Ethical Issues in Reproductive Medicine

2019

1. Introduction

1.1 Patients have the right to make their own decisions about reproduction and the use of available reproductive medicine. Access to reproductive medicine should be free from political or religious interference.

1.2 Reproductive medicine has an evolving and expanding role in health. In addition to the more traditional clinical services known as 'family planning' – contraception, sterilisation and abortion – reproductive medicine now encompasses many other roles. These include not only female and male infertility and their diagnosis and management but increasingly the management of inherited diseases. Assisted reproductive technologies (ART) such as in vitro fertilisation (IVF) techniques are employed to provide options for carriers of genetic mutations, for fertility preservation in cancer and newer services such as egg freezing.[1]

1.3 A patient who seeks or has undertaken any form of reproductive medicine should not be subject to discrimination or stigmatisation.

1.4 A patient must not be forced or coerced into undertaking (or not undertaking) any form of reproductive medicine.

1.5 Doctors who choose to provide clinical services, or conduct research, in reproductive medicine should not be subject to discrimination or stigmatisation.

1.6 Doctors who have conscientious objections should not be expected to participate in clinical or research activities to which they have an objection. A doctor's refusal to provide, or participate in, a treatment or procedure based on a conscientious objection, however, directly affects patients and the doctor has an obligation to inform the patient of their objection and minimise disruption to patient care. In an urgent situation where other care is not available (for example, complications of an abortion in a rural area), there is a clear obligation to provide and continue care for the patient until such time as other options are available. Doctors must never use a conscientious objection to intentionally impede patients' access to care.[2]

1.7 Clinical research into reproductive medicine should be conducted within the prevailing ethical, social, medical and legal frameworks.

1.8 There should be uniformity and clarity of all legislation related to reproductive medicine. Doctors should be familiar with relevant State, Territory and Commonwealth legislation.

2. Family planning

2.1 Access and consent to services

2.1.1 Everyone should be aware of, and have access to, family planning information and affordable services.

2.1.2 The ability to regulate and control fertility is fundamental to the physical, mental and social well-being of females of reproductive age. Family planning can contribute to the survival and health of mothers and children.

[1] Assisted reproductive technology (ART) is defined as the application of laboratory or clinical techniques to gametes and/or embryos for the purposes of reproduction. National Health and Medical Research Council (2017*). Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research.* Canberra: National Health and Medical Research Council.

[2] Refer to AMA *Position Statement on Conscientious Objection 2019* for further information.

2.1.3 It is important to recognise that males of reproductive age have specific reproductive health needs.

2.1.4 Doctors have an important educational role in informing patients about family planning options, their risks and benefits, both physical and psychological, including information about sexually transmitted infections. Any treatment affecting an individual's reproductive capacity also has potential implications for that person's partner. A patient should be encouraged to discuss such treatment with their partner.

2.1.5 People with impaired capacity should be included in the decision-making process regarding their use of reproductive medicine as with all medical treatments.

2.1.6 Where a person under the age of 18 years has decision-making capacity, and wishes that treatment to remain confidential, then doctors should respect and maintain that confidentiality.[3] When appropriate, such an individual should be encouraged to make decisions regarding family planning in collaboration with adult family members or guardians.

2.2 Contraception

2.2.1 There should be wide community education about all forms of contraception including emergency contraception.

2.2.2 Contraception can offer numerous physical and psychological health benefits. As with all medical treatments, these benefits should be weighed against potential side effects and complications.

2.2.3 Females should have access to emergency contraception.

2.3 Sterilisation

2.3.1 Despite advances in IVF, it is important that patients considering sterilisation procedures proceed on the basis that they will be undergoing potentially irreversible procedures.

2.3.2 Doctors should familiarise themselves with current legal requirements where the person lacks capacity to consent to the sterilisation procedure.

2.4 Abortion

2.4.1 Doctors hold differing views regarding abortion. Where a doctor has a conscientious objection to abortion, they must inform the patient of their objection and ensure the impact of a delay in treatment does not constitute a significant impediment to the patient accessing services. The doctor must take whatever steps are appropriate to ensure the patient's access to care is not impeded. Due to the time critical nature of abortion services, in some circumstances providing the patient with sufficient information on accessing such services may be sufficient while other situations may require an effective referral to another practitioner.

2.4.2 There should be equity of access across Australia to appropriate abortion services which should involve a multi-disciplinary team under the leadership of a doctor.

2.4.3 Medical abortion should be made available in cases where it is medically deemed to be a safe and appropriate option.

[3] This is often referred to as the 'mature minor' or 'Gillick competence' in reference to the 1986 English House of Lords judgment, Gillick v West Norfolk and Wisbech Area Health Authority, or the 'mature minor' doctrine. In certain Australian States or Territories, specific legislation covers the medical treatment of children while other States and Territories refer to the common law.

3. Assisted Reproductive Technologies

3.1 In vitro fertilisation (IVF)

3.1.1 IVF may require a gamete (sperm or ova) or embryo donor. Donation should follow counselling and be carefully regulated to avoid abuses including coercion of potential donors. It is inappropriate to offer money or benefits in kind to encourage donation but donors may be reimbursed for reasonable expenses.

3.1.2 Gamete donors should have the right to withdraw consent to donation at any time prior to insemination or fertilisation. Embryo donors should have the right to withdraw consent to donation any time prior to transfer of the embryo into the uterus of the recipient. Consent cannot be withdrawn once the donated gamete or embryo has been used.

3.1.3 Individuals should be fully informed of the benefits and potential risks, both physical and psychological, and be given realistic and personalised information about the outcomes of IVF. They should be informed of the psychological and social supports available and referred for assistance when appropriate.

3.1.4 In order for the child and their family to be medically informed throughout the child's life, where donor gametes have been used they should be able to access health and genetic information related to the donor(s).

3.2 'Surplus' gametes or embryos

3.2.1 ART may result in storage of gametes or embryos that are not used to treat those from whom they were obtained. These 'surplus' gametes and embryos may be stored, cryo-preserved for future use, donated to other patients, disposed or donated for research in accordance with established regulations. These available options must be explained clearly and precisely to individuals before donations are made. Any patients considering ART should be aware of the significant ethical, legal and social implications of gamete and embryo donation. Of particular significance is the fate of embryos where the couple do not remain in a relationship or where one person dies.

3.3 Pre-implantation genetic diagnosis (PGD)

3.3.1 PGD is a procedure used prior to embryo transfer to detect serious genetic conditions, diseases or abnormalities, which the gamete provider(s) are known to be at risk, to carry or to be predisposed.[i]

3.3.2 The use of PGD should be reserved for cases associated with serious diseases or conditions. The use of PGD techniques to select embryos on the basis of traits not associated with disease should be forbidden.

3.4 Artificial insemination and ovulation induction

3.4.1 The same principles as those outlined in Section 3.3 apply to artificial insemination and ovulation induction.

4. Surrogacy

4.1 Surrogacy arrangements managed by ART units typically involve several clinical situations. In the commonest, a woman who has eggs but who either cannot, or cannot safely, carry a pregnancy has the embryo created from her eggs transferred to the uterus of another woman (the surrogate[4]). Examples would include women who have undergone hysterectomy for cancer, women who were born without a uterus or women who have medical conditions that make it unsafe or impossible to carry a pregnancy.

[4] In accordance with the National Health and Medical Research Council's (NH&MRC) ethical guidance on assisted reproductive technology, a surrogate refers to an individual who carries a pregnancy for another individual.

4.2 Once such a pregnancy is established, the doctor's ethical and medical obligations to the surrogate mother and fetus are the same as those afforded any pregnant woman. A pregnant woman has the same rights to privacy, to bodily integrity, and to make her own informed, autonomous health care decisions as any other competent individual, consistent with the legal framework of that jurisdiction.[ii]

4.3 The surrogate mother, as well as the commissioning parents, require appropriate counselling and support before, during and after the surrogacy process.

4.4 It is inappropriate to offer money or benefits in kind to encourage surrogacy but they may be reimbursed for reasonable expenses; for example, verifiable out-of-pocket expenses directly associated with the surrogacy procedure, pregnancy or birth.[5,i]

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[i] National Health and Medical Research Council (2017). *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research.* Canberra: National Health and Medical Research Council.
[ii] Australian Medical Association. *Position Statement on Maternal Decision-Making 2013.*

[5] The NH&MRC's ethical guidance on assisted reproductive technology lists the following examples of verifiable out-of-pocket expense directly associated with the procedure or pregnancy, which may include: • medical and counselling costs, before, during and after the pregnancy or birth • travel and accommodation costs within Australia • loss of earnings• insurance • child care costs when needed to allow for attendance at appointments and procedures related to the surrogacy arrangement • legal advice. The NH&MRC notes there may be State or Territory legislation that regulates what out of-pocket expenses can and cannot be reimbursed under a surrogacy arrangement.