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ORIGINAL RESEARCH

Restricting Access to ART on the Basis of Criminal Record

An Ethical Analysis of a State-Enforced "Presumption Against Treatment" With Regard to Assisted Reproductive Technologies

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Abstract As assisted reproductive technologies (ART) become increasingly popular, debate has intensified over the ethical justification for restricting access to ART based on various medical and non-medical factors. In 2010, the Australian state of Victoria enacted world-first legislation that denies access to ART for all patients with certain criminal or child protection histories. Patients and their partners are identified via a compulsory police and child protection check prior to commencing ART and, if found to have a previous relevant conviction or child protection order, are given a "presumption against treatment." This article reviews the legislation and identifies arguments that may be used to justify restricting access to ART for various reasons. The arguments reviewed include limitations of reproductive rights, inheriting undesirable genetic traits, distributive justice, and the welfare of the future child. We show that none of these arguments justifies restricting access to ART in the context of past criminal history. We show that a "presumption against treatment" is an unjustified infringement on reproductive freedom and that it creates various inconsistencies in current social, medical, and legal policy. We argue that a state-enforced policy of restricting access to ART based on the non-medical factor of past criminal history is an example of unjust discrimination and cannot be ethically justified, with one important exception: in cases where ART treatment may be considered futile on the basis that the parents are not expected to raise the resulting child.

Keywords Assisted reproductive technology · IVF · Ethics · Access · Criminal · Police check · Child protection check legislation · Presumption against treatment

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As assisted reproductive technologies (ART), including in vitro fertilization (IVF), become increasingly popular (ART Review Committee 2006), debate has intensified over whether access to ART should be completely open or restricted in some way. Possible criteria for exclusion include obesity (Dondorp et al. 2010), maternal age (Goold 2005), psychiatric illness (Chen et al. 2004), HIV status (ASRM Ethics Committee Report 2004), smoking (Dondorp et al. 2010), alcohol use (Dondorp et al. 2010), and same-sex partner or single status (Peterson 2005). Internationally, regulation surrounding ART access is both varied and dynamic. Australia has been a world leader in ART and its legislation since the early days of reproductive technologies, producing the world's first donor-egg pregnancy and the first frozen embryo pregnancy (Leeton 2004). It was Australia that developed the first ever national guidelines for IVF practices, and it was the Australian state of Victoria that developed the first statute legislation regarding control of IVF procedures (Leeton 2004).

In 2010, the state of Victoria enacted legislation that denies access to ART for patients with certain criminal

or child protection histories (ART Act 2008). This world-first legislation raises new ethical dilemmas. Can a "presumption against treatment" for this non-medical factor be ethically justified?

In this article we will review the Victorian legislation and its context in current international ART regulation. We will then identify arguments in the literature that have been used to justify restricting access to ART for various reasons. We will argue that none of these is compelling in relation to criminal history, with the exception of one important argument. We will show that a "presumption against treatment" is an unjustified infringement on reproductive freedom and that it creates various inconsistencies in current social, medical, and legal policy. We will argue that a state-enforced policy of restricting access to ART based on the non-medical factor of past criminal history is discriminatory and cannot be ethically justified, with one important exception: in cases where ART treatment may be considered futile.

Victorian ART Act 2008

The Victorian Assisted Reproductive Treatment Act 2008, implemented in 2010, mandates that both a police check and a child protection order check be completed for all patients prior to commencing ART treatment. A "presumption against treatment" applies if either a woman or her partner has been convicted of a sexual or violent offence as specified in the relevant sentencing acts, or if a child protection order has previously been made to remove a child from the patient or her partner's care (ART Act 2008). Convictions under these acts include, but are not limited to, rape, assault with intent to rape, indecent assault, manslaughter, defensive homicide, recklessly causing serious injury, threats to kill, threats to inflict serious injury, and intentionally causing a very serious disease. A presumption against treatment applies to the woman, regardless of whether the conviction or child protection order in question applies to the woman or her partner. A "presumption against treatment" in this setting means that if a relevant conviction or child protection order has been made against a woman or her partner then ART treatment must be refused under Victorian law.

Patients wishing to appeal their "presumption against treatment" may apply to the Patient Review Panel. The patient may be present at the review and may make submissions but has no right to legal representation, unless specifically granted. In making its decision the panel is not bound by the rules of evidence but may inform itself in any way it thinks fit and is guided by the principle that "the welfare of a future child born of ART is paramount." If wishing to further appeal the panel's decision, the patient may then obtain a further review of this decision through the Victorian Civil and Administrative Tribunal (VCAT). Whilst complete data is not publicly available, it has been reported that the review panel has banned more than 50 patients in the 18 months following the initiation of the process in 2010 (McArthur and Deery 2011).

National and International Context

The Victorian legislation requiring police and child protection order checks is an Australian first. The legislation also appears to be unique internationally. In the United Kingdom, whilst there is a requirement to consider the welfare of a future child through a "Welfare of the Child" assessment, the requirement for a formal police or child protection report does not exist (Human Fertilisation and Embryology Authority 2005). Similarly in Canada and New Zealand no such requirement exists in the relevant Human Reproduction Acts (Health Canada 2013; New Zealand Legislation 2012), and in the United States there are no laws requiring clinics to screen IVF applicants (DeSante 2009).

All ART providers in Australia adhere to a code of practice (Fertility Society of Australia 2010) and are guided by a set of national guidelines (Australian Government 2007); however, state legislation, when it exists, takes legal precedence over these national guidelines. There is no reference to police or child protection checks in the national guidelines.

The Victorian legislation received a negative reaction from patients undergoing ART treatment (Australian Associated Press 2009), and the public website for Melbourne IVF states that the clinic "does not support the requirements of this legislation" (Melbourne IVF 2013, ¶6). The medical directors of the two major ART providers in Victoria have also both appeared on the public record to state their disagreement with the legislation (Bourke 2009).

What Arguments Have Been Used to Restrict Access to ART?

Two arguments are commonly used, in both clinical practice and ethical discussions, to restrict access to ART: appeals to patient non-maleficence, and the absence of infertility. An example of the former is concern for maternal safety during pregnancy in cases of severe maternal cardiac or renal conditions (Lockwood 1999). An example of the latter are cases involving lesbians and single women (Peterson 2005). Neither of these arguments can be used to deny ART access on the basis of criminal history. Past criminal history does not increase maternal pregnancy health risks, and people with a criminal history are no less likely to require medical treatment for infertility than the general population. In this paper we will therefore identify the eight remaining possible arguments from the bioethics literature that have been used to justify denying ART access to a subgroup of people and analyse whether they are compelling when applied to the setting of people with a criminal history.

Argument 1: Access to ART May Justifiably Be Restricted Due to Limitations of Reproductive Rights

Appeals to the limits of reproductive rights have been used in bioethics literature to justify restricting access to ART (Maclean 2005). Can the limits of reproductive rights be used to refuse access to ART for those with a criminal history?

Robertson defined the concept of "procreative liberty" as the basic right of people to choose to have or not have children, free from interference (Robertson 1996). According to Robertson, procreative liberty is of such importance that it should be given "presumptive priority" with the onus falling on opponents to justify any limitations on procreative choice (Robertson 1996, 16). Some argue that reproduction is only a *negative* right, meaning that the state cannot interfere with a person's choice to reproduce, but falls short of being a positive right, meaning no demands can be placed on the state to provide the resources for reproduction (Boivin and Pennings 2005).

If we view reproduction as a positive right, then individuals have some claim to the state for the cost of ART treatment. In this setting, allowing the majority of couples access to funding but denying funding to a small subgroup would be interfering in those people's positive rights to reproduction.

If however, we accept that reproduction is only a negative right, then the state does not have to pay for treatment but may not interfere with a couple's choice to reproduce. This is generally accepted as a minimum level of reproductive rights (Boivin and Pennings 2005). Denying an infertile individual access to IVF treatment, regardless of who pays, is removing the person's choice to conceive. This is interfering with an individual's negative right to reproduction.

If we accept the minimum standard of reproduction as a negative right, then individuals must be able to self-fund treatment in order to exercise their procreative liberty. In New Zealand, for example, public funding for ART is only provided to those who fit certain medical criteria. Those who do not meet these criteria are free to privately fund their ART treatment (Fertility Associates 2013), therefore ensuring that their negative right to reproduction is upheld. All ART in Australia is government-subsidized and -regulated. Choosing to completely self-fund ART treatment without any government assistance is not an option. By withholding the means to reproduce, regardless of who pays, the state is interfering with that individual's choice to conceive and therefore her or his basic negative right to reproductive autonomy. Restricting ART funding, and therefore a person's positive right to reproduction, can only be upheld if an option to self-fund is provided for those who have been excluded, preventing impinging on the minimally accepted standard of a negative right to reproduction. This is not the case in the Victorian context.

Argument 2: Infertility Is Not a True Medical Condition and Therefore Access to ART Treatment Does Not Have to Satisfy the Same Requirements and Ideals as Treatment of a Genuine Medical Condition

It has been argued that infertility is not a disease but a social condition that has been "recast" as a disease (Becker and Nachtigall 1992). Can the claim that infertility is not a medical condition—and therefore treatment of infertility is not a legitimate medical treatment—be used to justify restricting access to ART? Whilst the causes of infertility are varied, those such as cancer and endometriosis are unquestionably medical conditions. Others, such as lack of a partner, are considered by some to be "social" causes of infertility (Weston and Vollenhoven 2002). However, regardless of

causation, it is the consequences of infertility that can have a potentially profound impact on the well-being of individuals. Our society remains focused on the core value of the family unit and the importance of the parenting role. Infertile couples experience distress, loss of control, and ostracism (Cousineau 2007) as well as psychological disorders such as anxiety and major depression at higher rates than those seen in the general population (Chen et al. 2004). Fertility is considered part of basic human functioning; therefore, the loss of this function must be viewed as a medical condition or disease. The concept of infertility as a medical condition is well summarized in a recent 2010 Supreme Court Decision supporting IVF access for a Victorian prisoner. The judge concludes:

> IVF treatment is recognised as a legitimate medical treatment for a legitimate medical condition. I see no proper basis to treat IVF treatment differently from other forms of medical intervention that are considered to be necessary to enable people to live dignified and productive lives, unencumbered by the effects of disease or impairment (Emerton 2010, ¶5).

Infertility is a medical condition, and treatment of infertility is a medical treatment. It therefore demands the same requirements of fair distribution and accessibility that can be applied to all other forms of health care provision in Victoria. Furthermore, as will be discussed below, people with a criminal history have an equal claim to health care resources as those without a criminal history.

Argument 3: ART Access May Justifiably Be Restricted Because Health Care Resources Are Limited and Certain Groups Have Less of a Claim to These Limited Resources

The costs of ART do not exceed 0.25 percent of all total health care expenditure in Australia (Chambers et al. 2009), and criminals make up only a very small minority of those seeking ART in Victoria (McArthur and Deery 2011). Furthermore, the legislation applies only to certain sentencing acts and affects only a subset of all criminals, further reducing the proportion of those seeking ART being affected. Despite this, can claims appealing to cost and limitation of resources be used to justify restricting access to ART for criminals?

Some people believe that criminals have less of a claim to health care resources (Neuberger et al. 1998). However, international recognition of the importance of access to health care for convicted criminals is well established (United Nations 1998), and locally this right to health care is enshrined in the *Victorian Corrections Act 1986*. The Australian Medical Association similarly recognizes that "prisoners and detainees have the same right to access, equity and quality of health care as the general population" (Australian Medical Association 2012, ¶5).

There is no medical condition or treatment to which patients, *purely* by virtue of their criminal history, have less of a claim. Treatment of infertility, as a medical condition, should be no different.

Discussions regarding distributive justice in bioethics often reference organ donation. In the case of organ donation some patients, by virtue of limited organs, must miss out completely, as the organs cannot be evenly divided between all patients. Decisions must therefore be made to determine those more "deserving" of this limited resource. This situation does not apply to ART. In contrast to organ donation, the total number of ART cycles funded by the state *can* be evenly divided amongst all medically like patients. As resources can be divided there is no need to determine which medically like groups can access IVF and which must be refused access. Even if the requirement to exclude patients did exist, based on limited resources, patients with a criminal history have the same claim to health care resources and should not be discriminated against purely based on this non-medical factor.

There is currently no limit to how many IVF cycles are government-funded for eligible patients in Australia. Consequently, patients are able to receive a large number of funded cycles, making our ART bill higher than most other countries (ART Review Committee 2006). This is in contrast to countries such as New Zealand and the United Kingdom, where all medically like patients receive a share of the available ART funding in the form of one or two funded cycles (ART Review Committee 2006). Criminals make up a minority of patients seeking ART. If financial considerations are paramount, then a system that allows all medically like patients a smaller, yet even, share of the available pool of resources is fairer, and conceivably cheaper, than the current Victorian system, which allows the majority of patients to receive unlimited subsidized cycles, whilst completely blocking access for a small subgroup.

Finally, if financial concerns were the true driving force behind this legislation then this would only relate to restricting access to publicly funded subsidies for ART. Patients with a criminal history would still be given the option of directly funding ART themselves. The fact that they are not shows that this legislation is not motivated by concerns about distributive justice.

Argument 4: ART Access May Justifiably Be Restricted in Order to Protect Children From Inheriting Undesirable Genetic Traits

It has been argued that if a couple is at risk of having a child who will inherit certain genetic diseases or inheritable conditions it may be ethically preferable for that couple not to reproduce (Steinbock and McClamrock 1994). Some adoption studies have suggested the possibility of an inherited genetic link towards criminality (Brennan, Mednick, and Jacobsen 1996). Can the possibility of children inheriting a genetic tendency towards criminality be used to justify the Victorian legislation?

Whilst this argument may have merit in situations where a child will inherit a condition that renders his or her live not worth living, or at least close to this minimum standard, the argument does not apply to patients with a criminal history for two reasons. Firstly, a genetic predisposition to criminal behaviour would not show complete penetrance as a genetic trait. It would not be sufficient to produce criminal activities, given the overlay of environmental impacts, nor would it be expected to come close to causing the minimum criteria of a life not worth living. Secondly, the studies, whilst demonstrating a possible predisposition towards certain types of crime, usually via an increase in antisocial behaviour or aggression, do not imply direct causation. There is, in effect, no "criminal gene" (Cohen 2011).

If, hypothetically, there were a direct genetic link, and the intent of the legislation was to avoid this link, in order to be consistent it would also follow that all fertile criminals should be banned from reproducing to avoid the same genetic outcomes. The Victorian legislation allows any person to become an anonymous egg or sperm donor to a third party without the requirement for a police or child protection check. If the intention was to avoid children inheriting criminal tendencies then gamete donation would have the same regulations and checks as other forms of ART.

In Victoria, preimplantation genetic diagnosis (PGD) can be used under certain circumstances to select for or against embryos with specific genetic characteristics. If a hypothetical "criminal gene" did exist, two possible scenarios could be predicted. The first is that parents could select *for* the hypothetical criminal gene. The ethical questions in this scenario are complex and have been explored in other settings where IVF is using it to select for a perceived "undesirable trait" (Savulescu 2002). The second—and perhaps more likely—scenario is that parents could select *against* a criminal gene. It has been argued that, in this setting, IVF should in fact be encouraged to assist couples with a criminal history by allowing them to select *against* an embryo with the predisposing genes (Savulescu et al. 2006). In reality, however, criminals are freely able to both reproduce naturally and donate their gametes, and no "criminal gene" is known to exist, indicating that inheriting undesirable genetic traits is not a valid argument to support this legislation.

Argument 5: ART Access May Justifiably Be Restricted Based on the Welfare of the Future Child

The "welfare of the child" is the primary argument used to restrict access to ART based on non-medical factors (Boivin and Pennings 2005). Support for this legislation in Victorian parliament was based primarily on appeals to the welfare of the child (Parliament of Victoria 2008), and the "guiding principle" of the Victorian ART legislation is that the welfare of the child born of the treatment procedure is "paramount" (ART Act 2008, 8). This principle is replicated in other guidelines, including the National ART Ethical Guidelines, which state that: "clinical decisions must respect, primarily, the interests and welfare of the persons who may be born" (Australian Government 2007, 21). A recent Victorian Civil and Administrative Tribunal hearing on IVF access for a convicted criminal confirmed that paramount in this context means "overriding" (VCAT 2011).

Refusing ART treatment on the basis of the "welfare of the child" seems to suggest that it is better for the child not to exist than to be born to criminal parents. Secondly, it suggests that the possibility of harm to this potential child is so substantial that it overrides the counterclaim of the adult to reproductive autonomy and her or his right to medical treatment. Let's examine these claims in turn.

Claim One: It Is Better for the Child Not to Exist Than to Be Born to Criminal Parents

In order to protect the welfare of the child born to a parent with a criminal history, Victoria's legislated solution is to refuse ART and, in doing so, ensure the child does not exist. Would the life of this child be so terrible that it would be better for this child if it didn't exist? Savulescu argues that it is only in extreme cases, such as persistent vegetative state, constant pain, or severe impairment, that living "might" be considered worse than death (Savulescu 2002).

If it could be predicted that a potential child will be neglected to such an extent that his or her life is not worth living, then it would be in the child's best interest not to be conceived. This is extremely difficult to do for two reasons. Firstly, risk factors only indicate a possibility, or likelihood, that a particular child will be abused or neglected. Criminal history, whilst a risk factor, is not sufficient to ensure future child abuse or neglect. Secondly, unlike certain medical conditions with no potential for treatment or improvement, if the welfare of the child was jeopardized, there exist options for improvement in that child's life in the form of child protection, foster care, and support programs. It is important not to make light of the potentially devastating effects of child abuse or to downplay the significant impact that child abuse and neglect has in our society; however, it is incorrect to say that all victims of child abuse would be better off not existing, let alone to make that statement about all *potential* victims of abuse.

Furthermore it is important to recognize that there is a small but finite chance that any child could be abused. To be consistent, all adults who will feature in a future child's life should be screened with police and child custody checks. It follows, for example, that if a grandparent, uncle, or older sibling has a prior criminal conviction and will be involved in a child's care, then ART should be refused according to the same "welfare of the child" principle.

It also follows that additional risk factors for child abuse or neglect should be identified and such parents excluded from IVF. Low socioeconomic status, joblessness, isolation, certain racial backgrounds, and even certain neighbourhoods have been identified as risk factors for future child abuse (James 2000). If we are to be consistent in applying the "welfare of the child" principle, then all of these groups should be identified and excluded from accessing ART. It is therefore evident that applying the "welfare of the child" argument consistently has clearly counter-intuitive implications. Whilst risk factors and protective factors clearly exist, we cannot guarantee that any future child will or will not be abused. And what we certainly cannot do is declare that a future child's life will be so terrible as to be considered a life not worth living, based purely on one risk factor for possible future abuse.

This issue can be considered in the context of the "best life" or "maximum welfare" principle (Pennings 1999). Whilst it may be preferential to be born into a life of affluence and opportunity and with parents who lack criminal convictions, this is not a valid alternative for a child of these parents. This distinction is important and is where ART differs from cases of adoption. In adoption, the child exists and has a right to the "best life" out of a range of available alternatives. In ART it is not a case of a potential child choosing the "best" parents out of a range of possible options. Either this child is born to these parents or it is not born at all. This does not have to live up to the "best life" ideal.

It has been argued that using the minimum standard of a life worth living sets "an extremely low standard for morally permissible reproduction" (McDougall 2005, 602). However it is possible to acknowledge that this minimum standard may be too low without jeopardizing the argument in this context. Allowing parents with a certain type of criminal history access to ART does not depend on the bar being set at the very minimum level. Even if the bar were set higher than a life that is just worth living, it is likely that the lives of most children of criminal parents would fall well above this level.

If we apply the welfare of the child argument consistently, then similar measures must be in place to protect naturally conceived children in the same circumstances. The welfare of the child argument would demand that all parents be screened with police checks in hospital prior to being allowed to take their children home. It is inconsistent and illogical to legislate that the welfare of a child born of certain parents through IVF is at such high risk that such children should not be conceived, yet not make a similar effort to identify naturally conceived children with the same "high-risk" parents.

However, in contrast to a consistent application of this principle, clinical practice in Victoria would suggest that identifying patients and partners with a past criminal history is not considered a priority. The Victorian Maternity Record—a Victorian Government initiative that is designed to be used by all pregnant women

accessing public maternity services in Victoria—has sections that specifically address the following for all women: learning disabilities; physical disabilities; mental health; mental health of the partner; work/home/social relationships; domestic situations; accommodation issues; contact with DHS; financial concerns; heroin, cannabis, ecstasy, speed, and methadone use; smoking; and alcohol use. A history of past criminal conviction for the patient or her partner is not included in the Victorian Maternal Record. The reality of clinical practice appears to be that having a parent with a past criminal history is not considered as important to identify in the pregnant population as other potential risk factors such as homelessness and illicit drug use. The legislation's appeal to the "welfare of the child" as the primary reason to prevent patients with a criminal history accessing ART appears to be extremely inconsistent in this context.

Claim Two: The Possible Harm to a Potential Child Outweighs the Rights of the Adult Patient to Reproductive Autonomy

Central to this argument is the notion of patient autonomy, a core component of modern medicine. Autonomy has its base in Kantian ethical theory and can be defined as the right of an individual to make his or her own choices, as a competent free agent with due information and without coercion (Gracia 2012). The primary exception to autonomy is when a choice may harm another individual. The "welfare of the child" argument appeals to this exception.

Importantly, however, we do not apply this exception to cases of maternal versus foetal rights. Until delivery foetuses hold no legal rights. Maternal autonomy and welfare trump the welfare of the foetus. An obvious example is termination of pregnancy, in accordance with Victoria's Abortion Reform Bill of 2008. Mothers are also able to smoke, drink alcohol, and use recreational drugs during their pregnancy without facing litigation or forced medical intervention. Despite clear evidence of foetal risks, the autonomy of the mother outweighs the welfare and health outcomes of the future child. No legislation in Victoria espouses the welfare of the foetus as paramount to that of the mother.

Furthermore, maternal actions may be detrimental to the full *potential* of an existing foetus. A child with foetal alcohol syndrome born to a mother who consumed alcohol during the pregnancy may argue that its potential was harmed by the mother's actions. A child born to parents with a criminal history cannot argue that he or she has been harmed. Either they existed with criminal parents or they did not exist. Their potential has not been harmed.

In Victorian law and in medical practice, an adult's rights take precedence over the rights and welfare of an existing foetus. The Victorian ART legislation, however, overrides the adult's rights in favour of the rights and welfare of a potential foetus. This highlights a clear inconsistency.

Argument 6: Access to ART May Justifiably Be Restricted as ART Providers Are Complicit in Any Future Harm to the Child

It has been argued that access to ART should be restricted because IVF is different to natural conception, in that the "physician carries joint responsibility for the welfare of the child because of his or her causal and intentional contribution to the parental project" (Pennings et al. 2007, 2585).

Clinicians are frequently involved in decisions that determine life or death. When a doctor is necessary for the ongoing existence of a person, the doctor does not have an increased responsibility for that patient's ongoing life and welfare any more than would usually be the case in a doctor-patient relationship. Consider the following example: A child comes into the emergency department who has been assaulted by his or her father. The doctor performs lifesaving interventions. The fact that the doctor has contributed to the child still being alive does not mean the doctor has an increased responsibility, over and above usual professional expectations, for the child's subsequent welfare.

If we were to accept for a moment that clinicians have an increased responsibility for children who exist because of medical intervention, then this should not apply solely to ART. There is an inconsistency between the strict regulation of ART compared to the absence of regulation for other medical treatments of infertility, such as ovulation induction with clomiphene. The latter has the same intention and outcome as the former. Yet general practitioners are able to prescribe clomiphene, and the requirement for strict regulation and police checks does not exist. In order to maintain consistency, this regulation should apply to all medical interventions with the intention of achieving fertility, including fertility surgery and ovulation induction with medication.

In reality, clinicians have the same responsibility to any future child, whether conceived through ART, clomiphene, fertility surgery, or natural conception. Their responsibility is to provide or refer to safe antenatal and intrapartum care and to identify where further support is required in the form of social work or other assistance for the mother and future child. Furthermore, as argued above, any responsibility that does exist towards a potential child is almost never best exercised by preventing that child from existing.

Importantly, a clinician who contributes to a child's existence is not causing harm to that child's full potential. This is in contrast to myriad interventions clinicians perform in pregnancy for the benefit of the mother that *do* directly harm the potential of the resulting child. A common example in obstetric practice is the decision to deliver a premature foetus for a maternal medical indication. Here the clinician is acting in a way that may foreseeably and directly harm the resulting child. If an increased responsibility for a child's welfare following medical intervention does exist, it would best be attributed to a situation where a child's potential is negatively affected. No such claim can be made in ART.

Argument 7: Access to ART Can Initially Be Restricted Providing There Is a Safeguard in the Form of Review Process

Supporters of the legislation may argue that the existence of a review panel is a safeguard against unjust decisions. Whilst it is important that this review process exists, it is foreseeable that individuals targeted by this legislation may find this a difficult and intimidating process to negotiate.

The Victorian ART legislation overrides the reproductive rights of individuals. Merely providing a review process is not sufficient to justify this. The onus should be on the state to demonstrate that refusing access to ART is justified in each case and does not discriminate against the individual's procreative liberty (Robertson 1996). Instead, the legislation demands a "presumption" that all adults with this type of criminal history should be refused treatment. In doing so, it puts the burden of responsibility on the patient to fight for their basic reproductive and medical rights.

The principle of justice demands that like cases should be treated alike (Boivin and Pennings 2005). Whilst patients cannot demand provision of treatment that is considered harmful or futile, if treatment of infertility is to be available, then in order to satisfy just and fair provision of health care it should be available to all medically like patients who qualify and who seek it. If access to a medical procedure were refused purely based on a non-medical factor, such as religious belief or racial background, the onus would be on the provider to show that this refusal was not discriminatory. To offer a medical treatment to one group but to refuse it to another medically like group based on a non-medical factor is an example of unjust discrimination.

Argument 8: Access to ART Can Be Restricted in Cases Where Treatment Is Considered Futile

Given the above considerations, is it ever ethically justifiable to restrict access to ART based on criminal history? We will outline the one argument that can justify refusal of treatment on the basis of criminal history; this is the argument from futility. Whilst it is generally considered reasonable to refuse medical treatment if it is deemed futile (Schneiderman, Jecker, and Jonsen 1990), the concept of futility itself is debated in bioethics, and various definitions have been used. One approach is to define futility as either qualitative, where the contested issues relate to whether an outcome is worthwhile, or quantitative, which focuses on the chances of a certain outcome occurring (Wilkinson et al. 2012). An example of an appeal to quantitative futility in ART can be found in the refusal to treat patients with extremely advanced maternal age where the chances of successful treatment are considered remote (ART Review Committee 2006, 16).

A second question relates to defining the goals of treatment and how futility might relate to these goals. There are many reasons that individuals choose to reproduce (Overall 2012). One major reason is to pass on genetic material to the next generation. If we take this as the desired outcome of ART, then being unable to raise the resulting child would not be inconsistent with the desired outcome. In other words, treatment would not be futile. If, however, as argued by Solberg, we accept that the desired and qualitatively worthwhile outcome of most individuals undergoing ART is to raise the resulting child, then the inability to do so would render ART treatment futile (Solberg 2009).

An appeal to the concept of futility may therefore be used when faced with certain examples of criminal history in patients requesting ART. For example, a convicted violent offender who has had multiple previous children removed from his or her care may be viewed as extremely unlikely to raise any future children. In this circumstance, after comprehensive review of the case, ART treatment may be considered futile and therefore justifiably refused.

However, many individuals with a criminal history targeted by the Victorian legislation could reasonably be expected to raise their child, which therefore satisfies the desired outcome of infertility treatment. Denying access to ART on the basis of futility can therefore only be justified in those cases where it can be shown that the potential parents are not expected to raise the resulting child.

Conclusion

By highlighting various contradictions in policy and addressing possible arguments that may be used to support this legislation, we have demonstrated that a "presumption against treatment" for the non-medical factor of criminal history cannot be ethically justified. The one exception to this is in the extreme example of futility, where it is foreseeable that the parents will not be involved in raising the resulting child.

Like all medical treatment, ART should be offered to all those who seek it and who medically qualify. To refuse medical treatment based purely on a non-medical factor is an example of unjust discrimination. Once medical need has been established, available ART resources should be evenly distributed amongst this cohort. ART can be justifiably refused on the basis of futility and medical risk to the patient, as is the case for all medical treatment. A refusal on the basis of concerns for the welfare of the future child only applies if the child will, in all likelihood, live a life that is not worth living, which seems unlikely in this context. A police check demonstrating a parent's prior criminal conviction does not demonstrate that a future child's life will not be worth living, nor that the treatment is futile, and as such it is not sufficient to justify overriding the adult's reproductive autonomy. A "presumption against treatment" in this circumstance cannot be ethically justified.

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