investigators to express doubts about the effectiveness and validity of more specific guidelines (*Klitzman, 2016*). Since conducting the present research, Norwegian authorities compiled and published in April 2022 the circular ‘Assessment of suitability for assisted reproduction’ (*Norwegian Directorate of Health, 2022*). The document outlines what factors should be included in the assessment, i.e.

vulnerability factors and protective factors, and goes into detail on the formal requirements for the assessment. The guideline, however, is light on how the physician should weigh the different factors that could go into the assessment, and it makes no specific recommendations or examples of patients or couples who should be denied treatment owing to poor predicted parental abilities. As such, the guideline could be seen as setting out the process of assessment but leaves the decision to the ART physician. The present study indicates that Norwegian ART physicians are, in general, comfortable with that arrangement. The findings resonate with an Israeli study in which such guidelines were often ignored (*Sperling and Simon, 2010*).

### Strengths and weaknesses

A weakness of the study is that parental capacity assessments have not been studied directly. Only the physician’s own report of their experiences and evaluations have been studied. In a qualitative interview study, the data are co-constructed by the researchers and the interviewee. Although this gives rise to in-depth accounts, it also comes with a risk of bias. A strength is that the sample constitutes roughly one-half of all Norwegian fertility doctors.

In conclusion, whether societies should assess infertile patients’ capacity for parenthood before fertility treatment is an ethical and political question. Although sometimes a difficult task, Norwegian fertility doctors in general see it as important, and as something they are competent and suited to undertake. When in doubt, they benefit from consulting colleagues, physicians from other specialties who know the patient, and patient records. Although detailed guidelines for performing the assessment might standardize the assessments, guidelines would concurrently encroach upon the discretionary realm that physicians typically navigate, and which they value in this context.

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## DATA AVAILABILITY

The authors do not have permission to share data.

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