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Child welfare assessments and the regulation of access to publicly funded fertility treatment

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Abstract Assessment of the psychological and social circumstances of candidates for assisted reproduction is commonly justified with references to the welfare of the intended child. In nine focus group discussions with 64 clinic staff at four public fertility clinics in Sweden, the responsible use of public resources constituted another important justification for such assessments. Theoretically, this study draws on the identification of the role of regulatory conversations in decision makers' policy interpretations. Focus groups defined the desired outcome of assisted reproductive technology (ART) treatment as a well-functioning family, and represented the aim of ART treatment as solving problems without creating new problems for the candidates, the intended child or society. In the discourse of solving and preventing problems, the welfare of the child argument, the responsible use of resources argument and the discourse of personal responsibility merge. Lack of consideration for the circumstances in which the child will grow up was not considered a responsible use of resources because ART treatment would then risk creating more problems than it solved. The results of this study suggest that while publicly funded subsidization of fertility treatment has increased accessibility to ART treatment for candidates who lack the financial means to pay, clinic staff justified restricting access to ART treatment with concern for how public resources are spent.

KEYWORDS: assisted reproduction, parenting capacity, parent suitability, welfare of the child, public resources, assessment

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Introduction

Swedish regulation of access to treatment with assisted reproductive technology (ART) combines public coverage of the treatment costs with extensive child welfare assessments. Furthermore, Sweden combines comprehensive child and family welfare provisions (including 13 months of paid parental leave, universal child benefit, subsidized childcare, and free-of-charge health and dental care for children; Wells and Bergnehr, 2014) with eligibility criteria that concern the ability of candidates for treatment to provide for a child. This raises questions about the relationship between child welfare concerns and other concerns in the motivation of eligibility criteria.

National and regional policies that regulate access to ART treatment leave considerable room for interpretation at clinic level. Drawing on Julia Black's (2002) concept of 'regulatory conversations' and using focus group discussions (FGD) as the data collection method, this study was designed to examine whether fertility clinic staff express support for parenting capacity assessments, and if so, on what grounds.

Background — the regulation of access to treatment with ART in Sweden

Eligibility criteria in Swedish ART policies are related to two factors: the use of gametes from a donor, and the use of public resources for treatment. While the eligibility criteria regarding the use of donor gametes is regulated in national legislation (SFS, 2006:351) and in the guidelines published by the Swedish National Board of Health and Welfare (NBHW, 2016), the eligibility criteria for publicly funded treatment is regulated by the Swedish Association of Local Authorities and Regions (SALAR, 2016) and through guidelines at regional and clinic level.

According to Swedish legislation (SFS, 2006:351, Chap. 6 §3, Chap. 7 §5; see also NBHW, 2009, Chap. 4 §§9—11), ART treatment with donor gametes should be offered only if it can be assumed that the child 'will grow up in good circumstances' (hereafter referred to as the 'good circumstances requirement').[1] This requirement is justified by NBHW with the claim that 'society [should] not actively contribute to parenthood, when the preconditions for good parenthood are missing, if there are known risks that the child will fare badly' (NBHW, 2016, p. 16). This requirement applies only to treatment for which gametes are provided by a donor. When a couple's own gametes are used, there is no legal requirement for such an assessment (Lind, 2008; Sörgjerd, 2012). According to the NBHW guidelines, parents need to meet several conditions in order for a child to have a 'good and secure upbringing', including 'a positive attitude towards children and parenthood, readiness to put one's own needs in second place, [and] the capacity for responsiveness and care' (NBHW, 2016, p. 10). Therefore, the good circumstances requirement can be viewed as a demand for the assessment of candidates' parenting capacity, as this would provide a tool for determining if the conditions for good parenting are present. Furthermore, the NBHW (2016) guidelines identify a range of risk factors: older age of the parents, physical or mental illness, substantial disability, substance abuse and misuse, other forms of dependencies, previous children taken into care, serious shortcomings in the capacity to provide for a child or in the housing situation, history of having committed serious crimes, violence in the couple's relationship, lack of stability of the couple's relationship or uncertain marital status, ill-considered request for donor treatment, absence of a social network, and a negative attitude towards disclosing to the child that s/he is donor conceived. The requirement for the capacity to provide for a child is particularly interesting for two reasons. The fact that the costs of ART treatment are fully covered through the public healthcare scheme means that treatment is accessible to candidates regardless of their financial ability to pay for treatment. Hence, the self-deselection of candidates for financial reasons can be assumed to be limited. At the same time, due to Sweden's comprehensive child and family welfare provisions, few children are at risk of serious harm due to poverty.[2] This raises questions about the purpose of eligibility criteria related to the financial situation of candidates.

According to the recommendations of SALAR (2016), candidates who fulfil the eligibility criteria should be offered three in-vitro fertilization (IVF) cycles or six treatments with insemination free of charge. Eligibility criteria include the candidate's need for treatment, through confirmation of the infertility of heterosexual couples and childlessness of candidates (SALAR, 2016, pp. 2, 5), and the treatment must have a reasonable, 'more than 10 percent', chance of succeeding (Region Skåne, 2017, pp. 5, 9). Hence, not all eligibility criteria are motivated by concerns for the welfare of the child or of the woman undergoing treatment. The two criteria above suggest that candidates must be seen as deserving of access to treatment (i.e. their need must be legitimate and their treatment must be cost-effective). Furthermore, whereas the NBHW (2016) good circumstances requirement concerns treatment with donor gametes alone, the requirement at clinic level that there should be no 'manifest psychological and/or social contraindication to pregnancy and parenthood' in order for candidates to be eligible for publicly funded treatment applies to all forms of ART treatment, regardless of whether gametes from a donor are used (Region Skåne, 2017, p. 5; see also Akademiska sjukhuset Uppsala, 2019; Karolinska universitetssjukhuset, 2019; Region Halland, 2019; Region Östergötland, 2018). This suggests, I argue, that at clinic level, the parenting capacity requirement is motivated not only out of concern for the welfare of the child, but also out of concern for how public resources are used.

Previous research

Criticism aimed at child welfare concerns in assisted reproduction includes claims supporting the individual's right to freedom of choice surrounding reproduction (Robertson, 1994), and the impossibility of taking the

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[1] All quotes from Swedish sources have been translated by the author.

[2] According to the United Nations Children's Fund (UNICEF, 2013), fewer than 1.5% of Swedish children suffer from material deprivation in accordance with the indicators of the UNICEF child deprivation rate.

interests of a future child into consideration because it is difficult to claim that it would be in the best interests of any child not to come into existence (Heyd, 1992; Jackson, 2002). The ethical challenge in the regulation of access to ART treatment for child welfare purposes is to define eligibility criteria that protect the welfare of the child without discriminating against certain groups of candidates. The exclusion of candidates from access to ART treatment can be explicit in legislation (e.g. when treatment is available only to heterosexual couples) or implicit and perhaps even unintentional. The exclusion of ART treatment from public healthcare schemes has been argued to discriminate against those who cannot afford to pay for it (Ryan, 2003), and have, because of that, been ascribed eugenic effects (Daar, 2017). Definitions of child welfare may vary between countries and change over time, including views on whether children need a mother and a father, and hence are obviously informed by dominant political and cultural constructions of family and parenting norms (Blyth et al., 2008; Diekema, 2004; Pennings, 1999; Quigley, 2010). While some criteria appear to be objective, and culture and class neutral, their implementation may affect different groups of candidates differently. The outcome may be what has been referred to as 'stratified reproduction', defined as 'power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered' (Ginsberg and Rapp, 1995, p. 3).

The social stratification of reproduction as such, however, does not necessarily reveal anything about the thinking informing the practices that have led to stratification. Arguing against the claim made by feminist scholars, such as Dorothy Roberts (2009), that the punitive governance of the childbearing of poor minority women in the USA, as well as preimplantation genetic diagnosis, is informed by eugenic thinking, Nikolas Rose, (2007) describes the explicit goal of the eugenics movement of the 1930s and 1940s as improvement of the genetic composition of the population, and that such arguments are discursively impossible to use in most contexts today. In a Swedish context, Areschoug (2005) showed that after the rescinding of the sterilization policies, childbearing by women with intellectual disabilities continued to be regarded as problematic, and efforts were made to prevent pregnancies. The arguments, like the methods, shifted, however, from protection of the interests of society and the welfare of the child, to protection of the woman's own welfare. The focus of this study, too, is the explicit arguments put forward by clinic staff. It will not, however, reveal whether certain categories of candidates are discriminated against through the decisions made by clinic staff.

Internationally, several studies have examined clinical practices and staff attitudes concerning the implementation of the welfare of the child principle in assisted reproduction (Gurmankin et al., 2005; Lee et al., 2012, 2014; Thorpe et al., 2012). The findings of these studies indicated that the welfare of the child principle enjoys almost universal approval, but there is disagreement about its operationalization (Daniels et al., 2000). Whereas some clinic staff claimed they did not have the right to stop anyone from attempting to conceive a child or to decide who is a fit parent (Gurmankin et al., 2005; Thorpe et al., 2012), others claimed to be more restrictive than clinic policies, which, particularly in the USA, were described as permissive because of the belief in patient autonomy, fear of litigation, competitive pressures on clinics, and perceived difficulties in acquiring the necessary information about candidates to restrict access (Stern et al., 2002).

In the UK, the replacement of the wording 'including the need of that child for a father' with 'including the need of that child for supportive parenting' in the requirement that account shall be taken of the welfare of any child who may be born as a result of the treatment (Lee et al., 2017) in the British Human Fertilisation and Embryology Act of 2008 was followed by an addition to the Code of Practice:

> It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect (HFEA, 2009, para. 8.11).

While the removal of the 'need for a father' phrase meant that ART treatment was made accessible to new groups of candidates, the requirement for 'supportive parenting', according to Lee et al. (2017), at clinic level resulted in closer examination of the candidates' lifestyles, attitudes and feelings, which went well beyond the recommendations of the Code of Practice and the determination of risk of significant harm or neglect. Reporting on the same interview study with clinic staff, Sheldon et al. (2015) argued that the eligibility criteria emanating from welfare of the child assessments were, at times, difficult to distinguish from the criteria for National Health Service funding. Hence, it was not always clear whether questions relating to parental age or smoking in the family reflected clinical factors concerning the estimated chances of treatment success, funding eligibility or child welfare concerns.

Several of the studies referenced previously reported tensions between clinic staff's views of assessments as simultaneously necessary and intrusive, a struggle to combine an emphasis on individual choice in reproduction and a desire for clinic staff to distance themselves from eugenics, with the view that medical intervention in reproduction should be socially and professionally accountable [Ehrich et al., 2006; see De Lacey et al., 2015 for similar results for Australia and New Zealand]. This indicates that the same dilemmas confronted at policy level are also faced by individual clinic staff.

Theoretical approach — regulatory conversations

All regulation based on written norms, Black (2002, p. 172) argued, harbours 'a space both within and between rules in which decision makers exercise choice'. In order to understand the actions of decision makers, the understandings that form the basis for those actions must be analysed. Such understandings are created through what Black (2002) referred to as 'regulatory conversations'. In assisted reproduction, as in other healthcare practices, numerous decisions are made regarding the treatment of patients. Following Black (2002), I expect fertility clinic staff to be engaged in the interpretation of regulations and the grounds for their legitimization, the representation of problems, the identification of dilemmas, and the sharing of ideas and beliefs both in formal staff meetings and during informal interactions. All such interactions may constitute regulatory conversations, through which understandings and justifications of standpoints in dilemmas are produced and on which actions are based (Black, 2002). As many of these conversations occur spontaneously and are, thus, difficult to record, for the purposes of this study, I instead invited clinic staff to engage in conversations about the regulation of access to ART treatments in FGD.

Data collection and analysis — FGD with fertility clinic staff

In contrast to FGD studies in traditional social psychology, this study views attitudes from a discourse analytical perspective. Rather than being concerned with whether participants are accurately reporting their inner attitudes or beliefs, this study focuses on the opinions and views that are made explicit during FGD as 'evaluative practices' that are inextricably linked to the interactional context in which they occur (Puchta and Potter, 2004, p. 22). However, what is said, and how it is said, cannot be understood solely as a product of the ongoing interaction. FGD participants work together as colleagues at the same clinic and can, therefore, be considered interpretive communities. Their professional and social relationships with each other, the clinic's self-image and internal culture, and public opinions on fertility treatment all contribute to determining the context for the interactions during FGD. The aim of this study is to analyse what standpoints dominate these interactions, and which arguments are used to support them, as I suggest that this can reveal something about the socially shared knowledge and representations that circulate within fertility clinics and, thus, can be assumed to influence decisions (Black, 2002; Marková et al., 2007).

Recruitment of participants

The heads of all six public fertility clinics in Sweden were approached with information about the study and an invitation to participate. Four responded positively. I visited each of the four participating clinics to inform all clinic staff about the study during a scheduled meeting and to invite them to participate. Participants were informed that neither their names nor the names of the clinics would be disclosed. All clinic staff who had contact with candidates or contributed to the treatment process were invited to participate in the study. This included doctors, psychologists, embryologists and other laboratory staff,[3] and also midwives, nurses, assistant nurses and care administrators, because I was also interested in the standpoints of staff who contributed in vital ways to the treatment process without having a formal say in decisions about who should receive treatment (ESHRE Task Force, 2007).[4]

FGD procedures and participants

Nine FGD were conducted between October 2017 and March 2018, with a total of 64 participants (see Table 1). All FGD were carried out in meeting rooms at the respective clinics. Before each FGD, participants completed a consent form.

Each FGD lasted for approximately 1 h, and the number of participants ranged from five to nine. In the information presented to clinic staff, I emphasized the study's focus on the ethical dilemmas entailed in decisions regarding the regulation of access to ART treatment. Although my research interests concerned participants' standpoints in relation to ethical dilemmas, my opening questions often concerned clinic routines in order to get the discussion going. Once engaged in discussion, in all FGD, I posed two main questions: what motivated parenting capacity assessments and what was the difference between donor and non-donor treatment regarding the clinic's responsibility and mandate to make such assessments? It was important to keep all follow-up questions as neutral as possible because I first wanted to find out whether the conversation would turn towards a justification or critique of psychosocial assessments of candidates. As the discussion evolved and a joint

Table 1 Clinic, focus group discussion number, number of participants and staff categories.

Clinic	Focus group discussion no.	Number of participants	Clinic staff categories
A	1	7	Doctors ($n=2$), laboratory staff ($n=5$)
B	2	8	Doctors ($n=3$), midwives ($n=3$), behavioural scientist ($n=1$), laboratory staff ($n=1$)
B	3	7	Midwives ($n=3$), laboratory staff ($n=4$)
C	4	9	Doctors ($n=3$), midwife ($n=1$), laboratory staff ($n=1$), nurses ($n=2$), medical administrators ($n=2$)
C	5	5	Laboratory staff ($n=1$), nurses ($n=2$), assistant nurse ($n=1$), medical administrator ($n=1$)
C	6	7	Laboratory staff ($n=3$), nurse ($n=1$), medical administrators ($n=3$)
C	7	6	Doctors ($n=2$), midwife ($n=1$), behavioural scientist ($n=1$), nurses ($n=2$)
D	8	9	Doctor ($n=1$), midwives ($n=2$), behavioural scientist ($n=1$), laboratory staff ($n=3$), assistant nurses ($n=2$)
D	9	6	Midwives ($n=2$), laboratory staff ($n=2$), assistant nurses ($n=2$)

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[3] Laboratory staff included embryologists, biomedical analysts and molecular biologists.

[4] See also Lee et al. (2014) and Sheldon et al. (2015), who also included clinic staff from all categories in their interview study on welfare of the child assessments. They found there were no apparent differences in reasoning between staff from different categories.

standpoint emerged from the interaction, I began to ask probing questions in order to elicit further arguments in support of the standpoint taken, as well as to facilitate verbalization of the opposite standpoint. A few participants did not speak at all during the discussions, and I did not ask them specifically about their views. In addition to respecting their choice to remain silent, I was also not concerned about necessarily hearing everyone's view because I was mainly interested in discovering which lines of argument and what kind of representations would dominate the interaction. All FGD were conducted by the author, video recorded and transcribed verbatim.[5]

Data analysis

Due to the important role of conversations in regulatory processes, Black (2002) argued in favour of a discourse analytical approach, which harmonizes well with the analytical approaches to FGD suggested by Puchta and Potter (2004) and Marková et al. (2007). Marková et al. (2007) argued that traditional content analysis is not sufficient to capture the interactional generation of ideas and understandings, as statements belong to more comprehensive argumentation sequences. Hence, while coding the data, I kept longer discussion sequences on a certain ethical dilemma intact, and then, by reading and re-reading each sequence, I determined the dominant standpoint emerging in the interaction in relation to the dilemma and noted the different arguments that were offered in support of these standpoints. A standpoint was regarded as dominant in the discussion if it was not explicitly challenged or no alternative standpoints were offered. In the presentation of the analysis, I use shorter extracts from the discussions to exemplify how a certain standpoint was worded.

Results

Support for parenting capacity assessments

Although the focus groups generally described it as difficult to refuse treatment for psychosocial reasons, the dominant standpoint expressed in all nine FGD was that fertility clinics do have the responsibility to at least attempt to assess the parenting capacity of treatment candidates. However, some problems were raised with the current assessment process: doctors had too little time to make a thorough assessment of candidates' parenting capacity (FGD C:6, C:7), candidates did not always disclose relevant information about their circumstances (FGD B:3, C:6, D:8), and fear of negative attention may stop doctors from refusing treatment (FGD C:4, C:5).

Support in the FGD for such parenting capacity assessments in treatments involving the couple's own gametes was equally strong. No participants in any of the FGD claimed that there was a difference in the clinic's responsibility for assessing candidates' parenting capacity for non-donor treatment compared with donor treatment. Instead, the distinction that is made between donor and non-donor treatment in the legislation was explicitly questioned in all but one FGD (D:8), as in the following example:

> Are you really focusing on the child, when you have a more comprehensive assessment in some forms of treatment than others? Because the child is the child regardless (Embryologist, FGD B:3, p. 44).

The fact that only one of the parents would have a genetic bond to the child and the requirement for parents of donor-conceived children to disclose the manner of conception of their child was generally (in all FGD except C:4) claimed to make the parenting of a donor-conceived child more challenging, although the grounds for this view were also challenged (FGD A:1, D:8). While this was said to be the motivation for all intended recipients of donor gametes to be offered additional counselling, it was not used by participants to justify a stricter assessment of the parenting capacity of recipients of donor gametes.

The divergent voice

The almost unanimous support for the psychosocial assessment of candidates made divergent standpoints stand out. Although many participants expressed mixed feelings about refusing treatment, only one, a doctor, stated that s/he did not feel s/he had the right to tell candidates that they are unfit to be parents. Following discussions about substance abuse and unemployment as risk factors, this doctor argued that there are 'a hundred other unemployed people' and drug addicts who make their own children. Just because the candidates who come to the clinic have been 'unlucky' enough not to be able to conceive on their own, s/he continued, they should not have to fulfil parenting capacity criteria that are not required of other parents (FGD C:7, p. 11):

> I don't think we have the right to just, like, 'no, you're not a suitable person to have a child' (FGD C:7, p. 11).

Her/his view is an exception to the standpoint that was generally expressed in the FGD, and s/he was immediately challenged by a colleague:

> But in those cases, society doesn't have any obligation…when you have the possibility to give, to control – and I don't mean to stop them necessarily – but to make some sort of assessment at least (Doctor, FGD C:7, p. 11).

To summarize, clinic staff expressed almost unanimous support for the assessment of candidates' parenting capacity in treatment with either donor or their own gametes. In the following section, I discuss how parenting assessments were justified in the FGD. To categorize the stated reasons, I have distinguished between statements that define the goal and beneficiaries of such assessments and statements that legitimize why fertility clinics have the mandate and responsibility to assess parenting capacity.

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[5] The study was approved by the Regional Ethical Vetting Committee in Linköping, Sweden (2017/185-31).

The claimed goal and beneficiaries of parenting capacity assessments

Three claimed beneficiaries of parenting capacity assessments were identified in the analysis: the intended child, the candidates and society.

The welfare of the intended child

When discussing how the psychosocial assessment of candidates can be justified, the welfare of the intended child was brought up in all groups:

> If one suspects that this child will not have a good childhood or there is significant risk that they will not have a good childhood, then you refuse (Midwife, FGD B:2, p. 5).

Conversely, fertility clinics were claimed to have a responsibility for 'putting the perspective of the child centre stage' (Doctor, FGD C:5, p. 8) or 'to ensure that the life that the child will have is okay' (Nurse, FGD D:9, p. 2; see also FGD A:1, B:3, C:6, C:7). Similarly, the argument supporting parenting capacity assessments in non-donor treatment were also related to the welfare of the child, as in the following account, criticizing the distinction made in the legislation between donor and non-donor treatments before I had even raised the subject:

> It's difficult to understand why the same rights for children born after donor treatment shouldn't apply to children born with people's own gametes (Doctor, FGD C:4, p. 6; see also FGD B:3, C:6).

The welfare of the candidate

The interests of the candidates and the future child are put in potential conflict with each other through the positioning of consideration of the welfare of the future child, in policies as well as during FGD, as a reason for refusing treatment to a candidate who requests treatment. However, according to some focus groups, a decision to refuse treatment could also be motivated out of consideration for the welfare of candidates. The staff members who perhaps had the most extensive dialogues with candidates about their situations were the clinic psychologists. Both participating psychologists expressed reluctance to see themselves as judges who acted only on behalf of the interests of the child. They claimed that they wanted to reason with candidates about their circumstances and what implications a child would have for their individual situations. Decisions to deny treatment for candidates were argued as having been made as much out of consideration for the adults' situations as out of consideration for the future child's welfare (FGD A:1, C:6, C:7, D:8). The welfare of the candidate was, in one group, also referred to as a justification for the refusal of treatment that was easier to tolerate for clinic staff than the welfare of the child:

> it is easier to think that…you're helping that person instead of saying 'you should perhaps not have a child, because that child won't, (FGD B:3, p. 35).

These examples constitute reflections in the FGD not only on the reasons for denying treatment to a candidate, but also on clinic staff's personal approaches to such decisions.

The interests of society

A third beneficiary of parenting capacity assessments mentioned in a few FGD was society. Just as the welfare of the child was not always clearly distinguishable from the welfare of the candidates, it was also not easy to distinguish from the interests of society in justifications for parenting capacity assessments. In the FGD highlighted in the following section, some participants questioned eligibility criteria related to the candidates' financial situation; the account that follows can be interpreted as an attempt to justify the requirement that candidates must have an income, which had been discussed by the group earlier:

> But this about economics and so on, isn't that about national economics, too? […] That we contribute to making a child for a family or couple who doesn't have any income at all, then I think it should go without saying […] And then social services must come immediately and pay all the bills. Is that when we say no, […] so that we won't burden society with this family. Maybe they're the best parents in the world, but they don't have the finances (Midwife, FGD B:3, p. 30).

In this account, the explanation for why candidates who may be 'the best parents in the world' might be denied treatment was related to the fact that parents who cannot support their child will be a financial burden on society. Another example, in which the welfare of the child, the candidates and the interests of society are discussed together, is the following reasoning about candidates whose social or mental health situation is fragile:

> It [treatment] may scupper this family and this child, too. And then society must move in with an additional effort, when we, as a society, have already made an effort, financed by those of us who work and are on the street and pay taxes (Doctor, FGD A:1, p. 6; see also FGD B:2, C:6).

The use of public resources, as we will see in the next section, is also referred to in the legitimization of the mandate and responsibility of fertility clinics to perform parenting capacity assessments.

Legitimization of the mandate and responsibility of fertility clinics to perform parenting capacity assessments

The legitimization of fertility clinics' mandates and responsibility to assess the parenting capacity of candidates primarily concerns the personal responsibility and consciences of clinic staff and the responsible use of resources. In relation to treatments utilizing gametes from a donor, one additional justification for clinics' mandates and responsibility to perform parenting capacity assessments was mentioned: responsibility towards the donor to ensure that the child that would be conceived using her/his gametes would be cared for properly (FGD A:1, B:2, B:3, C:6, C:7, D:8).

The responsible use of resources

In all but two FGD (C:5, C:6), references were made to the fact that the treatments offered by public fertility clinics are tax or publicly funded. Taxpayers' money, as one biomedical analyst put it, should not be used 'for what we do not believe will turn out well' (FGD D:9). Hence, according to this line of argument, it is the fact that society contributes with resources that gives clinics the responsibility, and mandate, to deny access to candidates who are claimed to lack parenting capacity.

None of the groups discussed the distinction between publicly funded and self-funded treatment as a reason for different assessment procedures or psychosocial criteria. Neither was a comparison between insemination and IVF, the latter being about three times the cost of insemination for self-funded candidates, brought up in relation to a discussion about the responsible use of public resources. References to the responsible use of resources were instead made at a general level that did not distinguish between different categories of candidates or different types of treatment based on the amount of public resources required. Rather, as we will see in the next section, it was the scope of the clinic's contribution to a child's conception that was referred to as a determinant for clinic staff's mandate and responsibility to assess the parenting capacity of candidates.

Personal responsibility and conscience

One of the justifications that was offered for the negative responses to my question about whether access to treatment should be regarded as an entitlement was the following:

> But it's also about our need to feel that what we're doing is right. That we should feel good about it, feel that it's a good family in the end (Biomedical analyst, FGD C:5, pp. 3, 18).

Other participants talked about candidates who had been granted treatment, about whom they had gained information later that indicated their unfitness as parents. In addition to blaming themselves for not having foreseen those problems, two doctors also said that cases like these got to them (Doctor, FGD A:1; see also FGD C:4, p. 8).

What these examples indicate is the significance ascribed by clinic staff to their individual, professional responsibility and personal conscience, which is further illustrated by the following account:

> I don't know if you agree, but I've encountered it many times, that I get the feeling 'but what is this – these people, should they really have a child?' And that, then I get a little scared 'what am I doing?' (Embryologist, FGD B:3, p. 17).

Embryologists and other laboratory staff are seldom involved in the decision about whether a specific candidate should be offered treatment or not. Their contribution to bringing the child into existence, however, is significant, and so is the responsibility they ascribe to themselves for the outcome of the work they are doing.

The doctor, who objected to his colleague's claim that clinics do not have the right to determine a candidate as unfit for parenthood in a previous example, mentioned society's obligation, as well as the possibility of controlling access to treatment by assessing the candidates. The possibility of making parenting capacity an eligibility criterion for treatment was related by the participant to the fact that conception cannot occur without the assistance of clinic staff. I therefore raised the question during FGD of how clinic staff reasoned about the assessment of candidates' parenting capacity in other forms of fertility treatment, such as the unblocking of fallopian tubes or ovarian stimulation. In seven of the nine FGD, two main standpoints could be identified. In three FGD, participants claimed that logically there should be no difference because the outcome is a child in both cases, but emotionally there was a difference (FGD A:1, C:5, D:9). In all seven groups, there was agreement that the responsibility and mandate to perform parenting assessments were related to the scope of the treatment's contribution to conception. With hormone stimulation, 'we assist them to ovulate, we don't assist them to become pregnant' (FGD C:4, p. 21), as one doctor put it.

Concluding discussion: assisted reproduction as problem prevention

In all the FGD, I asked how the participants would define the overall purpose of the work they were doing or what counted as a successful outcome. Although the immediate answer in several groups was 'satisfied patients' (FGD C:4, p. 22) or 'born babies' (FGD C:7, p. 23), the subsequent turns in discussions qualified these responses by adding something like 'happy children and super happy families' (Medical administrator, FGD C:5, p. 21), 'to create families' (FGD D:8, p. 19) or 'delivered children, who will have good lives' (Psychologist, FGD C:7, p. 24). This represents the goal of assisted reproduction as the creation of functional families, rather than just babies. Participants stated that they did not want to solve one problem – a couple's or a woman's involuntary childlessness – by creating another – a child with unfit parents. Hence, rather than the view that 'reproductive strategies can improve society by reducing the births of socially marginalized people' (Roberts, 2009, p. 796), the explicit goal brought up by the focus groups is to prevent the creation of socially marginalized families.

Sweden has a long tradition of explicit commitment to protection of the interests of children in welfare discourse (Sandin, 2012). However, the best interests of the child argument in Swedish ART policy debates has been accused of serving as a rhetorical cover-up for state interests

(Liljestrand, 1995), as well as of constituting a rhetorical imperative and trump card (Lind, 2019). Hence, while child welfare concerns may be legitimate, they also lend themselves to the governing of families (Parton, 1991; Vandenbroeck et al., 2010). In the justification of parenting capacity assessments by the focus groups, the interests of the state and the interests of the child were intertwined. The following response was given by one participant in response to my probing question whether it might be better to accept everyone for treatment and leave any parenting capacity assessments to social services after the child is born:

> But it's also tax money that will be used if it doesn't go well. Social services, placement, care, treatment – it may sound cynical, but it's still like – we have a certain amount of money and perhaps we shouldn't create more problems or more costs, from a socio-economic perspective (Midwife, FGD B:2, p. 7).

Hence, a lack of consideration for the circumstances in which the intended child would grow up was said to risk creating a family that required further public spending.

If we accept, following Black (2002), that regulatory conversations are indicative of the understandings and norms that inform decision-making in fertility clinics, and if we accept the FGD that were arranged for this study as regulatory conversations between colleagues at public fertility clinics, we can conclude that clinic staff's interpretations of the legislation's good circumstances requirement is informed by a cost-efficiency principle. This is perhaps of little surprise as the ethical principles that govern prioritizations in Swedish public healthcare policies (Bill 1996/97:60), in addition to the principles of human dignity, needs and solidarity, include cost-efficiency. Patients who are assessed as not benefiting, in terms of improved health or quality of life, from a specific medical treatment are not regarded as needing such treatment. If assisted reproduction is viewed as a means to create families, rather than as infertility treatment – which seems to be the case in the FGD conducted for this study – and a candidate is not thought likely to be able to serve as a parent or benefit from becoming a parent, the cost-effectiveness of offering ART treatment to that candidate is likely to be assessed as low. Such reasoning is in line with Norwegian philosopher Berge Solberg's (2009) argument that the goal of ART treatment is to make parents out of adults who want to 'experience family life with children' (p. 374). Therefore, according to Solberg (2009), offering treatment to a person who is incapable of caring for a child would be futile because the goal of creating a functional family would not be achieved see also (Steinbock, 1995).

The mandate of fertility clinics to perform parenting capacity assessments was legitimized by the focus groups with reference to the contribution made by clinic staff and the use of public funds to the conception of the child. The study results suggest that while the public funding scheme of fertility treatment in Sweden makes assisted reproduction accessible independent of candidates' financial means, the concern at regional and clinic levels for how public resources are spent serves as motivation for restricting access to ART treatment.

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