

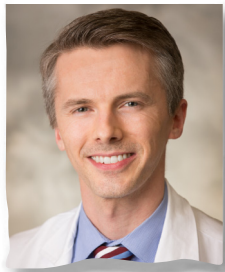
Article

Sociocultural determinants of US women's ethical views on various fertility treatments

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KEY MESSAGE

Ethical concerns over fertility treatments are not 'all-or-nothing', but rather are often specific to the treatment approach. Race, religious affiliation and religious attendance are three determinants of these ethical concerns. Increased understanding of such ethical concerns is important for improving the physician-patient relationship and may impact access to care.

ABSTRACT

Ethical concerns over treatments for infertility can discourage patients from pursuing fertility healthcare. This study aims to evaluate the sociocultural factors that influence the ethical views of reproductive-aged women regarding various fertility treatments. A publicly available cross-sectional survey of 4792 nationally representative US women aged 25–52 years was analysed to identify the frequency of ethical concerns over such interventions. Concerns were most common for treatments that increase the chance of twins (54%), followed by third-party reproductive strategies (48–51%), IVF (30%) and partner insemination (14%). Regression analysis revealed distinct sociocultural determinants for each of the treatment approaches. While being black was associated with a higher level of concern for several distinct fertility treatments, Hispanic ethnicity was only associated with increased ethical concern about donor eggs. Additionally, religious attendance predicts increased odds of ethical concern for IVF and all third-party approaches, while Catholic or Christian religious affiliations also predict ethical concern over partner insemination. These findings show that ethical concerns over fertility treatments are not generally 'all-or-nothing', but rather are often specific to the treatment approach. This knowledge may help explain differences in help-seeking behaviours and improve the physician-patient relationship.

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Introduction

Dating to the first report of successful donor insemination in the early 1900s, ethical concerns have been raised about treatments for

infertility (Hard, 1909). Reproductive healthcare providers play an active role in evaluating the ethical issues surrounding such treatments, formalizing professional recommendations and guidelines through such entities as the ASRM Ethics Committee (Ethics Committee of the American Society for Reproductive Medicine, 2014). While physician

Presented in preliminary form at the 72nd American Society for Reproductive Medicine Scientific Congress and Expo, 2016, Salt Lake City, UT.

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<http://dx.doi.org/10.1016/j.rbmo.2017.08.015>

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self-regulation is an essential component of maintaining public trust in the healthcare industry (Cruess and Cruess, 2005), broad acceptance of fertility treatments is also contingent upon the ethical approval of laypersons. When this approval is lacking, public policy can be employed to restrict the scope of legal interventions available to the infertile, such as via the Italian IVF restrictions from 2004 to 2009 (Benagiano and Gianaroli, 2010) or in proposed US personhood legislation (Collura and Collins, 2013). More indirectly, ethical concerns among laypersons have been associated with decreased likelihood of pursuing evaluation and treatment for infertility (Greil et al., 2011).

Given their role in both influencing legislation and discouraging fertility treatments, the ethical views of the general population regarding infertility healthcare are worthy of close examination. Previous research has focused predominantly on ethical concerns with fertility treatments in general, where several sociocultural factors have been found to associate with heightened opposition. Across the USA, ethical concerns over fertility treatments are more common among black, Hispanic and Asian women than among whites (Greil et al., 2011). A survey of women throughout the Midwest found greater ethical concern among older women with lower income and less education (Shreffler et al., 2010). Religion is also significantly associated with general ethical concern over fertility treatments (Missmer et al., 2011), mediated both by attendance at religious services (Greil et al., 2010) and by religious affiliation (Greil et al., 2016).

While previous research has investigated the sociocultural factors that predict ethical concern over fertility treatments collectively, there are reasons to suspect that such ethical concern is not truly an all-or-nothing phenomenon. Rather, it is likely that distinct sociocultural factors display a more nuanced effect on different treatment options. For instance, no major religions in the USA oppose ovulation induction or surgical treatment for infertility; partner insemination is uniquely opposed by the Catholic Church; and only assisted reproductive technologies involving donor gametes are of ethical concern in most Jewish and Islamic traditions (Schenker, 2005). Additionally, black women who are evaluated for infertility are significantly less likely than their white counterparts to pursue IVF, even after adjusting for socioeconomic status, education, insurance status and religion. Given that black and white utilization of medical and surgical treatments for infertility is the same (Kessler et al., 2013), this suggests that IVF is subject to different cultural reluctance among black women than other treatment modalities.

In this study, the association between relevant sociocultural factors and the ethical views were examined for a large representative sample of US women of reproductive age regarding various fertility treatments, including partner insemination, IVF, donor sperm, donor oocytes, gestational carriers, and treatments that incur an elevated risk of multiple gestation.

Materials and methods

Survey

Data were obtained from the National Survey of Fertility Barriers (NSFB), a large, nationally representative survey of US women of reproductive age, which was performed to assess the relationships between personal values, sociocultural factors, demographic characteristics, overall health and fertility outcomes. Funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the NSFB was designed by a multi-institutional team of

sociologists, who conducted a random-digit dialling telephone survey of 4792 women aged 25–52 years. The publicly-available Wave 1 of survey data was collected from 2004 to 2007. The sample is nationally representative, with oversampling of racial and ethnic minorities and women with fertility problems; this oversampling was factored into the analysis using sample weights provided by the NSFB. Further details on the design of the NSFB have been previously published (Greil et al., 2011; Park and Hill, 2014). Because the current study only involved the use of this de-identified, publicly-available data set, it was not subject to review by our local Institutional Review Board, in accordance with the Common Rule definition (45 CFR 46).

Surveyed women were asked whether they had ethical problems with various reproductive interventions, including intrauterine insemination (IUI) with partner sperm, IVF, IUI with donor sperm, use of a donor oocyte, use of a gestational carrier (GC), and the more general 'use of medical procedures which increase the chance of twins'. Valid responses included 'no ethical problem', 'some ethical problem', 'serious ethical problem' and 'don't know'. Respondents were not given any detailed explanation about the nature of these various techniques, so 'don't know' was the encouraged response if they were not familiar with a specific concept; such respondents (1.1% of the total) were excluded from the subsequent analysis. Because linearity could not be assumed for increasing ethical concern on a standard Likert scale (i.e. the difference between no ethical problem and some ethical problem may be less substantial than the difference between some ethical problem and serious ethical problem), the different levels of ethical concern were treated as ordinal variables.

In addition to value assessments, the NSFB also obtained pertinent demographic data, including respondent age, race/ethnicity, level of education, family income, marital status, current place of residence, religious affiliation, and frequency of attendance at religious services. Due to small numbers of such respondents, the races of Native Americans and Pacific Islanders were recoded as 'other race', and the religious affiliations of Jewish and Islamic women were recoded as 'other religion'. Divorced, widowed and separated women were recoded as 'formerly married' and cohabitating women and those in a lesbian partnership were recoded as 'never married'. Education level was recoded as 'less than high school graduate', 'high school graduate or GED', 'some higher education' or '4+ years of higher education'. Family income was recoded as 'less than \$15,000' (roughly equal to the poverty line for a family of two at the time of the survey), '\$15,000–\$29,999', '\$30,000–\$39,999', '\$40,000–\$49,999', '\$50,000–\$59,999', '\$60,000–\$74,999', '\$75,000–\$100,000' and 'greater than \$100,000'. Current place of residence was coded by location in one of nine US Census Divisions and by whether or not the respondent resided in one of the US Office of Management and Budget's metropolitan areas (i.e. within or surrounding an urban core of at least 50,000 residents). Regular religious attendance was defined as attending a religious service nearly every week or more often.

The NSFB also asked respondents for information on their pregnancy and fertility history. For women with a history of prior pregnancy, information was obtained on pregnancy outcomes. Women with no history of prior pregnancy or live birth were coded as nulligravid and nulliparous, respectively. Women with a history of 12 months of regular, unprotected intercourse without conception were coded as infertile.

Analysis

Multivariate logistic regression models were constructed to identify significant sociocultural factors which predict the level of ethical

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