ETHICAL CONSIDERATIONS OF ASSISTED REPRODUCTIVE TECHNOLOGIES

BY THE ETHICS COMMITTEE OF THE AMERICAN FERTILITY SOCIETY

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Chapter 4

Ethics and the assisted reproductive technologies

Many ethical questions have been raised about specific cases involving ART. This chapter seeks to survey some of the generic issues under discussion and to examine the ethical principles and theories that form the current debate.

ISSUES

The Naturalness or Artificiality of the Assisted Technologies

If one believes that nothing artificial should intrude into the sexual relations between human beings, that belief will have profound implications for one's attitude toward contraceptive techniques and ART. One critic of these technologies has formulated his objections as follows:

Is there possibly some wisdom in that mystery of nature which joins the pleasure of sex, the communication of love, and the desire for children in the very activity by which we continue the chain of human existence? . . . My point is simply this: there are more and less human ways of bringing a child into the world. I am arguing that the laboratory production of human beings is no longer human procreation, that making babies in the laboratories—even "perfect" babies—means a degradation of parenthood (Kass, 1972).

Diametrically opposed to this anti-technologic viewpoint is the perspective of those who regard the rational control of nature as one of the major achievements of human beings. According to this view, liberation from some of the unpredictable aspects of human reproduction is a major boon to the human species:

Should we leave the fruits of human reproduction to take shape at random, keeping our children dependent upon the accidents of romance and genetic endowment, of (the) sexual lottery, or what one physician calls "the meiotic roulette of his parents' chromosomes"? Or should we be responsible about this, that is, exercise our rational and human choice, no longer submissively trusting to the blind worship of raw nature? (Fletcher, 1974).

A third position tends to mediate between these radically divergent views. In agreement with the first, this third position accepts reproduction without technologic assistance as natural and good. However, this position also argues that the development and use of new methods of contraception or reproduction can be morally justifiable, depending on the circumstances and on the reasons adduced. According to this view, it is natural for human beings to create a social structure in an effort to cope with the uncertainties and inconveniences of the "natural" world; technology is an important part of that structure (Callahan, 1972). The Committee accepts this third position, as evidenced especially in chapter 11.

The Moral Status of the Human Preembryo

To speak of the moral status of anything is to use a shorthand expression for more complex formulations, such as "What are our moral obligations to X?" or "What moral rights does X possess?" Analogously, one can speak of the legal status of an adult, a newborn infant, or a human preembryo.

There are three principal viewpoints on the moral status of the human preembryo. The first viewpoint asserts that human preembryos are entitled to protection as human beings from the time of fertilization forward. According to this view, any research or other manipulation, such as freezing, that may damage a preembryo or interfere with its prospects for transfer to a uterus and its subsequent development is ethically unacceptable. This perspective on preembryonic status cites two kinds of factual evidence. First, a new genotype is established during fertilization. Second, given the appropriate environment, some preembryos have the potential to become full-term fetuses, children, and adults.

A second viewpoint denies that human preembryos have any moral status. According to this
viewpoint, we have no moral obligations to human preembryos. This position also appeals to scientific evidence, especially the fact that only 30% to 40% of preembryos produced through human sexual intercourse develop to maturity in utero and are delivered as live infants (Leridon, 1973). It also notes that the biologic individuality of the preembryo is assured only toward the end of the first 14 days of development; before that time, one preembryo can divide into twins, or experimentally, multiple preembryos with different genotypes can be combined into a single preembryo. Finally, this position argues that an undifferentiated entity like the preembryo—which has no organs, limbs, or sentience—cannot have moral status.

Again on this issue there is an intermediate position. This viewpoint accords some moral status to the preembryo on grounds both of its unique genotype and its potential. The potential to become an adult differentiates the preembryo from nonembryonic human tissues or cells. However, this third viewpoint acknowledges that our prima facie moral obligations to human preembryos can be outweighed by other moral duties, for example, the duty to develop new and better methods of providing care to infertile couples or pregnant women. Chapters 9 and 10 provide a detailed rationale for the Committee's adopting this intermediate position.

The Role of Family or Genetic Lineage

The modern techniques of insemination (DI, H1), IVF, and related ART have made the notion of "parenthood" more complex. In some contexts of medically assisted reproduction, one must distinguish among the genetic, gestational, and rearing mothers and between the genetic and rearing fathers.

The practice of donating gametes or preembryos has occasioned debate among commentators on ART. One view is that these technologies should be employed only within the traditional family unit. Proponents of this view conclude that if the couple cannot conceive a child by means of their own gametes, even with medical assistance, they should accept their infertility and explore alternatives such as adoption. According to this viewpoint, adoption is qualitatively different from the deliberate and premeditated introduction of "foreign" gametes or preembryos into the family unit, because adopting parents rescue an already existing child from a situation of homelessness (Appendix A).

The opposing viewpoint on gamete and preembryo donation is that these practices are morally justified when employed by a couple for good reasons, such as untreated infertility or the presence of a genetic defect in one or both partners. Assisted reproductive technology is therefore seen as a useful adjunct that allows couples to approximate, as closely as possible, the usual experience of reproduction.

In chapters 15 through 19 and 25, the Committee discusses various types of gamete or preembryo donation. The conclusion of the Committee in most of the donation scenarios is that the alleviation of infertility or the prevention of the transmission of known genetic defects provides a sufficient rationale for donation. On the other hand, the Committee finds that the use of donation for nonmedical reasons, such as the desire to produce a "superbaby," is ethically unacceptable (chapter 15).

A second controversial issue is the meaning of the term family. The traditional understanding of family was that it included a husband, a wife, and one or more children. This traditional understanding has been challenged not primarily by ART but rather by several social developments of the 20th century, especially divorce rates approaching 50% in the United States and the increasing number of children born to single women. The general debate about the meaning of family, however, will be carried over into discussions of ART as members of nontraditional families—unmarried heterosexual couples, homosexual couples, single men or women—request technical assistance in reproduction.

The Committee considers that parenthood by a heterosexual couple remains the most appropriate arrangement, other things being equal. However, the Committee discusses (particularly in chapter 5) the moral right to reproduce in terms that allow a role for other patterns of parenthood. The Committee is opposed to the legal prohibition of medically assisted reproduction by nontraditional families.*

A third controversial issue is whether or not the donors of gametes or preembryos should be known to members of the rearing family. If donations are made by relatives or close friends, they will

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* The statement is excessively broad. There are certain types of persons who would fall within the term "nontraditional families" but who might very appropriately be prohibited by law from having access to reproductive technologies; for example, teenagers, drug dependents. Similarly, further experience with surrogacy may well indicate the need for some form of prohibitive legislation (RAM).
automatically be known to the recipient couple. In other donation situations, practice has varied. With DI, the donor usually remains anonymous. With egg donation, wide variation exists in respect to policies governing anonymity. The Committee viewpoint is that practice in this area should be governed by the results of careful empiric research on the effects of the arrangements on the participants, which includes the children, and by the wishes of the principals involved. However, the Committee considers it an ethical obligation of the health professionals involved to retain some means for recontacting donors and providing medical follow-up (Appendices B and C). This information link with donors becomes especially critical if offspring are born with genetic defects or would require, for example, an organ or tissue transplantation (Robertson, 1986).

The Moral Legitimacy of Payments to Gamete Providers and Surrogates

The providers of semen or oocytes, the genetic parents of preembryos, and surrogate mothers may receive compensation for their participation in ART. In cases where gametes or preembryos are involved, the compensation is quite modest. In cases involving surrogate parenting arrangements, where the intensity and duration of the woman’s involvement are greater, the payments can be much more substantial.

There are six major policy approaches to this question. The first cites the analogy of whole-blood donation and argues that semen and oocyte providers, at least, should be genuine donors; that is, they should be encouraged to provide their gametes to infertile couples as a public service, without compensation even for their time and expenses. The French government has sought to embody this charitable approach in a regional network of sperm banks, and the Warnock Committee report of 1984 advocated that the United Kingdom adopt a similar policy (Great Britain, 1984). A second policy advocates that gamete providers or surrogates be reimbursed for actual out-of-pocket expenses and medical fees, but that no payment be made for the time of the participant or for the “product” of the donation process, whether that product is a gamete, preembryo, or an infant.

A third possible policy is similar to the second but would allow, in addition, reasonable payment for the time of the gamete provider or surrogate, or for his/her pain, risk, and inconvenience. In the case of gamete providers, this policy would involve, at most, a specified number of hours or days. Furthermore, there would be a clear differential between semen and oocyte providers, because the latter must undergo a more complex procedure and may receive prior hormonal stimulation as well. In the case of surrogate mothers, this policy would allow monetary compensation for pre- and postpartum leave from a job and could include the entire period from the woman’s first involvement with the commissioning couple to the end of the postpartum leave.

Three other policy options would allow payment for specific “products” of third-party involvement in the reproductive process. The first of these, and the fourth option of the six, would permit payment for gametes but not for preembryos or infants. The second would accept payment for both gametes and preembryos, but not for infants. The third would permit payment for infants as well.

In accord with deeply rooted and well-founded moral sentiments in our society, the Committee rejects the buying and selling of infants as demeaning to all parties involved. While recognizing the clear difference between infants and preembryos, the Committee is also opposed to payments for preembryos because it views such commercial transactions as incompatible with the respect due to preembryos (see chapter 10). The Committee has grave reservations about the sale and purchase of gametes because of the dehumanization that such practices might entail. In particular, the Committee is concerned that the advertising and marketing of human gametes might cause these important cells to be viewed as mere commodities (chapters 6,7). In the Committee’s view, the same kind of noncommercial environment that surrounds the transfer of solid organs in our society would be appropriate for the provision and receipt of human sperm and oocytes.

As will become clear in the chapters that follow, the Committee’s position most closely approximates the third policy approach enumerated above, allowing payment for time, risk, medical cost, and inconvenience to gamete providers and surrogates.† (See especially chapters 15 to 17, 24 and 25.) This policy respects the autonomous choices of

† The Committee cautions against allowing reimbursement to the donors of preembryos for expenses associated with producing and storing the preembryos because of the potential abuse that could be associated with this practice.
adults who agree to become involved in reproduction, while at the same time attempting to avoid inappropriate commercialization and to protect the welfare of children who may result from ART.

The Possible Role of Gender Preselection

A reliable methodology for distinguishing XX and XY preembryos exists. The methodology for distinguishing X- and Y-bearing sperm, however, has limited efficiency. Couples employing ART will have the option of choosing, with a high degree of probability, the gender of their future children. The best available empirical data indicate that approximately two-thirds of women in the United States have a gender preference for their first child and that approximately two-thirds of women who have a preference would want to have a male child first (Pebley and Westoff, 1982).

In the Committee’s view, this arena is one in which moral suasion rather than government intervention is the most appropriate policy. Specifically, it should be suggested to couples employing ART that they allow the gender of their children to be determined by chance rather than by preselection, unless a sex-linked genetic condition renders this decision imprudent. The Committee regards this moral advice as a natural outgrowth of its commitment to nondiscrimination on the basis of gender.

The Appropriate Role of Government

To philosophers like Plato, the classical Western view of the proper role of the government was that it should promote virtue in its citizens, who were viewed as parts of an organic whole, the state. In modern times, this view has been rejected by most Western political philosophers. The closest modern parallel to the Platonic viewpoint is that a government should ensure that its citizens act in accordance with the principles of morality. According to this view, governments are justified in intervening to prevent even private immoral behavior, such as illicit sexual activity, because in the long run such behavior undermines the public good (Devlin, 1965).

A second viewpoint sees the primary role of government as protecting individual liberties and preventing persons from inflicting harm on others. This view often includes the “clear and present danger” test, namely, that only serious, imminent harms are of sufficient importance to warrant government intrusion (Feinberg, 1973). According to this view, government would not normally intervene in the private sexual activities or reproductive efforts of consenting adults except perhaps to prevent tangible substantial harm to offspring or others.

A third view limits individual liberty, not only to protect citizens from harm, but also to ensure that every citizen enjoys at least a certain minimum of welfare—income, food, clothing, shelter, and health care (Rawls, 1971; Daniels, 1985). Applied to ART, this view of government might include infertility treatment within the scope of guaranteed minimum health services.

The Committee is aware that the general role of government in the delivery of health care services differs among the countries that have devoted the most detailed discussion to ART. The Committee clearly subscribes to the view that government should intervene to prevent substantial harm to offspring, for example, by requiring donor screening if such screening is not voluntarily practiced by sperm banks or health practitioners involved in the donation process (Appendices B and C). The Committee discusses the role of government in more detail in chapters 2, 3, 5, 27, and 29. As is apparent in these chapters, the Committee’s view of government’s appropriate role includes elements of both the second and third views outlined above.

PRINCIPLES

Contemporary moral philosophers have identified three ethical principles that underlie particular moral judgments: respect for autonomy, beneficence, and justice (Beauchamp, 1994).

Respect for Autonomy

The principle of respect for autonomy acknowledges a sphere in which the individual should be free to exert control. One classic formulation of this principle, in John Stuart Mill’s On Liberty, is that individuals should be able to choose freely what they will do, unless or until their actions cause serious harm to others or seriously limit others’ liberty. This principle is closely related to the liberty rights discussed in chapters 2 and 5. It is also clearly pertinent to the notion of informed consent, for only well-informed and uncoerced persons can make autonomous choices (chapter 3). The principle of autonomy provides the basis for our concern about protecting confidentiality, particularly in the context of gamete or preembryo donation.

Beneficence

Beneficence includes two distinct aspects. Positively, it refers to promoting the welfare of others.
Negatively, it refers to "doing no harm" to other persons. The principle of beneficence has traditionally faced at least two major problems. The first is identifying whose welfare or harm is to be taken into account. In discussions of ART, especially of research with human preembryos, a critical question will therefore be whether preembryos can be the objects of either benefit or harm (chapter 26). A second problem is the relative weight to be assigned to different kinds of benefits or harms. In the reproductive context, for example, physical harm to the wife must sometimes be compared with psychological benefits for her and her spouse.

In the following chapters on specific technologies, the Committee sometimes recommends measures for minimizing the possible harms associated with a specific reproductive technology (for example, chapters 15 and 25). In other cases, the Committee judges the potential harm of a technique to be so uncertain that it recommends the conduct of a clinical experiment or trial, rather than the immediate adoption of a technique into clinical practice (chapters 19 and 21). In still other cases, the Committee concludes, on the basis of extensive experience, that the risks of a technique are minimal (chapter 11).

Justice

Justice governs the distribution of liberties on the one hand, and harms and benefits on the other hand. Most people can agree on the formal principle of justice: "to everyone his or her due." What is more controversial is the answer to the question, "What is due to various individuals and on what basis is it due?" Several answers to this question have been proposed, including the following:

a. To everyone according to his or her merit
b. To everyone according to his or her need
c. To everyone an equal share
d. To everyone what he or she has acquired by proper means

Because justice is concerned in part with the distribution of benefits and harms, the question of who is included or excluded recurs again with this principle. Further, viewpoints of "what is due" will determine, in part, whether or not the inability of some members of society to afford ART is regarded as an ethical problem. If one accepts answer a or d above, the de facto lack of access may not be seen as an injustice. However, if one accepts answer b or c, then economic exclusion from access may be viewed as unjust (chapter 5).

ETHICAL THEORIES

Some ethical theories give precedence to one of the above three principles in any case of conflict among the principles. In a sense, one principle always takes precedence over the other two. For utilitarians, the principle of beneficence is always uppermost; for libertarians, the principle of respect for autonomy; for egalitarians, a particular understanding of the principle of justice.

In this report, the Committee has been unwilling to assign universal precedence to any of the three principles. Concern for the potential harms and the long-term social impact of ART looms large in the Committee's thinking, but so does respect for the autonomy of persons making reproductive decisions and the autonomy of researchers and clinicians who develop or offer these technologies. The principle of justice informs the Committee's efforts to avoid discriminating against particular groups and the Committee's interest in the problem of access. Thus, the Committee is pluralistic in its ethical theory, holding the three ethical principles in tension and regarding each of the three as fundamentally important. Each informs the Committee's consideration of what is due to the person integrally and adequately considered (chapter 1).

Recent Writings and Developments on These Issues

In March 1987, six months after the publication of the original version of this Report, the Vatican's Congregation for the Doctrine of the Faith released a major position paper entitled Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation (Vatican, 1987). This document articulated and sought to defend the conservative position on several of the issues surveyed in this chapter. The Ethics Committee of The American Fertility Society published a response to the Vatican Instruction in 1988 (Appendix E).

The Office of Technology Assessment (OTA), an agency of the United States Congress, produced a comprehensive report on ART in 1988. Chapter 11 of that report, which is entitled Infertility: Medical and Social Choices (United States Congress, 1988), surveys issues like those treated here. The OTA report also provides an overview of ethical and policy discussion outside the United States in its Appendix E and a review of religious perspectives in its Appendix F.
Chapter 5

The moral right to reproduce and its limitations

According to Article 16.1 of the United Nations Declaration of Human Rights, "Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and found a family" (United Nations, 1978). The goal of this chapter is to explore the scope and possible limits of the moral right to "found a family."

Moral philosophers generally distinguish two types of rights: negative (liberty) rights and positive (welfare) rights. Applied to the question of procreation, a liberty right would encompass the moral freedom to reproduce or to assist others in reproducing without violating any countervailing moral obligations. A welfare right to reproduce would morally entitle one to be assisted by another party (or other parties) in achieving the goal of reproduction.

THE LIBERTY RIGHT TO REPRODUCE

The thesis of this section is that the moral right to freedom in reproductive decisions may be limited, whereas the legal liberty right is virtually unlimited in current United States constitutional law. Because discussions of moral rights usually postdate and frequently borrow from discussions of legal rights, this section begins with a discussion of legal rights.

The United States Supreme Court has reviewed the liberty right to reproduce primarily in two contexts: the proposed sterilization of a criminal or of a mentally retarded person and access to contraceptive measures. In a line of important decisions between 1942 and 1977, the Supreme Court clearly affirmed the right of couples to use contraceptives to avoid pregnancy and indicated its strong support for procreative liberty, particularly the procreative liberty of married persons. Presumably, this sphere of procreative liberty would be broad enough to include a couple's freedom to employ an available technique for assisting in reproduction (Flannery, 1979).

However, our moral obligations are sometimes more stringent than our legal obligations. Reciprocally, our moral rights may be narrower in their scope than our legal rights. In addition, ethical standards, unlike legal rules, are generally not enforced by the coercive power of the state. Thus, a greater role may be given to moral suasion or moral counseling.

The ethical question "What are appropriate limitations on the moral right to reproduce?" can also be formulated as follows: "Under what circumstances does one have a moral obligation to refrain from reproducing or from assisting others in reproducing?" In the Committee's view, these questions should be considered by everyone who is considering reproduction, whether by conventional or by technically assisted means. If one remembers that the ethical sphere is one for thoughtful discussion or counseling, rather than for coercion, then these questions can be considered calmly, without fear of governmental intrusion.

Parents

There are at least six grounds on the basis of which one might have a moral duty not to reproduce, that is, on the basis of which one's liberty right to reproduce might be ethically constrained. The last three of these grounds remain controversial.

Transmission of Disease to Offspring

Past discussions of this constraint on the moral right to reproduce have centered on the transmission of genetic or chromosomal abnormalities to one's offspring (Haering, 1976). One ethicist has even sought to develop an "ethic of genetic duty" (Ramsey, 1970). According to this view, couples whose members both carry a serious genetic defect have a moral obligation to refrain from producing children who have a high risk of being afflicted with the defect. In more recent times, men and women infected with the human immunodeficiency virus
(HIV) have faced the moral question of whether they should bear or beget children and thereby place the children at risk of contracting this devastating infection (see chapter 28).

Unwillingness to Provide Proper Prenatal Care

Some congenital defects are caused by the voluntary behavior of the parents. Fetal damage caused by substance abuse is one example of a teratogenic effect of maternal behavior. Similarly, a husband's exposure of his wife to toxic chemicals or sexually transmitted disease could be deleterious both to her and to the fetus that she is carrying. Unless a couple is prepared to "be good to the baby before it is born," the couple ought not, from a moral point of view, conceive a child.

Inability to Rear Children

Constitutional law emphasizes the liberty of couples to make decisions about bearing or begetting children. However, a positive decision to bear or beget, unlike a decision to employ contraceptives, normally carries with it an obligation not only to bear or beget but also to rear a child to adulthood. Therefore, it can be argued that a person who is not in a position to take on the responsibilities of providing food, clothing, shelter, education, and health care for a child ought not, from an ethical standpoint, have a child (O'Neill, 1979).

Psychologic Harm to Offspring

Some critics of technologically assisted modes of reproduction—particularly those involving third parties—contend that these modes could produce psychologic damage to children who later discover the circumstances of their conception. Like the data on the psychologic effects of adoption, the data on the potential harm to children are currently inconclusive. Such harm therefore remains speculative.

Overpopulation

Some commentators have argued that when the population of a region or nation already places a serious strain on available resources, that fact of life may place a constraint on the liberty right to reproduce (Bayles, 1979). One thinks, for example, of severe food shortages that have occurred in some nations. However, this possible ethical constraint on the moral right to reproduce does not seem to apply in the context of the United States at present.

Nonmarriage

It can also be argued that single persons or homosexual couples ought not to bring children into the world. This view holds that it is helpful for children to have role models of both genders. However, changing patterns of family life, particularly with respect to divorce and adoption, have called the traditional presumption into question. Other things being equal, the Committee regards the setting of heterosexual marriage as the most appropriate context for the rearing of children. But because other factors are often not equal, the Committee is willing to accept the view that nontraditional arrangements can be compatible with a nurturing environment and hence compatible with the moral right to reproduce.*

The common thread running through these six possible constraints on the moral right to reproduce is a concern about harm, particularly harm to the child, but also harm to the public good. In light of the foregoing discussion, it seems reasonable to say that couples have a liberty right to reproduce, limited by ethical constraints. This right is a moral right that exists independently of statutory, constitutional, or case law. The moral right to reproduce would seem to encompass the freedom to resort to newly developed means for assisting reproduction.

The Committee would include within the moral right to reproduce the freedom to enlist the services of third parties in cases in which one or both members of the couple are physically incapable of reproducing by themselves. (However, see Appendix A.)

* We believe that the child's best interest is served when it is born and reared in the environment of a heterosexual couple in a stable marriage. Therefore, we find it, in general, ethically questionable to offer infertility services to single individuals who do not provide this most appropriate environment. We realize that the practice is too recent to have generated serious studies. Our reservations stem from the overall desirability of a stable marriage for the child's welfare. In this connection see, for example, Hetherington (1989) and Amato (1993). (RAM, HWJ)
Donors

Two of the above six constraints also apply to prospective donors whose assistance in reproduction may be requested.

Transmission of Disease to Offspring

The freedom to serve as a provider of gametes or as a surrogate mother or carrier—either with or without remuneration—should be constrained by the moral duty not to transmit genetic or infectious disease. For this reason, prospective gamete donors or surrogates have a moral obligation to disclose familial genetic problems and to cooperate in appropriate screening programs.

Unwillingness to Provide Proper Prenatal Care

The freedom to serve as a surrogate mother should be constrained by the moral duty to adopt a healthy lifestyle for the sake of the fetus that one is carrying on behalf of an adopting couple. This constraint may require special emphasis because the surrogate knows that she will not bear long-term responsibility for rearing the child that she is carrying.

THE WELFARE RIGHT TO ASSISTANCE IN REPRODUCTION

The majority of persons seeking to reproduce need no assistance in order to initiate a pregnancy. However, a substantial minority of couples, perhaps 1 in 12 in the United States (Mosher, 1990), need assistance if they are to reproduce at all or if they are to reduce the probability of transmitting a serious disease to their offspring. In addition, some single persons desire to reproduce. Couples or single persons in this position might choose to assert moral welfare rights against three distinct types of moral agents: (a) health professionals, (b) gamete providers or surrogates, and (c) society at large.

Health Professionals

In this case, a single person or a couple would claim, as a moral entitlement, the assistance of health professionals in overcoming infertility problems or possible disease-transmission problems. There are health professionals who have expertise in the alleviation of such problems. However, it is not clear that any particular health professional—or health professionals as a group—has a moral obligation to provide such service to infertile couples, unless a satisfactory mutual agreement to enter into a professional-patient relationship can be worked out. Any other view on this question would seem to violate the liberty rights of health providers.

Gamete Providers or Surrogates

A given couple may need the assistance of a sperm or an oocyte provider (often called a “donor”) or of a surrogate mother if the couple is to have a child who is in some sense the couple’s own. However, generally it would appear that no particular person has a moral obligation to provide assistance to a particular couple or to infertile couples. Particular persons may, at their discretion, agree to come to the aid of such couples, but such assistance is likely to be either a benevolent gift or the sale of a service, not the fulfillment of a strict moral obligation.

Society as a Whole

Perhaps the most difficult question in this chapter is whether infertile couples have any special moral welfare rights against the larger society in their quest to overcome involuntary infertility or other reproductive difficulties. The correlative question, phrased in terms of obligations, is this: “Does the larger society have any special moral obligations to infertile couples?”

If one accepts the notion that society as a whole ought to provide volunteer subjects for nontherapeutic research or whole blood for transfusion or organs for transplantation, then one might accept the notion that society as a whole ought to encourage its members to provide gametes for couples who are physically incapable of producing functional gametes. In fact, Great Britain and France seem to have moved toward voluntary nonprofit systems for fulfilling this perceived obligation (Great Britain, 1984). This general obligation of society would, of course, not apply to any member of the society who is conscientiously opposed to gamete donation. Also, it seems unlikely that such a system would be adequate for surrogate motherhood arrangements (HFEA, 1990).

Society may have a moral obligation to provide, either directly or indirectly, access to health services for the treatment of infertility. One approach
to the resolution of this problem is that taken in the United States by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. In its report entitled Securing Access to Health Care (1983), the Commission argued that society has an ethical obligation to provide an adequate level of health care to every citizen. If this general obligation is accepted as binding, the specific question in the case of noncoital reproduction becomes this: Is ART for infertile couples included within the notion of "an adequate level of health care?" This is surely a controversial question, one that will need to be addressed through surveys of public opinion and an open, democratic policy-ranking process. In the United States by 1991, 10 states† had passed legislation requiring that certain types of infertility benefits be included in at least some health insurance policies written in those states. Some countries have even broader coverage (e.g., Australia, United Kingdom, Canada, and Israel).

† States requiring coverage of IVF in at least some situations (and year that legislation was enacted): Maryland (1985), Arkansas (1987), Hawaii (1987), and Illinois (1991); states requiring infertility diagnosis and treatment including IVF: Massachusetts (1987) and Rhode Island (1989); state requiring infertility diagnosis and treatment excluding IVF: New York (1989); states requiring insurance companies to offer IVF and/or infertility diagnosis and treatment: California (1989), Connecticut (1989), and Texas (1987).
Chapter 7

Commercialization

BACKGROUND

Marketing provides the public with information regarding products or services to enable potential consumers to select among various options available. Advertising is a component of marketing that has developed into a major industry, utilizing influential techniques that highlight specific advantages of products and/or services to make them more attractive than those of competitors. By embellishment of the most attractive aspects of a given product or service, consumers can be motivated to select that offering over others. In essence, the mode of advertising influences freedom of choice (Beauchamp, 1984). When advertising and/or marketing is presented accurately and incorporates a fair statement of the disadvantages of the specific product or service, it provides reliable information that facilitates an informed choice. However, by focusing on the attributes of a given product or service, while minimizing other less positive characteristics, the advertiser or marketer creates an incomplete picture of the particular item being advertised or marketed. The lack of a balanced perspective is contrary to the standards held for the physician or other healthcare provider who renders information about a treatment or procedure that influences primarily an individual's health or welfare. The information, for example, provided in a package insert for a pharmaceutical product or the wording of an informed consent document that is executed prior to a medical procedure must be complete, objective, and presented in an unbiased manner.

The primary purpose of providing information in a medical context is to educate the patients, thereby enabling them to make informed choices. Until relatively recently, it was considered unethical for physicians to advertise. Since legal obstacles to advertising by physicians were lifted, advertising and marketing have been widely used to attract patients. This approach raises the possibility of conveying a false or incomplete message. Such a message runs the risk at one extreme of injuring or at the other of not helping the targeted individual(s). Although it is possible via legal channels to recover for some injuries sustained as a result of misrepresentation, all misrepresentation is considered unethical.

RECOMMENDATIONS

Information directed toward patients includes advertisements, brochures, and direct discussion. All information disseminated should be true and accurate. Advertising and brochures must not be misleading. Information shared directly with potential patients should be scrupulously accurate and should disclose all accurate information that a reasonable patient would want to know (see chapter 6). In view of the above considerations, the following guidelines are offered with respect to ART.

a. The specific procedure(s) offered must be accurately described in language understandable to prospective patients.

b. In the case of a novel procedure, utilized rarely or never before, the patient should be made aware of the experimental implications. Procedures viewed as clinical experiments (see Glossary) are not considered suitable for advertising and/or marketing.

c. The success rate for each ART center and how it is derived by that center or provider (e.g., for IVF: woman's age, sperm status, and cryopreservation) should be disclosed to its patients (Society for Assisted Reproductive Technology, 1993).

d. The number of specific procedures performed by that individual and/or program should be disclosed (Society for Assisted Reproductive Technology, 1993).

e. The patient should be informed that program-specific data are available for certain ART procedures by contacting The American Fertility Society (The American Fertility Society, 1993a).

f. The qualifications (e.g., training and experi-
ence) of the healthcare providers must be presented to each patient.

g. The use of incomplete, misleading, inaccurate marketing devices (e.g., erroneous or misleading certification) is condemned.

h. The opportunity to obtain additional opinions is encouraged.

All of this information should be conveyed in an educational manner in which dialogue between the couple and the medical team is promoted.

Chapter 10

The moral and legal status of the preembryo

Many issues in noncoital reproduction concern the actions that may appropriately be taken with preembryos. In vitro fertilization is of great significance because it isolates the preembryo and makes it accessible to observation or intervention. The status of the preembryo must therefore be considered apart from the status of embryos and fetuses at more advanced stages of development within the mother’s body.

The moral and legal status of the preembryo will determine the limits of actions and omissions of actions regarding preembryos and thus the freedom that physicians and patients have in activities concerning preembryos. The main issues that depend on preembryo status are these: (a) what can be done to preembryos before transfer, (b) whether all preembryos must be transferred and, if not, (c) what can be done to preembryos that are not transferred.

The questions raised are novel but not unanswerable. Although the extracorporeal preembryo has never had to be considered before, legal and moral principles exist to guide analysis and evaluation of this new situation. This chapter describes various positions in the debate over preembryo status and the consensus that is emerging among deliberative groups that have addressed the issue.

Some of the disputes and uncertainties about preembryo status result from the failure to distinguish carefully between preembryos and more advanced embryos and fetuses.*

As noted in chapter 9, the preembryo is a living, genetically unique entity with a statistical potential to implant, if exposed to a receptive uterus, and to be delivered as a newborn infant. Through organogenesis, the preembryo gives rise to the far more complex embryo, which in turn is succeeded by the rapidly growing and maturing fetus.

There has been a tendency among opponents in the abortion debate for individuals to carry over their views about the fetus to the preembryo (Robertson, 1986). But the preembryo differs substantially not only in its potential but also in both its biological nature and its extraterrestrial location, whether in vitro or in vivo. Accordingly, the moral and legal status of the preembryo should be considered on its own merits with these differences in mind.

DIFFERENT POSITIONS IN THE DEBATE OVER PREEMBRYO STATUS

Three major ethical positions have been articulated in the debate over preembryo status (chapter 4). At one extreme is the view of the preembryo as a human subject after fertilization, which requires that it be accorded the rights of a person. This position entails an obligation to provide an opportunity for implantation to occur and tends to ban any action before transfer that might harm the preembryo or that is not immediately therapeutic, such as freezing and some preembryo research.

At the opposite extreme is the view that the preembryo has a status no different from that of

* The preembryo is a multicellular aggregate without even rudimentary human form. If transferred to a receptive uterus, an individual preembryo has only a moderate chance of developing to term. Moreover, it is not yet established as a single individual, being able under unusual circumstances to undergo twinning to yield two or more individuals, or fusion with another preembryo to become a composite embryo. The preembryo is therefore not yet developmentally stabilized as a single individual.

The embryo, on the other hand, is developmentally single, more complex, and significantly more likely to develop to term. Normally it is imbedded in the wall of the uterus and is developing bodily form and various organs, thereby advancing in size, structure, and specialization of both form and function. Near the end of the embryonic period, neuro-musculo-skeletal maturation is sufficient to permit primitive movements, marking the onset of behavior.

In IVF and related forms of medically assisted reproduction, the preembryo may not be situated within a woman’s body. A woman’s interest in controlling the conceptus differs from her interest in controlling an extracorporeal preembryo that she does not wish transferred to her uterus.
any other human tissue. With the consent of those who have decision-making authority over the preembryo, no limits should be imposed on actions taken with preembryos.

A third view—one that is most widely held—takes an intermediate position between the other two. It holds that the preembryo deserves respect greater than that accorded to human tissue but not the respect accorded to actual persons. The preembryo is due greater respect than other human tissue because of its potential to become a person and because of its symbolic meaning for many people. Yet, it should not be treated as a person, because it has not yet developed the features of personhood, is not yet established as developmentally individual, and may never realize its biologic potential.

EMERGING CONSENSUS ON PREEMBRYO STATUS

An analysis of the question of preembryo status shows that there is considerably more consensus than is generally recognized. When law, ethical commentary, and the reports of official or professional advisory bodies are consulted, there is a wide consensus that the preembryo has a special moral status but not a status equivalent to that of a person.

The Ethics Advisory Board, for example, unanimously agreed in 1979 that “the human embryo [i.e., preembryo in this report] is entitled to profound respect, but this respect does not necessarily encompass the full legal and moral rights attributed to persons” (Ethics Advisory Board, 1979).

In 1984, the Warnock Committee took a similar position when it stated that “the human embryo . . . is not under the present law of the United Kingdom accorded the same status as a living child or an adult, nor do we necessarily wish it to be accorded the same status. Nevertheless, we were agreed that the embryo of the human species ought to have a special status” (Great Britain, 1984).

The Ontario Law Reform Commission (Canada, 1985), which completed an extensive review of the issue in 1985, also took this view, as have nearly all other professional and official advisory bodies that have reviewed the question of preembryo status (Walters, 1985). Only groups holding the view that “personhood” begins at conception have taken a different position.

The advisory body conclusions parallel the traditional Anglo-American legal view of prenatal life.

Given the legal precedents about fetuses of more advanced development, it is extremely unlikely that American law would assign to the preembryo the rights of persons (Flannery, 1979; Ethics Advisory Board, 1979). The law does not regard fetuses or embryos as rights-bearing entities, although it has recognized that prenatal actions could affect the postnatal well-being of persons. Currently, with few exceptions the preembryo is not a legal subject in its own right and is not protected by laws against homicide or wrongful death (Robertson, 1990). The preembryo generally has legal cognizance only if the interests of an actual person are at stake, such as when transfer occurs and offspring may be affected or when someone wrongfully interferes with the authority of another person to determine disposition of the preembryo (NY Times, 1978).

The biology of early human embryo development is relevant to an assessment of our obligations to the preembryo. As we have seen in chapter 9, the preembryo does not have differentiated organs, much less the developed brain, nervous system, and capacity for sentience that legal subjects ordinarily have. Indeed, the preembryo is not yet individual, because twinning or mosaicism can still occur. Thus, it is not surprising that the law does not recognize the preembryo itself as a legal subject.

THE MEANING OF SPECIAL RESPECT

Therefore, we find a widespread consensus that the preembryo is not a person but is to be treated with special respect because it is a genetically unique, living human entity that might become a person. In cases in which transfer to a uterus is possible, special respect is necessary to protect the welfare of potential offspring. In that case, the preembryo deserves respect because it might come into existence as a person. This viewpoint imposes the traditional duty of reasonable prenatal care when actions risk harm to prospective offspring. Research on or intervention with a preembryo, followed by transfer, thus creates obligations not to hurt or injure the offspring who might be born after transfer.

On the question of whether all preembryos must be transferred to a uterus and whether research can be done with nontransferred preembryos, the demands of special respect are less clear. Persons who view the preembryo itself as a human subject with the same rights as newborn infants would require that all preembryos be transferred and would
greatly limit nontherapeutic research with non-transferred preembryos. Others may agree that preembryos should be transferred whenever reasonably possible but would allow discard and preembryo research in certain circumstances.

DECISION-MAKING AUTHORITY AND THE PREEMBRYO

Currently, the responsibility for establishing policies on the transfer or nontransfer of preembryos lies with the programs that offer medical assistance in reproduction. Each program should develop and announce to candidate couples explicit policies on the options of transfer, donation, preembryo research, storage, and discard. These policies should be developed in the light of ethical and legal considerations like those discussed in this report.† In developing and implementing such policies, programs should seek to avoid coercing couples. Program policies on these issues should be reviewed in advance by Institutional Review Boards or other authorized and legitimate authorities (chapter 27).

Within the limits set by institutional policies, decision-making authority regarding preembryos should reside with the persons who have provided the gametes. Gamete providers may, at their discretion, transfer this decision-making authority to other persons. As a matter of law, it is reasonable to assume that the gamete providers have primary decision-making authority regarding preembryos in the absence of specific legislation on the subject. A person's liberty to procreate or to avoid procreation is directly involved in most decisions involving preembryos. Analogously, the right of persons to control the disposition of organs, tissue, and body parts is recognized in laws governing live and cadaveric anatomic gifts, such as the Uniform Anatomical Gift Act.

Persons with dispositional control over preembryos should also be able to exercise such control by prior agreements or directives entered into at the time of forming, storing, or transferring preembryos. Such agreements should be viewed as binding on all the parties in the event of divorce, death, dispute, or later unavailability. They should be subject to alteration at any later time if all parties are agreed. Honoring such agreements will give all parties advance certainty about their rights and duties, and avoid litigation to solve such disputes. Davis v. Davis (1), a divorce case involving a dispute over disposition of seven frozen preembryos, arose because no agreement for preembryo disposition had been signed. In resolving that case, the Tennessee Supreme Court indicated that such agreements would be given binding effect in resolving future disputes.

† This statement offers little guidance because there are no clear ethical and legal conclusions offered with regard to the preembryo. For instance, there are no guiding principles in control of the decision to transfer or not to transfer a particular preembryo. In effect, then, each program can draw up its own policies in a way that will practically dissolve any realistic concern for the preembryo (RAM).

REFERENCE