
BIOETHICS OUTLOOK

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Reproductive Technologies: a proposal to legislate in New South Wales

In this issue

The first thing that regular readers of *Bioethics Outlook* should notice is the increased size of this issue. The entire issue is devoted to one topic: a proposal to consider legislation to regulate reproductive technologies in New South Wales. Since the publication of our next issue will come close to the closing date for submissions on this proposal, we have included all three papers, and a summary of what was said at a recent Forum conducted by the Plunkett Centre, in one expanded issue.

No space then to advertise other activities of the Centre (though flyers for our annual Intensive Bioethics Course in Sydney, and for three other 'Intensives' we are conducting this year around the country, are included). Nor even properly to introduce Sr Mary Byrne, RSC, who has recently joined us as a Research Associate. Mary, a Sister of Charity, experienced nurse, honours graduate in Theology and Philosophy (from the Philosophy Department of the University of Melbourne), has already become an integral member of our team.

Bernadette Tobin

Late last year, the New South Wales Health Department issued a Discussion Paper entitled "Assisted Reproductive Technologies". This Paper is the first part of a process designed to obtain the views of the community on '... whether laws should be passed to ensure that research and developments in the field of human reproduction are consistent with the community's values and wishes'. Similar legislation has already been passed in Victoria, South Australia and Western Australia, and indeed the National Health and Medical Research Council (NHMRC) has urged all the states and territories to adopt complementary legislation. On 3rd March this year, the Plunkett Centre sponsored a public forum for health professionals and interested others on the questions raised in this Discussion Paper

The New South Wales Discussion Paper canvasses arguments for and against regulating reproductive technologies by legislation. It covers such topics as: the current procedures for monitoring clinical applications and research in New South Wales; eligibility for the technologies; research on embryos; practices already or likely to be prohibited; storage, use and disposal of embryos and gametes; record keeping and access to information; screening of donors and infection control; and surrogacy.'

In his introduction to the Discussion Paper, the Minister for Health, Mr Andrew Refshauge, says that the NSW government has decided to proscribe two procedures: 'human cloning'² and 'transpecies fertilisation involving human gametes or embryos'. By implication, it has not decided how much further to go in the matter of regulating the application of, and research into, reproductive technologies.

Given that current reproductive technologies raise ethical issues of great depth, complexity and significance to the whole community, we decided that it would be appropriate for the Plunkett Centre to host a forum at which the opinions of people with differing approaches to the ethical issues, and differing views on the desirability of, or necessity for, regulation by legislation, could put those opinions forward and have them discussed. This was not to be a consensus-gathering forum: the purpose was rather to enable people with an interest in these questions (and, in particular, people who might be thinking of making a submission to the NSW Health Department on the subject) to become better informed not only about current clinical applications and research but also about the ethical issues and about the arguments for and against regulation by legislation.

Eleven speakers took part. Some gave formal papers, most simply spoke from lecture notes or from accompanying slides. Two key papers - those presented by Dr Sandra Webb and Dr Gerald Gleeson - are reproduced in full elsewhere in this issue of *Bioethics Outlook*. In what follows here, I have attempted to summarize - in what is little more than a journalistic style - some of the key points made by the other speakers.

NHMRC recommends legislation

The first speaker, Ms Deborah Frew, Legal Officer of the NSW Department of Health, set out the background to the writing of the paper, explained that there is no departmental view on whether legislation would be desirable, and encouraged members of the audience to participate in the process of community consultation.

The second speaker, Professor Don Chalmers, explained why the NHMRC

strongly recommended legislation to the Commonwealth Minister for Health and through him to the Ministers for Health in each state and territory. Professor Chalmers chairs the Australian Health Ethics Committee (AHEC), a principal committee of the NHMRC. Over a year ago, when AHEC issued its new ethical guidelines on reproductive technologies, the Committee was unanimously of the view that complementary legislation governing the use of reproductive technologies ought to be introduced in every state and territory. (Three states, Victoria, South Australia and Western Australia, already have such legislation in place.) AHEC guidelines set standards only for research. They govern the deliberations of institutional ethics committees in such matters as: the nature of the information which must be conveyed to the couples who have recourse to these technologies; the necessity for having counselling available; legitimate and illegitimate forms of research on embryos; the storage and destruction of embryos; and practices (such as the deliberate cloning of human beings) which are prohibited. However AHEC's guidelines have two main limitations. They govern only the activities of those clinicians and researchers who seek funding from the NHMRC or the Australian Research Council (ARC): they do not govern the activities of clinicians and researchers whose work is funded from any other source. Secondly, they have no authority on the many 'social' issues which the use of these technologies raises.

Professor Chalmers told the audience that complementary legislation in every state and territory is needed to determine what is, and is not, socially acceptable in the following matters: how information should be kept about individuals who have recourse to these technologies; who is entitled to enter the programmes; under what conditions and to whom access to information (in particular, identifying information) should be available; whether posthumous use may be made of gametes; whether it is legitimate to conduct genetic tests on embryos; how the service of reproductive technology should be delivered; and whether surrogacy arrangements should be legitimate.

Why legislation is needed

The next speaker, Mr Nicholas Tonti-Filippini, an independent ethicist from Melbourne, argued that both self-regulation by the clinicians and researchers involved in this area of medicine on the one hand, and regulation by the common law on the other, are inadequate. Legislation is required, he argued, both to enshrine certain ideas that are by now undisputed, and to settle a whole range of currently disputed questions. Amongst the undisputed issues he mentioned (a) the need to protect the right of any child conceived of these technologies to its own identity (a right which, he pointed out, is recognized in both the United Nations' *Convention on the Rights of the Child* and the United Nations' *Convention on Political and Civil Rights*), (b) the right of those born of these technologies not to be experimented on, (c) participants' need for proper information, (d) the necessity to exclude contracts which exploit participants and (e) the need to protect participants' privacy.

Mr Tonti-Filippini admitted that the use of reproductive technologies raised many morally-contentious issues, for example whether same-sex couples and single people should have access to the technologies, whether public funds should be used to support the technologies, whether reproductive technologies should be used for the purpose of genetic discrimination, whether non-therapeutic and destructive experiments are legitimate, and whether surrogacy arrangements ought to be enforceable. He argued that these are all issues on which the community must make some decision (which legislation should then embody).

In concluding, Mr Tonti-Filippini decried current arrangements which permit children born of these technologies to suffer 'genealogical bewilderment'. The paramountcy of the interests and needs of any children who may be born requires that children are conceived and brought up within a family. Legislation is needed, he argued, to ensure that children conceived by technological means enjoy that basic human right.

The next speaker was Dr Sandra Webb who is the Executive Director of the Reproductive Technology Council of Western Australia. Dr

Webb's paper was entitled 'The benefits and the limitations of legislation' and it is reprinted in full elsewhere in this issue of *Bioethics Outlook*.

Current research and clinical applications in NSW

In the second session of the Forum, Professor Robert Jansen, Clinical Professor at the University of Sydney and Medical Director of Sydney IVF, outlined current clinical practices in reproductive technologies. Speaking mainly to detailed slides, Professor Jansen explained both the causes of infertility and subfertility and the ways in which IVF clinics respond to these conditions. In this session, Professor Douglas Saunders, Professor and Head of the Department of Obstetrics and Gynaecology at the University of Sydney and Royal North Shore Hospital, explained both the need for good research in this area (he mentioned IVF's limited success rates and the limits to the use of animal models in this part of medicine) and the applications of research outside the area of infertility (such as pre-implantation genetic diagnosis and the possibility for pre-implantation therapy). He then outlined the main directions of current research, and finished by evaluating various modes of regulating and moderating that research.

Ms Sandra Dill, the Executive Director of Access Infertility Network, NSW, discussed some of the ethical difficulties associated with the provision of reproductive technologies. She opposed regulation by legislation on the grounds that 'self-regulation' can and does work.

Personal experience

In a movingly personal talk, Mr Ken Quail, of the Donor Conception Support Group of Australia, described his experience of offering himself as a donor of sperm twenty years ago not then knowing that he was infertile. The counselling he was offered addressed the needs of infertile couples but said nothing at all about the welfare of children born of reproductive technologies. When he married, and his infertility was discovered, he and his wife tried to have children by 'known donor'. Three things prompted them to take this course: they would know the character of the person who would be the genetic father of

their children; their children would know who were their half-siblings; and their children would be able to have further contact with their genetic father should they so wish. When that failed, he and his wife approached a fertility clinic. They were then, in his words, 'beyond deciding wisely'; they just wanted to have children. They now have two much loved children with the help of anonymous donor sperm. Was it ethical of them, Mr Quail asked, to have children knowing that their children's rights to knowledge of their genetic origins were not fully protected? Without trying to answer that question, he went on to say that he and his wife now want to bring about social change for the better, in particular the establishment of a National Register of all donors and of all children born by donor insemination. Such a Register is needed, he said, so as to ensure that the children have a complete sense of their own identity, so they can know to whom they are related, so that they can develop a proper medical history. It is also needed for statistical purposes (for instance, so that a check can be made on the number of births per donor) and in general to protect the rights of children born of donor insemination. He suggested that a voluntary retrospective donor register might not be out of the question, that there might be individuals who have been donors in the past who (once they are assured that being identified does not entail their having social obligations to the child) have changed their minds on some of the key ethical issues.

Current data keeping

Associate Professor Paul Lancaster, the Director of the National Perinatal Statistics Unit (NPSU) of the Australian Institute of Health and Welfare, was the next speaker. Professor Lancaster addressed three subjects: the current arrangements for the systematic collection of data on reproductive technology in Australia; some ways in which the data is being used; and the gaps which exist in that data. The data kept by the NPSU is a register of treatment and its outcomes. Originally a voluntary agreement entered into by all the IVF clinics in order to record birth defects associated with the use of reproductive technology, it is now a requirement of registration with the Fertility Society of Australia's Reproductive Technology

Accreditation Committee (RTAC) that clinics supply data to the NPSU. In summary the data collected relates to each pregnancy achieved, each treatment cycle undertaken by a woman, pregnancy rates, information about laboratory procedures, and (recently) adverse events and pre-implantation diagnosis. The data is used in a variety of ways: the NPSU publishes an annual report and contributes, where required, to state and international reports and makes available to individual clinics certain comparative data (for instance, comparative pregnancy rates). The data is also used in collaborative research projects and made available to the media. With a history of fifteen years collecting data, the NPSU is able to identify certain trends in the application of reproductive technologies (for instance, a diminution in the number of embryos transferred to a woman from between four and five in the mid-eighties to an average of 2.5 in the mid-nineties). However, there are significant gaps in the data which is kept. The NPSU has no information about the biological or genetic origins of children conceived through the application of these technologies. As yet it has no information about the risks of cancer associated with the use of reproductive technologies (although there are several studies of this question now underway). Finally, it keeps no information about artificial insemination.

Ms Jo Cooper, the Director of the Centre for Health Law, Ethics and Policy at the University of Newcastle, was the next speaker. Starting from the assumption that information about reproductive technologies would be adequately recorded and thus could be accessed, she raised some of the issues reflection upon (and debate about which) would help to shape policy in New South Wales. She pointed out that whereas access to information on health records usually required a weighing up of just two public interests (the individual's right to privacy and the public interest in having research conducted), in the area of reproductive technology there is an additional question: whose information is it? She opened up that question by asking: Who has an interest in the question of whether donor information should be recorded and accessible? Ms Cooper listed the following

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Legislation: benefits and limitations

Sandra Webb

At the first reading of the New South Wales Health Department's 'Review of the Human Tissue Act Discussion Paper: Assisted Reproductive Technologies', what most concerned me was that its apparent starting point was competition policy: it seemed possible that decisions about the appropriateness of legislation, or elements of it, might be made on the basis of simplistic cost/benefit analyses, like ordinary business decisions. However, when I read the Discussion Paper in detail I was very impressed that the breadth and complexity of the issues to be weighed up were clearly set out throughout the document. In fact, the foreword itself made quite clear that "*these are not just issues for doctors, scientists, politicians and lawyers, but for all of us*", as the assisted reproductive technologies are having a "*profound effect on our society and challenging the values that underpin it*".

It is a very interesting time to read and ponder on the discussion points in the document, as the Western Australia Human Reproductive Technology Act is now five years old and is in the process of a compulsory review by a Parliamentary Select Committee. We have five years of practical experience with a comprehensive piece of legislation, and so I will try to distil some of my own personal views on what I think law in this area can achieve to the benefit of all, and what the limitations of such law can be.

It is also interesting to be looking in depth at these issues when we have had up to fifteen years of experience with legislation in the area of reproductive technologies around the world, and twenty years of the clinical practice of In Vitro Fertilisation (IVF). During this time we have come to take so much about these technologies for granted, and yet we continue to be amazed by the twists and turns in what is possible and what was not anticipated.

Qualitative differences in this area of medicine

The statements in the foreword of the NSW Discussion Paper outline, in part, why I believe this area of medicine is qualitatively different from any other, and why the interest in it goes beyond the doctor and those who are the focal point of these reproductive technologies, that is, those being assisted in having the children they long for. There are so many "third parties" in this area of medicine, others whose rights may be in conflict with the rights of those being treated. They can include the children who are to be born (and who can so easily be forgotten at the time of treatment); the possible donors; surrogate mothers; the extended families and grandparents; and the community at large. The continuing media coverage is a clear indication of public interest and concern over the possibilities raised by these technologies.

Why legislation is necessary

Reproductive technologies not only potentially allow those being treated to match the expectations of others in the community about establishing a family, they also bring the potential to exceed normal expectations. For example the storage of gametes and embryos, or their donation, are relatively simple procedures. However, they bring the capacity for reproduction beyond the normal reproductive age in women, or the capacity for reproduction beyond the death of the gamete provider. It is the significant social and ethical ramifications of these sorts of developments that we in the broader community need to have the opportunity to weigh up. I believe that these valid community concerns, as well as the potential for conflict between the rights of those directly concerned, are all convincing reasons why legislation is needed to regulate reproductive technologies.

What features would good legislation have?

It must be recognised that, although there are strong arguments for legislation, many different styles of legislation are possible. Restrictive, inflexible legislation would not serve well those seeking treatment, as it could not cope with the pace of change in this area. Nor could it be responsive to evolving community views. I will try to set out what I see as the main features of good legislation in relation to reproductive technologies.

Licensing of Clinics with a Code Of Practice

The law must allow responsiveness to rapid change in technology and community views. This is best achieved, as in reproductive technology legislation in Western Australia, South Australia, Victoria and the United Kingdom, by a system of licensing of clinics based on compliance with a code of practice that may be responsive to the need for adaptation.

Ideally in Australia this code should be based on both the professional guidelines that set clinical and laboratory standards which have been issued by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia and the National Health and Medical Research Council's (NHMRC) ethical guidelines which were issued in 1996. This would enhance national consistency, which is highly desirable. These two sets of standards form the basis of the system of licensing provided for in the legislation in Western Australia, Victoria and South Australia.

I do not agree with claims made in several places in the New South Wales Discussion Paper that, in the absence of some such licensing system, a "breach of the NHMRC guidelines would have dramatic effects for institutions in terms of loss of funding and resources". As very little of the clinic research is funded by peer reviewed grants, I believe that unless compliance with the guidelines is enforced by legislation, or perhaps required for Medicare rebates to be payable, there would be little impact resulting from a breach. Therefore I think licensing and compliance with the Code of Practice needs to be enforced by offences in legislation.

Prohibition of certain practices

Secondly, I have also come to think that there is a need for other clear boundaries to be set in legislation, with sanctions for breaches of them. The prohibited practices should be those set out in the NHMRC guidelines or the New South Wales Discussion Paper. Although many of these may seem like science fiction activities, only to be carried out by mad people, and although we have no real fears that our doctors would carry out any of them, there is a fear of excess in the community. I think there is a need for the public to be reassured as to what the absolute boundaries are. When the media presents stories, as it has over the last weeks of men such as the American physicist Dr Seed saying that he will clone humans, this need is confirmed.

However, it is also vital that, when absolute boundaries are to be set in the law, the drafting exactly achieves what is intended. For example, unless carefully worded, a ban on cloning could result in an unintentional ban on pre-implantation genetic diagnosis.

Establishment of a Regulatory Body

There is a need to establish who is to make the decisions that set the standards in the Code of Practice: which body of people should it be, and what range of interests and expertise they should have? This is to ensure public accountability and confidence, and understanding of the decision making processes. I have noticed that the greater the potential flexibility of the law the greater is the public interest and concern about who these people should be, and this is quite understandable.

Nationally this body could be developed through modifications to the NHMRC or the RTAC that maximised the breadth, expertise and independence of the regulatory body. If regulatory bodies are to be established in those states where there is currently no specific legislation regulating the technologies, these could be bodies similar to the Western Australian Reproductive Technology Council, Victoria's Infertility Treatment Authority or the South Australian Council on Reproductive Technology. These bodies are established under State laws to be broadly representational, with well defined powers.

Clarification of potential conflicts of rights

The storage of gametes and embryos, and the practice of donating sperm and oocytes, bring particularly complex ramifications and potential for conflicts. One example of these conflicts is the situation where a couple is in dispute over an embryo. What should be done? Other issues include the right of a donor offspring to identifying information about the donor, and the confusion over whose is a child born from donated gametes. There is a need to clarify, in legislation, some of the potentially conflicting "rights" issues, which reproductive technologies bring in abundance.

Effective Data Keeping

There is a need to ensure the availability of comprehensive and objective information about the procedures carried out, and to ensure that this information is available over the very long term. There are two sets of reasons for keeping this information.

The first reasons can be thought of as "public health" related. The keeping of information about treatments and their outcomes allows monitoring of what is going on *in the short term*. For example: what are the trends in the treatments being carried out, what types of infertility are being treated, what are the success rates? This type of information assists informed decision making by those being treated, as well as assisting the treating medical practitioners and policy makers. This type of information can also assist *in the long term* monitoring of effects on those treated and their offspring, again to build information about the safety of the procedures and their effectiveness, and so assist informed decision making.

When the keeping of this sort of information is considered, the issues to be weighed up include the public need for good research and adequate monitoring, and the question of how this may impact on the rights to privacy of those being treated.

The second set of reasons can be classified as having a more personal focus. Information kept may also be of great value to an individual directly involved with the treatment. This personal information may be sought for purely medical reasons. For example, in a situation like the recent CJD

scare, women who have been treated in the past may be able to access, from a central register, information that could readily establish whether or not they were exposed to a treatment that put them at risk in some way.

Or if donation has been involved, registers may provide valuable demographic, personal, and historical information for donors and offspring, to which most people now think the children, at least, have rights. However, when donation is a part of the treatment, there is a greater potential for conflict between donors (with their personal wishes and rights to privacy of information) and those whom they assist, and this requires careful resolution.

With regard to the question of who should be responsible for the establishment of these registers of information, I think it is hard to refute an argument that State governments should take up the responsibility to establish the Donor Registers. To collect these data nationally may be too difficult. As well, clinics and individual doctors come and go. However, these data must be kept for people to have access to when they need it, and so the State seems to be the appropriate level.

When we move beyond this personal information to the keeping of public health data it is harder to argue for the establishment of State-held registers. A considerable amount may be achieved by setting high standards for record keeping in the clinics and continuing to support the current national IVF database at the National Perinatal Statistics Unit. However, these national data could be greatly enhanced by the establishment of State-held registers of information about reproductive technology procedures and their outcomes. This would facilitate valuable public health studies, which can only be carried out at State level, through linkage of the reproductive technology information to other State-held registers of information, such as Midwives' registries, cancer registries, or birth defects registries. Information collected comprehensively at the State level in this way could then be collated at the national level to provide sufficient numbers for more rapid completion of such studies. The extent of these registers, whether they should contain identifying information and, if so, who should establish them and who should have access to them, are major issues for discussion.

Limits to legislation

With these potential benefits, what are the limitations to regulation by law? There are some things that cannot be achieved by legislation or that legislation does badly.

In theory at least legislation could be stifling. An overly restrictive law might stifle progress in the field of reproductive technology and limit access to the best and latest treatment options of those in need. In my observation this sometimes does come about as a result of amendments moved in Parliament that have not been carefully thought out.

Insufficient way of slowing the pace of change

However, I think the greater or main limitation of legislation is the opposite of the previous problem. It is a clumsy tool when trying to slow the pace of change in this area. Developments are still being introduced without enough public debate or scientific evidence to support them. In the case of the Western Australian Act, for example, the objects of the Act are exemplary. They set out the breadth of the interests to be considered in any decisions, with the interests of the child alongside the interests of those who are being treated. The potential power of the Act to regulate research and clinical innovation is great. But, in practice, the inherent nature of clinical practice means there are basic problems with setting a reasonable boundary to the limits to clinical freedom. The right and need of a doctor to make decisions for each case makes defining where this clinical freedom should end, and where innovative practice should be considered experimental, difficult.

In addition, it is often difficult, in making decisions about whether or not to allow new practices, to decide which end points are appropriate. How should a successful treatment be measured? For example, should the success of a new reproductive technology procedure be measured by the achievement of a pregnancy (as is so often the case in published literature in this field) or in the birth of a healthy child? Although it may appear desirable to provide patients with good information and support to guide their decision making and leave all the choices to them, there is reason to be concerned, also,

about patients' objectivity. New developments are often published in the press far too early for patients genuinely to know if they are truly safe or effective. The debate about the potential risks or benefits is often highly technical, but once the 'benefits' are presented they can become very appealing.

Difficulty in enforcing effective limits and prohibitions

I think that while it is not appropriate for the law to define when human life begins (this surely is for the philosophers), it is quite appropriate for the law to set limits to acceptable practices involving embryos. But are these in any way enforceable? Someone, somewhere, may well carry out the unacceptable practices and be quite undetected. At least, however, the law will prevent this being carried out in the mainstream, published, talked about at professional meetings and offered routinely to patients.

Difficulty of identifying the interests of the child

Consideration is too rarely given to the outcome likely for the child. Such consideration should also include the question of who should be eligible for treatment. Unfortunately, there is very little concrete evidence as to what kinds of people or relationships will benefit or harm children. The current emphasis on compliance with anti-discrimination legislation means that these decisions will probably have to be made on a case by case basis. However, it is impossible to provide, in legislation, reasonable criteria to guide those who have to make these decisions. There is simply no firm evidence to provide a basis for such guidance.

Conclusion

In the area of reproductive technology, medical and social concerns intersect. For example: Who is infertile? Which genetic diseases are serious enough to seek to avoid them by utilising reproductive technologies? Who should be responsible for considering the welfare of the child in decisions about eligibility for treatment? Who should be

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Ethical issues in reproductive technology: some Catholic insights

Gerald Gleeson

It may seem strange that a forum on Assisted Reproductive Technologies (ART) is being held on the campus of a Catholic health care facility where these technologies are not employed. The goal of the discussions today, however, has been to enable conversation between those in our community with differing views on ART, to raise ethical and legal issues of concern to all, and then, in this final session, to discuss some of the insights of the Catholic moral tradition in relation to human reproduction.

Transparent terminology

The first issue I wish to raise concerns the accurate naming of our topic. The term "assisted reproductive technology" seems to be an amalgam of two distinct notions: that of *assisted reproduction* and that of *reproductive technology*. The amalgam is grammatically deficient at the very least, for what does the word "assisted" modify? Presumably the presence of the term "assisted" derives from the early portrayal of In Vitro Fertilisation (IVF) as a way of "assisting" infertile couples to have a child they could not otherwise have. Since then, however, "reproductive technologies" have come to be used in contexts which are quite remote from infertility or from any couples' desire to have a child (e.g. destructive experimentation on embryos). While it remains true that some technologies do *assist* couples to conceive and bear a child of their own (e.g. by moving an ovum past a blockage in the fallopian tube), most reproductive technologies, including IVF and Embryo Transfer (ET) are really *alternative* or *substitute* ways of bringing about the conception of a child.

I do not, of course, deny that one can speak generally of reproductive technology "assisting" couples who wish to have a child. But once we make the crucial distinction between *assisted reproduction* and *reproductive technology* the important ethical issues emerge

more clearly. First, we need to understand what constitute truly human forms of reproduction, in order to determine whether a technology *assists* it or *substitutes* for it. We are then, secondly, in a position to assess the appropriateness of any form of technology which would *substitute* for human reproduction. Accordingly, in this paper, I will speak generally of "reproductive technology", not ART, in order to leave open, rather than pre-empt, the ethical question about how these new technologies *ought* to be used.

In order to determine whether a technology *assists a couple to reproduce* we must identify the characteristics of authentic human reproduction. Technologies may substitute for the physiological and biological components of reproduction, but *human* reproduction is never just a matter of biology. Human reproduction *as properly human activity* is constituted by intentions and motivations, choices and commitments, and the nature of the relationships between those men and women engaged in it. The ethical dimensions of decisions surrounding human reproduction are shaped by these intentions, choices, and relationships. To take an extreme example, I think most of us would agree that properly human reproduction should never become a *commercial* transaction: the profit motive would be incompatible with any reproductive activity we would judge worthy of human beings. (For the same reasons we forbid commercial transactions in relation to organ donation and transplantation.)

Evaluating outcomes in their context

My second point is that, as the case of commercialisation shows, ethical judgment is often much more than a matter of assessing the "outcomes" of an action. In itself, the existence of a child is always good, and a child ought to be accorded the respect and dignity that is owed to every human being. This remains true no

matter how a child was conceived. But this recognition of the value and dignity of every child should not blind us to the fact that there are better and worse ways for children to come into existence. Although we should never say of any child that it would be better if he or she had not been born, we may at times be required to acknowledge that it would have been better if a child had not been conceived in the way in which he or she was conceived. Hence, in addition to the good "outcome" that a child is conceived, we must also consider the appropriateness of those human choices and actions which led to conception, along with their context and the inherent significance of the actions taken, in particular, the inherent significance of any technology that was used to achieve conception. We ought not, for example, overlook such questions as whether the attempted implantation of *several* embryos in order to raise the chance of at least one embryo implanting successfully, involves the unethical, because unjust, choice to use some embryos in the interests of others.

The human context for reproduction

I turn, thirdly, to the question of the proper context for human reproduction, that is to say, the proper context for a child's coming into existence. Most people recognise the importance of considering the *future* context in which a child will be raised. It would be irresponsible to conceive a child in circumstance in which the child could not be adequately cared for, raised and educated. There is much dispute in our society about what constitutes an adequate and appropriate future context: is a single parent or a same-sexed couple sufficient? Or is a committed marriage relationship essential? As you know, the Catholic church teaches that the only appropriate prospective context for bringing a child into the world is that provided by the promised stability and fidelity of marriage. To be sure, children are often conceived outside marriage, just as they are often conceived without due planning within marriage, and once they are conceived we must care for them as best we can. Nonetheless, the ideal and ethically sound context for reproduction remains that of committed marriage in which a couple make wise decisions about responsible parenthood.

In addition to our concern with the future context into which a child will be born, Catholic teaching directs our attention to the *prior context out of which* a child is conceived, and this is a far more contentious point. The Church asks us to reflect on the context of conception to which the child will be able to look back. It teaches that every child should be able to look back to his or her origin in an act of sexual loving between his or her mother and father within marriage. On this point there is debate among Catholic theologians. Some argue that it is sufficient for children to be able to find their origin in the love of their parents and their desire to have a child, and so conclude that technologies like IVF are permissible within the context of marriage, provided other safeguards are in place (e.g. that every created embryo is given a chance to develop normally). The Church's official teaching, however, is that a child's origin should be found, not simply in the love of its parents, but more specifically their *act of sexual love* as husband and wife.¹

The more restrictive, official teaching is based on the thought that when parents allow their child to be the fruit of a specific act of sexual love, the parents are seeking to have a child in a way which embodies the truth that their child is not an object of manipulation or a product of technological intervention, let alone a commodity or property to which they have "a right". This is because, among other reasons, the couple's sexual intercourse does not, of itself, bring about fertilisation and conception. Intercourse is, rather, the act of bodily union by which a couple share their fertility with each other and thereby enable their loving to be open to the gift of new life. When conception follows sexual loving it is clear that the child is both an expression of marital love and a free gift which lies beyond the domination of his or her parents. It is this "prior context" of sexual union — so the Church teaches — which provides the most appropriate origin for the procreation of a new human being as an independent person, someone equal in dignity and value to his or her parents.

Why generate the dilemmas?

No doubt, the Church's teaching identifies the appropriate context for conception in a

more restrictive way than would be proposed by many in our society. Yet our society's widespread acceptance of reproductive technologies in their many uses is by no means unproblematic. All acknowledge that once technologies are employed, ethical dilemmas are generated: e.g. between the competing "rights" and "interests" of the child and the various "parents" concerned: between donors, birth mothers, social parents, frozen but unclaimed embryos, doctors, genetic siblings, and so on. In general, when such dilemmas are discussed, as they have been at our forum today, speakers acknowledge the many competing moral claims and so demonstrate their appreciation of just how difficult these questions are. Speakers then conclude by saying (or hoping) that those who must make the decisions will somehow make defensible decisions in situations where no right decision, which meets all the moral claims at stake, is possible.

In the light of such irresolvable dilemmas the radical simplicity of the Catholic position has much to recommend it. For the Church is suggesting that we should refrain from generating these dilemmas in the first place. Once the conception of a child is removed from the sexual embrace of husband and wife, once third parties and technologies dominate the context of conception, we are bound to encounter competing claims which cannot all be met. The case of surrogacy demonstrates this clearly. To be sure, there is something attractive about the idea of one person offering to bear a child for another who cannot bear children herself. But on further reflection we should realise that such an apparently "generous" act is fraught with complications. We know from the experience of adoption the almost inevitable tensions over identity which arise for a child torn between birth parents and social parents, as well as the possible tensions between the parents themselves. While adoption is often a good and wise solution when a child cannot be cared for by his or her birth mother, the use of surrogacy would involve *deliberately bringing about* a situation in which such irresolvable tensions were inevitable. Is it not clear that we would do better to prevent such difficulties arising by not separating conception from marital intercourse?

I trust my outline of the Church's teaching will not suggest that I underestimate the suffering which infertility imposes on many couples. But even as we acknowledge this suffering, we should not avoid recognising both that reproductive technology is still only successful in a minority of cases, and that the mystery of suffering touches every human being in one or more ways. Science and technology have improved the human lot in innumerable ways, but they can never offer the ultimate solution to the mysteries of the human condition.

A concluding "Catholic" comment

I conclude by noting that what the Church offers in this area, as in other areas of morality, is *teaching* addressed to our minds and hearts. Although this teaching is authoritative, above all for Catholics, the Church does not, and may not, make moral decisions for people. Church teaching, with its varying levels of authority, is rather "at the service" of the conscientious judgments people must make for themselves. Church teaching is meant to help us think about ethical issues and to bring to bear on them a wider perspective than that which any of us is likely to attain on our own. This teaching shapes the way we understand ourselves and our actions, and so helps us make wise decisions about what we ought to do. But in the end, the decisions we take must be our own decisions, decisions we take in faith before God, decisions we can look back on without anger or regret. No doubt some questions will always remain. Alternative views are rarely silenced completely, and in these matters there are no water-tight, absolutely persuasive arguments. Catholics are simply asked to engage with the Church's teaching and hence, to strive to understand moral issues in the way the Church does. Having sought to do this as best they can, they must then make their own conscientious judgments about how they should act in the circumstances in which they find themselves.

¹ For discussion of these contrasting views see James F. Keenan, "Moral Horizons in Health Care: Reproductive Technologies and Catholic Identity", in *Infertility: A Crossroad of Faith, Medicine, and Technology*, Kevin Wm. Wildes (ed.), (Dordrecht: Kluwer Academic, 1997), pp. 53-71. The Vatican's Congregation for the Doctrine of the Faith issued its *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* in 1987 (Homebush: St Paul Publications, 1987).

Reproductive Technologies: a forum on the proposal to introduce legislation in New South Wales (continued from page 1)

possibilities: the child born as a result of the application of reproductive technologies; the clinic in which the procedure was performed; the Commonwealth Government (given the availability of Medicare rebates for these procedures and thus the society's interest in the use of scarce resources); the couple assisted to achieve a pregnancy; the donor of a gamete; future generations born to children conceived through reproductive technologies; and the State of New South Wales in its provision of health services.

Ms Cooper then raised a number of issues in relation to the idea that each of these parties has an interest in this information. She focussed on questions about the 'best interests' of any children who might be conceived and born through the application of the technologies. Some international instruments (such as Article 3 of the United Nations' *Convention on the Rights of the Child*) require that in all actions concerning children, the best interests of the child must be a *primary* consideration; some State and Commonwealth laws go further and require that the child's welfare must be the *paramount* consideration. Ms Cooper outlined some of the empirical research which has been undertaken to establish, with respect to disclosure of information, what is in the child's best interests.

Finally the last session of the day was devoted specifically to a consideration of some of the ethical issues. Dr Gerald Gleeson of the Plunkett Centre was the speaker. His talk is reprinted in full in this issue of *Bioethics Outlook*.

Notes:

1. Copies of the Discussion Paper can be obtained from the Legal and Legislative Services Branch of the NSW Department of Health, Locked Mail Bag 961, North Sydney, NSW 2059. This is also the address for submissions, the closing date for which is 31 July 1998.

2. The term 'human cloning' is ambiguous; it may mean the cloning of body parts (such as cells) or the deliberate cloning of human beings. I assume that it is the cloning of human beings which New South Wales intends to proscribe.

Legislation: benefits and limitations (continued from page 5)

responsible for measuring and evaluating outcomes from the child's perspective when new treatments are carried out? The boundaries are vague and the ground keeps moving, so legislators must act in good faith and with care, to produce legislation without flaws that will address these important issues but still allow beneficial progress. And the medical profession has to be asked to act responsibly too, within the grey areas, with an awareness of the broader concerns.

Dr Sandra Webb is the Senior Policy Officer/ Reproductive Technology in the Health Department of Western Australia and the Executive Officer of the WA Reproductive Technology Council.

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Telephone (02) 9361 2869
Facsimile (02) 9361 0975
email: plunkett@plunkett.edu.au

Guest Editor: Mary Byrne RSC

Layout: Sandra Menteith

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Surrogacy: some ethical issues

Mary Byrne RSC

Surrogacy is one of the areas addressed in the New South Wales Health Department Discussion Paper for proposed legislation on Assisted Reproductive Technologies. Currently, there is no legislation in New South Wales concerning surrogacy. In Victoria, Tasmania, South Australia and Queensland it is illegal to attempt to facilitate any type of surrogacy agreement and any such contract is void. In the Australian Capital Territory only commercial surrogacy arrangements are illegal. As the discussions continue in relation to reproductive technologies one question is: How should the law respond to the fact that surrogacy is now a technological possibility? This question raises both ethical and legal issues and in this paper I will attempt to explore a few of the ethical issues.

What is surrogacy?

The term "surrogacy" is generally used to refer to "surrogate motherhood". It can encompass a variety of different specific situations but a general definition is "the bearing or gestating of a child by a woman for another woman."¹ A "gestating" mother agrees to hand the child over to a "commissioning couple" at, or closely after, birth. This agreement is reached prior to conception. The conception of the child is a response to this agreement.

Several distinctions are made within this general understanding of surrogacy. "Full" or "total" surrogacy describes a situation in which a woman carries a child who has been conceived with the ovum of another woman, either the ovum of the woman who has commissioned the child or the donated ovum from a third woman. This method of surrogacy incorporates In Vitro Fertilisation (IVF) techniques. "Partial" surrogacy describes a situation in which a child is conceived utilising an ovum of the woman who is carrying the child, the "gestating mother". In both cases, the sperm involved in the conception of the child could have come from the husband (or partner) of the woman carrying the child, the husband (or partner) of the woman

commissioning the child or another donor. Advances in reproductive technology have made all of these arrangements possible.

Two other terms used in discussions are: "commercial" surrogacy and "altruistic" surrogacy. In some discussions these terms are simply used to indicate whether or not the surrogate mother has financially profited from undertaking the surrogacy. A more comprehensive way of approaching this distinction is to begin from the reason why a woman has entered a surrogacy arrangement. The intention can be either to make a profit or to be of service to an infertile couple. This distinction is not precise, as a woman may have a variety of reasons for entering into a surrogacy arrangement. Some women may seek to gain a profit but also be motivated by the desire to serve couples who are infertile. It is more realistic to describe a continuum between purely commercial surrogacy and purely altruistic surrogacy.

The range of issues

There are many legal and ethical issues that arise when contemplating surrogacy. Some of the legal issues are: the status of surrogacy contracts and the question of whether they should be made enforceable; the type of screening needed to prevent infection; the type of information that should be kept, who should keep it and who should have access to it; and who should be penalised if surrogacy is made illegal. Each of these issues is important and needs to be addressed in a discussion on the need for legislation, and the type of legislation that should be enacted.

However, prior to considering whether and, if so, under what conditions surrogacy should be permitted by legislation more fundamental ethical issues, that are necessarily raised by the practice of surrogacy, need to be addressed. Only then can it be determined whether surrogacy is something we wish to affirm or not. These ethical issues include: the competing interests involved, including the "right" to have a child and the importance of

the welfare of the child; the defining and understanding of the relationships of the several people involved in the conceiving of a new life; the understanding of surrogacy in relation to pregnancy and giving birth; and what surrogacy demands of the surrogate mother.

In whose interests?

Most forms of medical treatment involve only the person who is receiving the treatment. In contrast surrogacy, and all forms of reproductive technology, also involve a child who may be born as a result of the application of these technologies. However, they are usually described and discussed as a treatment for the couple, an overcoming of infertility and childlessness. The interests of the couple are considered and addressed. This does not guarantee that the interests of the child who may be born have also been considered. The best interests of the child are not necessarily aligned with the interests of the couple seeking to have a child.

The first problem, then, is to decide whose interests should take priority, those of the child who may be born or those of the couple who are infertile. There are reasons for responding to the interests of each and it is not the case that these interests will conflict every time. There are many precedents for recognising the interests of the child, including the *United Nations Convention on the Rights of the Child* and the *Children (Care and Protection) Act (1987) of New South Wales*. These strengthen the claim that the rights and interests of the child should be given priority over any "right" to have a child and the interests of the couple.

Once the interests of the child who may be born are made primary, if not paramount, a second problem arises. How is it possible for such a child to have a voice in the decision making? No-one involved in the process is a neutral person in regard to such a child and therefore no-one can really be an advocate for the interests of the child. One issue that is intrinsic to surrogacy is the problem of guaranteeing that the interests of the child will be primary and will be addressed.

What are the relationships?

A second issue that affects a child born through surrogacy is the blurring or confusing

of the basic relationships the child will have. There is at least a third person, if not more, brought into the life of the child and the family through this conception and birth. There is the possibility, with surrogacy, of a gestational mother, a biological mother and a social mother as well as a biological father and a social father. There could be five people who have some relationship to the child that is normally contained in the role of two parents.

It should be acknowledged that there are some instances, such as adoption and remarriage, where children do experience a split between biological and social parenting and do not suffer permanent problems. However, these situations have not been deliberately planned prior to the conception of the child. They are a response, seeking the best possible situation, when the ideal of family life is not possible.

In addressing the moral aspects of surrogacy, the Catholic Church has pointed to the right of children to have a "filial relationship with [their] parental origins"² and has stressed the importance that this relationship has on the development of their own identity. The child has a right to come into the life of a family. The result of surrogacy is the deliberate ending of a unique relationship between the unborn child and her or his mother, as well as a deliberate splitting of the physical, moral, social and emotional elements of a family.³ This is a second aspect intrinsic to surrogacy.

There is also the question of the interests of the woman who agrees to be the surrogate. Whether or not these interests have been considered depends on how surrogacy is understood. This is the next issue to be discussed.

How is surrogacy understood?

It is of great importance to clarify how we understand what surrogacy is, as the way it is perceived affects the ethical understanding of it. The differences partly arise from the principles that underpin these understandings. This can be seen in the following two examples.

When the National Bioethics Consultative Committee looked at surrogacy they utilised three basic principles in their discussion. These principles were: personal autonomy, justice,

and the common good. Such an approach sits easily with an understanding of surrogacy as a service that a woman offers, like any other service or labour that a woman could offer. On this view, a woman's labour is being used as the means to another person's end - the desire to have a child. This is so even if the woman is treated with great respect. She is expected to have no feelings about the pregnancy and the child to be born. At the least she is expected not to have any feelings beyond what she would feel about anything else she could create through her own labour. A woman's reproductive capacity is perceived as a commodity, something to be used for gain. On this understanding it is claimed that there are no ethical problems with surrogacy, provided the woman freely consents to participate. The emphasis is on the autonomy of the woman and her right to choose what she wishes to do and the freedom of the commissioning couple to seek a way of overcoming childlessness. There are two problems with this above approach. Firstly, the child is perceived as a possession. Secondly, pregnancy is equated with any other physical labour that a woman may undertake.

By contrast, there is a way of understanding surrogacy which acknowledges that pregnancy is intrinsically different from any other form of human labour. The result is *someone*, not *something*. Even expressing it like this can come close to dehumanising the special experience that a pregnancy is. The relationship that arises "is a meaningful end in itself, and not ... a means to some other end."⁴ The conscious awareness of the significance of the pregnancy and the expectation of the birth of the child are an integral part of pregnancy. In this sense surrogacy is dehumanising as it is expecting a denial, or at least a suppression, of this consciousness and expectation. Even though such feelings and awareness may not arise with some normal pregnancies, and a person who gives her or his child up for adoption may also have to deny some of the feelings that she or he has: these are not reasons for accepting surrogacy.

These are two ways in which surrogacy can be understood and so described. Both indicate why surrogacy is ethically problematic, for on both accounts the surrogate mother is forced

to deny and suppress some features of pregnancy that should always be acknowledged and affirmed, namely the significance and uniqueness of the experience of pregnancy and the developing bond between the mother and the child.

Who could be a surrogate mother?

Some of the publicity that has arisen in cases where the surrogate mother, or the commissioning couple, have had a change of mind during the pregnancy, or at the birth, has shown that some participants will change their minds during the time of the surrogacy arrangement and this can cause great trauma. This experience raises the further issue of who could possibly be a surrogate mother.

This issue challenges the appeal that is made, by advocates of surrogacy, to the principle of personal autonomy. Are the participants in a surrogacy arrangement able freely and knowingly to consider whether to participate or not? There are many factors that can affect the autonomy of such a decision. It is possible that the financial pressure of impoverished circumstances can cause a woman to agree to a commercial surrogacy for the sake of financial benefit. This has been used as an argument to limit surrogacy to altruistic cases. Yet here, too, there is the possibility of pressure. This would be more of an emotional pressure, particularly if family or close friends are involved where one woman is capable of bearing a child and another woman is not.

Along with these possible pressures that could restrict the choice a woman has in deciding whether or not to participate in a surrogacy arrangement are further pressures when the child is born. Is the woman who has carried the child free to decide at the time of birth whether she will relinquish the child to the commissioning couple who are seeking a child, and may be considerably distressed if there is a possibility that they will not gain custody of the child? In such a situation it is very hard to claim that there is no pressure on the woman and that she is free to review her original agreement at that point. An integral aspect of surrogacy is that it involves the strong risk of trauma. Surrogacy agreements cannot provide a way of ensuring that the initial choice that the woman made will not be changed by the experience of pregnancy.

Therefore, it is very hard to claim that any woman can freely and knowingly agree to the full requirements of a surrogacy arrangement.

A possibility for decreasing the risk of ongoing trauma is only to allow commercial surrogacy where the women who are sought to act as surrogate mothers are those who can guarantee that they will not love or want the child that they have carried and given birth to. Is such a "virtue" one that we wish to have encouraged or valued in society? Do we wish to affirm the splitting of the wonder of pregnancy and the development of the mother's love for her child?

The Catholic Church also addresses this issue when looking at surrogacy. The affirmation of such a split is a denial of the obligations and responsibility of maternal love. It is also an offence to the dignity of the child. In short, the fourth problematic feature of surrogacy is that it involves either the strong risk of trauma for the many people involved or the affirming of a value that is normally abhorrent to society.

Conclusion

These four issues highlight a number of ethical problems that are intrinsic to surrogacy. It requires at least a blurring, if not a splitting, of different aspects of the relationship a child should be able to have with his or her parents. It addresses the interests of the couple rather than the interests of the child who may be born. It is also very hard to claim that any participant is able freely and knowingly to consent to all aspects of a surrogacy arrangement. Finally, surrogacy requires a woman to deny or repress significant integral aspects of the experience of pregnancy. To overcome this, and avoid the trauma when the surrogate mother chooses not to give the child up at birth, it would seem to be necessary to seek a woman who will guarantee that she will not love or want a child that she has carried and given birth to. The question is whether we want a society in which this "virtue" is encouraged and, if not, what our response to childlessness and surrogacy should be, both morally and legally. When this question has been addressed the appropriate legislation can then be considered.

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Notes:

- 1 The National Bioethics Consultative Committee, *Surrogacy: Report 1 April 1990*, p. 3.
- 2 Sacred Congregation For the Doctrine of the Faith, *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation* St Paul Publications: Homebush, 1987, p. 37.
- 3 In the *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation* it is stated: Surrogate motherhood "is contrary to the unity of marriage and to the dignity of the procreation of the human person. Surrogate motherhood represents an objective failure to meet the obligations of maternal love, of conjugal fidelity and of responsible motherhood; it offends the dignity and the right of the child to be conceived, carried in the womb, brought into the world and brought up by his own parents; it sets up, to the detriment of families, a division between the physical, psychological and moral elements which constitute those families." *Ibid.*, p. 39.
- 4 A. Van Niekerk & L. van Zyl, "The ethics of surrogacy: women's reproductive labour" *Journal of Medical Ethics* 21 (December 1995), p. 347.

Mary Byrne is a Research Associate at the Plunkett Centre for Ethics.