Assisted reproduction and morality

George F Winter explores the complicated topic of assisted reproductive technology and the ethical and moral responsibilities that it may confer on those involved in assisted conception

In matters of medical ethics, it is inviting to infer that as the medical profession evolved, its members were motivated by patient-centred altruism to develop a code of practice that regulated the relationships between doctors and their patients and allowed ethical dilemmas to be resolved satisfactorily. However, such a view might need to be tempered by evidence adduced by Waddington (1984) on the evolution of medical ethics in England. For example, his analysis of 19th-century writings on medical ethics not only shows that 'medical men were no more given to abstract philosophical speculation than was any other section of the educated classes', but that 'ethical problems within the doctor-patient relationship [occupied] only a minor place' compared to resolving 'structural tensions within the profession' (Waddington, 1984).

Given this historical context, it does not necessarily follow that present-day medical professionals have a monopoly on wisdom – or even expertise – when it comes to how moral and ethical challenges might be best addressed. Indeed, it is perhaps the shifting nature of today's reproductive landscape that makes it imperative that patients, their families and healthcare professionals all develop an independence of thought. After all, if a degree of proportionality between the rights of the individual and those of the community is to be sought, it is essential that the views of as wide a societal spectrum as possible are canvassed.

But, as can be inferred from Scott (2018), the rate of change can be challenging, and

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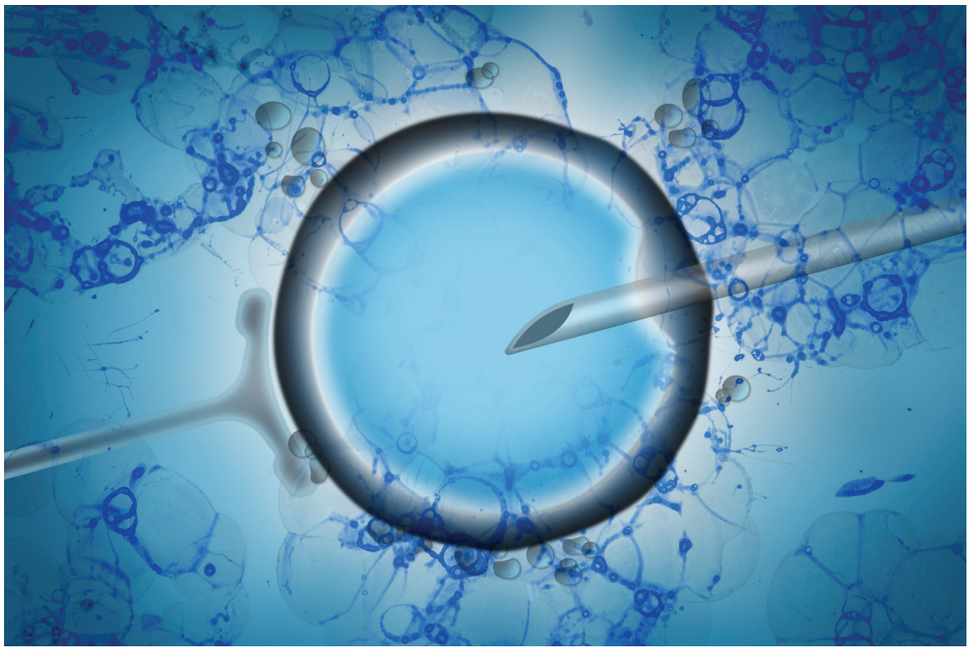

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There is debate over the responsibilities of healthcare professionals who aid conception through assistive reproductive technology. As participants in cases involving infertility and assisted conception, midwives may need to consider this issue

reproductive technologies that are not yet legal loom on the horizon: 'for instance, the moral and legal permissibility of nuclear genome editing technologies…to avoid serious genetic conditions in offspring… In these and other cases, questions will arise about the degree of need and the appropriate scope of autonomy'.

This appropriate scope of autonomy was considered by Gupta and Richters (2008), in relation to how assisted reproduction technology has transformed the female (potentially) 'reproductive' body into a 'productive' body, with marketable body parts, and they ask whether women 'are "agents" (subjects) in control over their own bodies and owners of its parts or are they "victims" (objects) of the new technologies and the actors and factors which drive their use?'.

It could be argued that one expression of the agency discussed by Gupta and Richters (2008) is the freedom to indulge in so-called 'procreative tourism', a term coined in 1991 to describe individuals who assert their personal reproductive choices by 'travelling from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire' (Pennings, 2002). The more widespread this phenomenon, the louder the call for international measures to stop these movements, but Pennings (2002) favoured such tourism, contending that reproductive tourism is an expression of tolerance that prevents conflict between 'the majority who imposes its view and the minority who

claim to have a moral right to some medical service.'

However, an assumed right to bodily autonomy is open to questioning from those who view assistive reproductive technology as a collaborative process involving a moral dimension. For example, one might consider egg or sperm donors, embryologists, fertility doctors etc as service providers who hold little, if any, meaningful parental relationship to offspring from assisted reproductive technology. However, Fahmy (2013) challenged this view by asserting a principle of procreative responsibility and suggesting that by considering all the participants in assisted reproductive technology as 'accessories to procreation' they are all 'participating in a supply chain designed to bring about new persons'. As such, fertility industry standards 'should be structured such that they permit, facilitate, and encourage agents to satisfy the requirements of procreative responsibility' (Fahmy, 2013). It is a persuasive argument, yet as Singer (1979) made clear, while some people can display a sensitivity to general issues of justice and ethics, 'others, for a variety of reasons, have only a limited awareness of such principles'.

But should a limited awareness disqualify a competent individual from expressing a view, especially if such an individual is an assisted reproductive technology participant, as described by Fahmy (2013)? Not necessarily, with Hall (2023) suggesting that 'clinician and state join the non-sexual reproductive project at the point of triggering conception' and claiming that having a child amounts to more than the provision and regulation of healthcare, 'it generates rights and confers responsibilities on all who join this morally significant project'. Hall (2023) also made the interesting point that all collaborators in assisted reproductive technology can choose whether to participate or not, something that is intuitively understood in the sexual sense, but where non-sexual reproduction is concerned, it is 'a pluralist pursuit that morally implicates more than the genetic and gestational contributors'.

How relevant is the foregoing to midwifery? The issue of bodily autonomy and the assertion of an assumed moral right to have a child through assisted reproductive technology raises questions both for prospective parents and – as Fahmy (2013) and Hall (2023) indicated – potential collaborators in the process. Waddington (1984) showed that the medical profession is not always an infallible exemplar when medical ethics are discussed, and it might be that as assisted reproductive technology evolves, midwives may be (willing or unwilling) participants in the process. **BJM**

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