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Non-standard requests? – Ethical and legal aspects of medically assisted reproduction in singles, lesbian and gay couples, and transsexuals

Special Interest Group Ethics and Law

5

1 July 2012
Istanbul, Turkey

'Non-standard requests?' – Ethical and legal aspects of medically assisted reproduction in singles, lesbian and gay couples, and transsexuals

Istanbul, Turkey
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Organised by
the Special Interest Group Ethics and Law

Contents

Course coordinators

Guido M.W.R. de Wert (The Netherlands) and Wybo J. Dondorp (The Netherlands)

Course description

Aim: to scrutinize ethical and legal aspects of medically assisted reproduction in unconventional relationships and 'nonstandard sexual identities'.
Background: Medically assisted reproduction is mostly offered to heterosexual couples (either married or in a stable relationship). However, there is a variety of applications in unconventional relationships and in persons with 'nonstandard' sexual identities. This includes single women, lesbian couples, homosexual male couples and, more recently, transgender men and women. These nonstandard cases raise ethical and legal issues regarding access to (different forms of) medically assisted reproduction, regarding non-discrimination and centre/provider autonomy and regarding the welfare of the child. More generally, by challenging normative conceptions of reproduction, parenthood and sexual identity, these applications and requests have a wider relevance with regard to understanding the aim and place of medically assisted reproduction in modern society.

Target audience

The target audience consists of congress participants who as clinicians (counsellors, gynaecologists) are faced with 'non-standard' requests for help that they may find difficult to answer, participants with a general interest in the ethics of assisted reproduction, policy makers, etc.

Scientific programme

Chair: Guido De Wert (The Netherlands)

09.00 - 09.30	Assisted reproduction in single women: problematic or not at all? - **Berna Arda (Turkey)**
09.30 - 09.45	Discussion
09.45 - 10.15	Lesbian couples sharing biological motherhood: IVF for reproductively healthy women? – **Wybo Dondorp (Netherlands)**
10.15 - 10.30	Discussion
10.30 - 11.00	Coffee break
11.00 - 11.30	Two men and a baby: ethical and legal issues in surrogacy and egg donation for gay male couples – **Juliet Tizzard (United Kingdom)**
11.30 - 11.45	Discussion
11.45 - 12.15	Clinically assisted reproduction and fertility preservation with transgender men and women – **Timothy Murphy (USA)**
12.15 - 12.30	Discussion
12.30 - 13.30	Lunch

Chair: Wybo Dondorp (The Netherlands)

13.30 - 14.00	Welfare of the child: scrutinizing evaluation criteria – **Guido Pennings (Belgium)**
14.00 - 14.15	Discussion
14.15 - 14.45	Non-discrimination, human rights and institutional autonomy in the provision of assisted conception services – **Emily Jackson (United Kingdom)**
14.45 - 15.00	Discussion
15.00 - 15.30	Coffee break
15.30 - 16.00	Gifts with moral strings attached: Should gamete donors have a right to exclude non-standard couples/persons as recipients? -– **Christoph Rehmann-Sutter (Germany)**
16.00 - 16.15	Discussion
16.15 - 17.00	Concluding debate session – **Guido de Wert (The Netherlands)**

Assisted reproduction in single women; problematic or not at all?

Berna Arda (MD,Med Spec, PhD)
Ankara University, Faculty of Medicine, Medical Ethics Department
Ankara -TURKEY

- No conflict of interest
- No financial relationships with manufacturers of pharmaceuticals, laboratory supplies and/or medical devices

overview of the main points

- Aim and learning objectives
- Principalism in medical ethics
- Ethics - law relationship
- A legislation sample
- Belief systems
- Cultural approach and feminism
- As a conclusion
- References

Aim

to describe the ethical issues in assisted reproduction related with single woman

Learning Objectives

*to describe the principalism,
*to think about the social responsibility of science and the borders of sci- curiosity,
*to describe cultural, religious and feminist approachs
*to recognize the ethical problems which would release from the "unusual" requests in assisted reproduction.

Ethics, medical ethics

- A broad field over the prohibited and the permitted and draws the general tendencies of any given philosophical system
- A debate as to what is "right" and "wrong"
- The reflections to the medical field

Ethical theories and principalism

- Duty ethics, deontological approach (Kantianism)
- Utilitarianism
- Rights centered ethics(Liberal individualism)
- Virtue ethics
- Casuistry
- Narrative ethics
- Communitarianism
- **Principalism**

Basic ethical principles in medicine

- *nonmaleficence ("non nocere")*
- *beneficence*
- *respect for autonomy*
- *justice*

Ethics-Law Relationship

4 levels;

1st. "pure ethics topics", no universal agreement

2nd. "universal agreement" on general principles, no domestic legislation

3rd. domestic "soft" regulations, (no sanctions, no clear responsibilities yet)

4th. domestic strict legislation

A current legislation sample

- Republic of Turkey
- It is permissible for infertile couple
- No sperm bank
- "To have legitimate descendant"

The statute on IVF/ET centers

- "Regulation on Treatment Centers Assisting Reproduction" issued in 1987, revised in 1996 and 2005
- by units licensed by the ministry
- approved by a scientific committee

Criteria for patient selection

- being married,
- using ovum or sperm which belongs to the spouse only,
- being unable to conceive with known treatment methods,

Belief systems

Similar points between Jewish, Christianity and Islamic perspectives

in general; "permissible"

*a solution for infertile couple

*therapeutic aims

* "to be born in a marriage" is essential

Cultural approach and feminism

- Infertility is a serious problem from women point of view, especially in underdeveloping world.
- To be mother means struggle with the families, the circles, the societies.
- A few opposite views; *"ART is immorality of the western world", "intervening to Allah's function, is a sin", " is the society ready to accept such this applications?" "is ART it appropriate to the cultural body and family structure?"*
- Stigmatization seems to be a trouble.

Feminist approach

- Using ART by single women is an important point in feminist agenda.
- In 1970s, believe that if women resist the social and psychological pressure for motherhood, they have some freedoms and benefits that man already have

Changing tendencies in the world

- 1980s;
  new conservatism rises,
  "motherhood" is placed prominently and evaluated as an enrichment experience.
- 1990s;
  to give birth without a father gets importance on the feminist agenda

Feminism and sperm banks

- Like whether want to have a baby or not; using sperm donation should evaluated in the context of fertility rights, as an important part of human rights. Submit to sperm bank is a basic selection right related with own body and own sexuality. In this way, as an indicator of authority and power, penis loses its importance.

Feminism and the family

- Radical feminists argue that weakness of women and the gender contradictions based on family concept.
- Antropologic studies revealed the presence of gender equality in "paleolithic" period.
- Women is in the many areas from making pottery to agricultural production in this period.
- The incertanities related with sexuality has create a powerful and mystical women. No marriage in this period, who the father is unclear. To give birth into the society is sufficient of glorification of the women.

Feminism and the family

- Women had a powerful position in the mid and upper Paleolithic era.
- Engels emphasizes women's oppression is not something eternal, the emergence of the family institution of today has been synchronized with the emergence of property. The ownership and the accumulation of the property has create an institutional need legacy be transferred by the human beings. This is provided through the control of female body.

"to reject" the family concept

- Birth process has been controlled by the restriction of the female body and sexuality, determined by the birth control. The fatherhood and property have become important. For that reason, radical feminists reject the family institution.

Accept the biological destiny or not?

- Women's role generally limited with just birth and motherhood.
- Some authors believes reproductive technology should use as a solution to get rid of "biological destiny"

"To postpone death of penis is possible"?

- Men and women may release some of gender-based roles and responsibilities. The weakening of patriarchy will be possible in the continuation. To relieve from oppression of lesbians and homosexuals completely, will be possible, should be given the rights to become mother/parents "without men".

To protect state through by family

- The origin of state has been based on the family institution. For that reason, state has been protected the "family" (mother, father and children) by legislative means and health legislation has been based on the marriage.

As a conclusion

- Ethical "norm" need
- the question; "whether putting everything into effect which is sci-technically possible is justifiable or not"
- Determine the borders between "technically possible" and "ethically acceptable"

- Several studies revealed that father's absence has not negative effect on the social and emotional development of the children.
- Time to think about whether there is stigmatization for the children or not.

- New reproduction technics should not be create a sort of pressure on the parents and women especially.
- To protect the women does possible in the light of biomed-ethical principles?
- The accessibility of such technics should discussed.

- Labor of motherhood should evaluate on the "care labor" context
- Social rights and social supports should take for mothers in public means

- Some possible problems may occure in the future should not be accepted as an obstacle to women's fertility right.
- To give priority to women autonomy on her body; seems crucial in a Human Rights' based society.

- Why not the request of a single women for ART is possible in a human rights based society?

- Thanks for your participation and kind attention.

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Lesbian couples sharing biological motherhood: IVF for reproductively healthy women?

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Conflicting Interests

- I have no conflicts of interest to declare

Objectives

- Clarify the background of the proposition of shared biological motherhood as an option for lesbian couples
- Discuss different scenarios in which a request for Reception of Oocytes from Partner (ROPA) may arise.
- Show why the immediate reaction from the profession (they can have a child with donorinsemination) is inadequate.
- Stress the wider importance of the debate about ROPA: forces us to rethink the fundamental aims of Medically Assisted Reproduction (MAR).

Medically Assisted Reproduction (MAR) for Lesbian couples (1)

1. Normally fertile women
- MAR: donorinsemination (DI)
- Ethical issues:
  - 'social infertility'
  - creation of unusual families
    - welfare of the child at stake?
    - institution of marriage under threat ?

MAR for lesbian couples (2)

2. Lesbian couples with a fertility problem
- MAR:
  - IVF with donor sperm
  - IVF with donor sperm + donor oocytes
- Question:
  - what about the other partner having DI?

MAR for lesbian couples (3)

3. Lesbian couples wanting to share biological motherhood
- MAR: IVF resulting in:
  - *Genetic motherhood* for partner who provides the oocytes
  - *Gestational motherhood* for partner who receives the fertilized oocytes in her uterus, carries the pregnancy and gives birth to the child.
- Reception of Oocytes from Partner (ROPA)

BBC NEWS

One-Minute World News

Lesbian couple want 'rare IVF'

A lesbian is hoping to have a child using an egg donated by her partner, and donor sperm.

Lesbian couples regularly have babies using IVF treatment, but it is rare for a partner to donate an egg in such a way.

Must simply use donor sperm to inseminate one partner.

Hayley Marlow, 29, and Vicky Hill, 30, both from Banbury, said they wanted to have a baby this way so that the baby "truly came from both of them".

The couple who have been together for just over a year have spoken to their GP about their plans, but have not yet been referred to a consultant.

Ms Marlow told the Oxford Mail: "A lot of lesbians do have children using male friends as sperm donors but we want a baby that has truly come from both of us and the only way to do that is by me carrying Vicky's baby."

"We hope we will get some of the treatment on the NHS but it is still going to cost a lot of money"

Hayley Marlow

ROPA: scenarios (1)

1. Medical indication for IVF + donor oocytes
- ROPA instead of IVF with oocytes *from external donor* ('intra-partner oocyte donation')
- Aims
  - obtaining oocytes in face of shortage
  - benefits of genetic relatedness
  - shared genetic/gestational motherhood
- Acceptable?
  - no specific ethical objections
  - no divergence from indicated treatment
  - clear benefits even apart from those possibly involved in shared biological motherhood

ROPA: scenarios (2)

2. Medical indication for 'regular IVF'
- ROPA instead of IVF with oocytes *from patient*
- Aim: shared genetic/gestational motherhood
- Acceptable?
  - limited divergence of indicated treatment, leading to lower success rate
  - benefits of shared biological motherhood?

ROPA: scenarios (3)

3. Absence of medical indication
- ROPA instead of DI
- Aim: shared genetic/gestational motherhood
- Acceptable?
  - IVF without medical reason
  - benefits of shared biological motherhood?

Human Reproduction, Vol.25, No.4 pp. 938–941, 2010

human reproduction ORIGINAL ARTICLE *Psychology and counselling*

Sharing motherhood: biological lesbian co-mothers, a new IVF indication

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Submitted on September 9, 2009; resubmitted on November 30, 2009; accepted on December 3, 2009

BACKGROUND: We herein present the initial experiences of the CEFER Institute of Reproduction in the formation of a new family model: non-biological mothers, lesbians, *one* who provides the eggs and the other who carries the embryos in her womb. We have called this family model ROPA (Reception of Oocytes from Partner). It is a pioneer event in Spain and among the first at a worldwide level.

METHODS AND RESULTS: Fourteen lesbian couples have undergone treatment using the ROPA technique. This paper briefly describes the technique. Six pregnancies have been obtained from 13 embryo transfers. There were two miscarriages and there are three ongoing pregnancies, one of them twins. One healthy female baby was born. The following aspects are addressed: (i) legal status of lesbian couples in Western countries; (ii) the lesbian couple's access to assisted reproduction techniques; (iii) ethical aspects; (iv) medical acceptability; and (v) single mother versus lesbian mothers.

CONCLUSIONS: In countries where the ROPA technique is legal, it offers lesbian couples a more favourable route, involving both partners, to start a family, and doctors who treat lesbian couples must be sensitive to this new family model.

IVF for no medical reason

- Dutch newspaper story (*Telegraaf* 8-4-2000):
  - Request for ROPA rejected by Dutch IVF centers because there was no medical indication
- Comment from one Dutch fertility specialist:
  - *No sound medical indication for exposing these women to the risk of IVF treatment, not even at their own request*.

Arguments against ROPA (sc 3)

- Non-maleficence: extra risks *for no good reason* (paternalist argument)
- Cost-effectiveness of IVF compared to DI: extra costs *for no good reason*
- Creation of surplus embryos *for no good reason*

- *No good reason* = they can have a child though DI as a simpler means to SAME END

A different end

- Couples requesting ROPA do not just want a child; they want 'a child together'
- How to evaluate this: just a preference? Or a need intrinsically related to the aims of MAR?
- Analogy with ICSI: allows heterosexual couples with male infertility to have 'a child together' when they could also have a child through DI.
- Fox (1993): why are lesbian couples not entitled to the same opportunity?

ICSI analogy

- Rejoinder: low sperm count is a biological problem that is more fully solved through ICSI than DI. Whereas lesbian childlessness is a social problem that can be solved with DI.
- Is this convincing? Why is an ICSI-child a better outcome of MAR than a DI-child? Any answer to this will have to refer to what it means for human couples to have a child from both partners. Eg:
  - Contribution of both in creation of the child
  - Confirmation of relationship
  - Foundation of as shared responsibility for the child

Shared biological motherhood

- We need to know more about how 'shared biological motherhood' affects family dynamics in lesbian-first families.
- Pelka (2009): knowing to be either the genetic or the birth mother 'appears to ameliorate emotional insecurities':
  - externally (in response to challenges to maternal legitimacy)
  - internally (when confronted with infant preference for other parent).

Legal implications

- In case of separation, who can claim to be the legal mother?
- Murphy (1993): ROPA 'can demonstrate that two women did at one time intend to share their children together, which may offer courts options for recognizing partner claims that they may not recognize now'

Conclusions 1

- Beneficence / non maleficence: the case for ROPA depends on whether the possible psychosocial advantage that it may provide outweighs the disadvantages of IVF
- Respect for autonomy: even if the ICSI analogy has only limited force, paternalist arguments against ROPA are not convincing.
- Justice: although at present only for privately paying patients, the ICSI analogy may lead to debate about whether it is fair to exclude ROPA from coverage.

Conclusions 2

- Given the small numbers of women potentially requesting ROPA the issue may not seem very important
- However, what makes the proposition important is that it urges us to rethink the aims of MAR. Is it to help the infertile (or the childless) to have a child, period? Or is it to help couples to have children together?

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Two men and a baby: ethical and legal issues in surrogacy and egg donation for gay male couples

Juliet Tizzard
Head of Policy and Communications
Human Fertilisation and Embryology Authority, UK

ESHRE Ethics and Law pre-congress course, Istanbul 2012

Conflict of interest statement

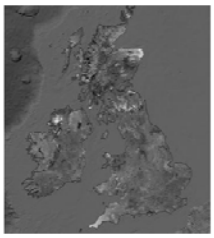
No commercial relationships relevant to the content of this presentation

Learning objectives

Participants of the pre-congress course will gain:

- ➔ an understanding of the different legal frameworks surrounding surrogacy for gay male couples
- ➔ an appreciation of the changing social attitudes around gay parenting in general and gay male parenting in particular
- ➔ a chance to discuss the ethical and social issues surrounding gay male parenting via surrogacy, through comparison with other forms of same-sex parenting

The UK fertility sector



- ➔ 77 IVF clinics of which 34 offer egg, sperm or embryo donation
- ➔ 57,000 cycles of IVF in 2010, of which 1250 using donor eggs
- ➔ Less than 100 IVF surrogacy cases each year

UK legal issues

Surrogacy Arrangements Act 1985
Human Fertilisation and Embryology Act 1990 and 2008

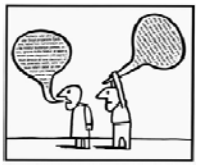
- ➔ Surrogacy lawful, but no payment or advertising allowed
- ➔ Surrogacy contracts unenforceable
- ➔ Parental orders used to be just for married couples
- ➔ Since April 2010 available to those in any marriage/partnership


Human Fertilisation and Embryology Act 2008

Changes in the past decade

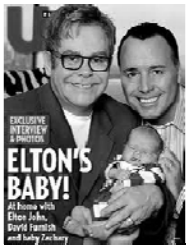
- ➔ Adoption by gay couples possible in UK since 2002
- ➔ Gay couples (male and female) now make up 4% of adoptive parents in England
- ➔ 2000: First UK gay couple having children through surrogacy and recognised on birth certificate
- ➔ Since April 2010, parental orders for gay couples on the rise

Clarifying the issues



- ➔ Ethics of surrogacy not in question here
- ➔ Ethics of gay parenting a separate issue
- ➔ Focus instead should be on:
  - difference between heterosexual surrogacy and gay surrogacy
  - difference between gay adoption and gay surrogacy
  - difference between gay female parenting and gay male parenting

Ethical and social issues



- ➔ Biological connectedness
- ➔ Babies as 'accessories'
- ➔ International surrogacy arrangements: potential for exploitation
- ➔ Public funding
- ➔ The availability of alternatives
- ➔ The need for a mother?

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Clinically Assisted Reproduction & Fertility Preservation with Transgender Men and Women

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Conflicts of Interest

I have no financial or other conflicts of interest to declare in regard to this presentation.

Learning Objectives

I. **Identify psychiatric status of transgenderism**
II. **Identify certain requests for ARTs**
III. **Identify ethical aspects of the**

Motives + Process + Effects in providing ARTs

IV. **Identify moral defense of access to ARTs and fertility preservation by transgender men and women**

I. Psychiatric Status of Transgenderism

A. The WHO describes cross-sex identities as disordered. ICD-10, 1992

B. Some national medical associations also treat cross-sex identities as disordered, including the American Psychiatric Association. DSM-IV, 1994

Essential Diagnostic Criteria: The assertion of a gender-identity at odds with the body's sex traits is a disorder if it involves persistent distress, involves clinically significant social discomfort and is not an artifact of another condition.

Criticism of 'Gender Identity Disorder'

A. Human bodies do not exhibit strict male / female bifurcation.
B. Body sex ≠ gender identity.
C. Transgender problems are largely social artifacts.
D. How one expresses gender is an 'innocent choice.' MCCLOSKEY, 2000

The countervailing argument: transgender identities are not pathological.

American Psychiatric Association is shifting to new interpretation of gender expression in 2013.

Instead of 'Gender Identity Disorder,' the Association will diagnose and treat 'gender identity dysphoria.' Emphasis is on the 'discomfort' and 'unease' of the condition rather than on disorder.

Some trans-men and trans-women will *not* qualify for the condition because they do not exhibit clinically significant distress or impairment. (www.dsmV.org)

So: the interpretation of gender expression is in flux.

II. Requests for ARTS by Trans Men and Women

Some transgender men and women have children but usually prior to transitioning.

E.g.: MTF tennis player Renee Richards had a son, prior to transitioning.

More people are coming forward for help in having children, as transgender men and women.

In the USA in 1999, FTM Matt Rice bore a son, with FTM partner, Patrick Califia. He relied on donor sperm.

Male-identified Matt Rice not recognized by law as male at the time.

In the USA, in 2007 and 2008, FTM Thomas Beattie and his wife had two children by donor insemination.

He **gestated the children.**

Thomas Beattie was recognized as male by the law at the time of his pregnancies and births.

BEATTIE, 2008

A Few More Cases . . .

Bristol, UK - 2000

- A couple contacts clinicians.
- The "male partner was a woman who had undergone gender reassignment."
- The couple was seeking donor insemination of the female partner.

BROTHERS ET AL., 2001

Philadelphia, USA – 2010

- A couple contacts clinicians.
- Both are trans: MTF and FTM.
- The MTF partner has HIV infection.
- They request IVF and sperm washing, + other help.

MURPHY, 2012

Outcome of these Cases

Bristol UK Case

- The clinicians referred the request to an ethics committee.
- The ethics committee reported that reassigned gender should not automatically exclude an individual from consideration for ARTs.

Philadelphia USA Case

The HIV infection *not* an impediment to clinical care.

The couple withdrew from pursuing a child because of the costs associated with the procedures.

NO AUTHOR, 2012

III. The Ethics of ARTs with Transgender People

I will analyze the ethics of helping transgender men and women have children by looking at these elements:

A. **Motives**
B. **Process**
C. **Social Effects**

III.A Ethical Aspects: *Motives*

① There is nothing inherently objectionable about wanting children.

② Nothing about transgenderism indicates that the desire for children is an artefact of the underlying 'disorder.'

③ There is nothing about transgenderism that obstructs understanding the nature and consequences of having children.

- GID is a very narrow 'disorder': people misapprehend their sex. While there can be co-morbidities such as depression, other faculties remain intact.
- By itself, GID does not impair the ability of trans men and women to understand the nature and consequences of having children.

III.B Ethical Aspects: *Process*

- The risks of ARTs to trans people are not magnified in kind because of their GID.
- The totality of ARTs needed by trans people have precedents in the treatments offered to others.

- Gamete storage
- Gamete donation
- Insemination
- IVF
- Embryo donation
- Embryo transfer
- Gestational surrogacy

All these practices are accepted as moral in the practice of fertility medicine. Their use with trans men and women would not be unique.

III.C Ethical Aspects: *Effects*

① **The real arguments about extending ARTs to trans men and women come in regard to effects.**

② **In particular, the question about the welfare of children comes up time and again.**

③ **Should clinicians decline to offer clinical services to trans people in the name of protecting the welfare of children? For example, could children exhibit gender confusion or other complications?**

- **Bear in mind the background ethics: People are entitled to have children for any reason that is important to them; the state applies no test to conception of children.**
- **The ethical question is whether the children of transgender parents face risks greater than the risks to all other children of all other parents.**
- **Why presume a higher degree of scrutiny in advance for transgender parents?**

WHAT DOES THE EVIDENCE SHOW?

Very little.

One study: N = 37 children of homosexual or transsexual parents.

7 were children of Male-to-Females
9 were children of Female-to-Males

36 of 37 reported conventional toy, game, clothing, and peer group preferences.

Post-pubertal children reported heterosexual erotic fantasies and/or behavior.

GREEN, 1978

- One small study: N = 18 children of trans parents.
- In this case report, no evidence that the children are confused in their gender.
- No evidence of durable, hostile treatment by peer group.

GREEN, 1998

- Some legal analysis in USA finds no obstacle to custody by trans parents.

CARTER, 2006

- Some children experience dissonance over their parents' gender transition.
- This problem might be eased if people transitioned *before* becoming parents, since no adaptation to *new* parental identities would be required by children.

- One concern: FTMs – who retain uterus / ovaries but who take male hormones.
- Risks to fetus from those hormones, akin to congenital adrenal hyperplasia effects?
- Thomas Beattie observed a 'wash out' period, refraining from hormone TX prior to and during pregnancy.
- So this risk is manageable.

- What about fertility preservation for people transitioning?
- Fertility preservation rationale: keep option of gametic parenthood viable following certain cancer TX or occupational exposures.
- Some clinicians and professional groups advise counsel for transgender people about this option during their clinical care.

DE SUTTER, 2001; WPATH, 2011

- Fertility preservation would enable novel combinations:

  ALL – As adult: sperm / ova donors
  FTM – As adult: gametic mother / social father
  MTF – As adult: gametic father / social mother
- No cases like this in the literature, but not unimaginable.
- No reason to rule them out in advance.

Summary: Motives

- Most people say they want children; trans men and women no different in this regard.

  WIERCKX ET AL., 2012

- No impediment to offering ARTs is to be found in an ethical analysis of the MOTIVES of transgender men and women who want children.
- Transgender identities do not disable the ability to understand the nature and consequences of having children.

Summary: Process

- No impediment to offering ARTs is to be found in an ethical analysis of the PROCESS of transgender men and women who want children.
- Helping transgender men and women would require no intervention that is not already used in fertility medicine.
- This is not to say: no risks. But these are known and manageable risks.

Summary: Effects

No impediment to offering ARTs is to be found in an ethical analysis of the EFFECTS of transgender men and women having children.

- To date, the study of these children is scant.
- However, no obvious reason to bar.
- Especially since other parents may have children for any reason important to them.

THE LAST WORD

- **Despite some religious, moral and medical dispute, transgender identities are becoming increasingly normalized around the world.**
- **No impediment to offering ARTs is to be found in an ethical analysis of the motives of transgender men and women who want children, and not either in the process or effects.**
- **Clinicians are entitled to offer ARTs, though free to decline in certain instances on a case-by-case basis if the person in question is unable to understand the nature and consequences of having children.**

MURPHY, 2010

THANK YOU / TEŞEKKÜR EDERIM

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The welfare of the child: scrutinizing evaluation criteria

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PCC, ESHRE, Istanbul 1 July 2012

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Preliminaries

I have no conflicts of interest to reveal.

Learning objectives:

- situate the 'welfare of the child' argument within normative ethics

- demonstrate that one should not evaluate reproduction in certain family types by comparing the welfare of the child with that in the classic nuclear family

- show some intricacies in the use of the 'welfare of the child' argument

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Alternative families

General question: pluralism of family types

In 2000, there were ~ 600.000 same-sex households in the US.

~ 35% of lesbian couples and 22% of gay couples raise children.

Single parent families: main difficulty: one should focus on single mothers by choice.

Multiple factors lead to the downfall of the hegemony of the 'classic' nuclear family both in alternative families and in newly composed families.

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Alternative families

General remark: “the welfare of the future child is primordial”

Yes, but there are no good arguments that justify giving more importance to the interests of the child than to the interests of other persons.

The specificity in the context of reproduction and medically assisted reproduction is “the bringing into existence”. But does that determine the standard that should be applied?

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Normative ethics

Two groups of theories in ethics :

1. Deontological theories: an act (decision etc.) is right when it is in accordance with a moral rule or principle.

The rules are given by raison / nature / God
When given by reason, this leads to the ‘human rights’. Deontological theories are not necessarily ‘conservative’.

2. Consequentialist theories (utilitarianism): an act (decision etc.) is good when it maximises well-being compared to all alternative acts.

‘the welfare of the child’ is a typical consequentialist argument.

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Deontological ethics

Important problem for deontological arguments: they refer to a theory (worldview, religion, ideology …) that is not shared by others.

What to do in a pluralist society?

“Secular arguments”: in a liberal democracy, only generally acceptable reasons can be used in the public discussion.
Particular moral and religious traditions have to ‘translate’ their arguments into secular arguments.

Important consequence: when one can empirically demonstrate that the secular reason (welfare of persons, consequences) is not valid, people will not change their position since the original arguments (violation of the rules of nature or God) are still there.

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Deontological ethics

When a person states that being raised by a homosexual couple is against the best interests of the child, then one expects her to change her position when it is shown that this is false.

However, the idea that homosexuality goes against nature or against God's commands is still there and she will still be against homosexual parenting but then for other reasons.

The ethical debate turns into a kind of shadow boxing.

However, also consequentialists frequently draw the wrong conclusions from the empirical evidence.

Welfare of the child in same-sex families

Argument: goes against the best interests of the child

1. Risk of being homosexual
Being homosexual is a disadvantage but this is completely due to hostile reactions from a homophobic society

2. Children will be ostracized
Again a consequence of reactions from social environment
Moreover, the same applies for numerous parental features like obesity.

3. A child needs a mother and a father
Necessary for a normal psycho-social development
- Need for a father?
- Need for a mother? Gay couples have a much harder time convincing people of the acceptability of their child wish.

Criteria to evaluate the welfare of the child

1. '***maximal well-being***': infertility treatment is only allowed when the circumstances are optimal or perfect.

Almost no one should have children

2. '***minimal threshold***': infertility treatment is only unacceptable if the life of the future child is not worth living ('wrongful life' or 'worse than death' standard).

Almost everyone can have children

3. '***reasonable welfare***': infertility treatment is only acceptable if there is a reasonable chance that the future child will have a reasonably life quality (high risk of serious harm)

Avoids counter-intuitive conclusions and is compatible with the judgements we make about natural reproduction.

Comparison

Studies use heterosexual families as the control group
Due to homophobic attitude: control group becomes the gold standard.
Most studies therefore try to show “no difference”: highly defensive.

Family type A: child welfare 10 QALY
Family type B: child welfare 15 QALY

Conclusion: persons in family type A should not have children (and a fortiori should not have access to ART)

Hidden premisses:

- maximising principle: only families with highest child welfare should have children
- lower QoL of the child means morally unacceptable parenthood

Comparison

Significant differences in self-esteem and psychological well-being of children between lesbian and heterosexual couples were in favour of lesbian families.

Conclusion: heterosexual couples should not have children and should not receive ART

If one does not accept this conclusion, one needs to show why the reasoning would be valid if lesbian families would do worse.

Solution: criterion of moral acceptability should be reasonable welfare
If the expected well-being of the future child is above this threshold, reproduction and parenting is acceptable.

Necessary or recommendable condition

A characteristic is necessary if its absence would hold a high risk that the child will not have a reasonably happy life.

A characteristic is recommendable if its presence in general has a positive effect on the welfare of the child.

Example: the presence of a father is not necessary but the presence of a supportive parent is recommendable.

Opponents frequently present recommendable characteristics as necessary.

Precautionary principle and burden of proof

Opponents of reproduction in alternative families advance the precautionary principle: we need to be certain about the welfare of the children before we start treating these would-be parents.

- first problem: “catch-22”: these families have to show that being born in such family is good for the child but they can only show this by having children and they can’t have children because they first have to show ...

- second problem: human rights include the right to reproduce
The burden of proof is on those who want to deny the right.

Welfare determining factors

Why focus on sexual orientation of parents? Or generally, from the deviations from the heterosexual couple?
All studies show no negative influence and still we keep repeating them.

1. **Parental income**: children raised in poor families are considerable worse off than children in well-off families.

Poverty is strongly linked to lower educational achievements, worse socio-emotional development and higher incidence of behavioural problems.

Conclusion: poor people should not have access to ART.

Social and psychological suffering

2. **Having been abused as a child**

50% of the parents who have themselves been abused as a child abuse their children = high risk of serious harm.

How many clinics screen their patients for child abuse?

This risk is many times more serious than any possible risk in alternative families.

Supportive measures

The cases above show that the presence of a negative factor is not in itself a reason to deny patients access to treatment.

We expect society to do something about the negative factors, for instance, by providing financial support so that poor families can have children and the children do not suffer from the poverty.

Knowledge of negative factors is an opportunity to remedy and/or compensate.

Highly negative factor for same-sex families: lack of societal recognition
Welfare increasing factor: marriage: improves financial, social and psychological stability.
Homosexual parents have the same obligations as heterosexual parents but they do not get the same means to do the job.

Conclusions

Families types should not be compared to each other. One should determine whether the future children have a reasonable chance to have a reasonably happy life.

If the welfare of the child is indeed our primary goal, we should adopt measures to maximise their chances in all family types.

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Non-discrimination, human rights and institutional autonomy in the provision of assisted conception services

Professor Emily Jackson
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Conflicts of Interest

- Deputy Chair of Human Fertilisation and Embryology Authority (UK).

Learning Objectives

- To consider if there is a tension between institutional autonomy and the human rights and right not to be discriminated against of would-be patients.
- To consider whether it makes a difference whether the clinic is a public or private provider.
- To explore the relevant legal provisions, in relation to the European Convention on Human Rights, using the UK's regulatory system as a case study.

European Convention on Human Rights

Art 8:

- § 1 Everyone has the right to respect for his private and family life, his home and his correspondence.
- § 2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

European Convention on Human Rights

Art 9:

- § 1 Everyone has the right to freedom of thought, conscience and religion
- § 2 Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or the protection of the rights and freedoms of others.

European Convention on Human Rights

- Art 12: Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right
- Art 14: The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Are fertility clinics bound by the ECHR?

- European Convention on Human Rights

  Section 1: The High Contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms defined in Section I of this Convention.
- c.f. Human Rights Act 1998 section 6 (1)

  It is unlawful for a public authority to act in a way which is incompatible with a Convention right.

UK case study

- Human Fertilisation and Embryology Act 1990 (original version)
- Section 13(5): A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment, (including the need of that child for a father), and of any other child who may be affected by the birth.

Susan Golombok and Fiona Tasker (Human Reproduction, 1994)

- Existing research on lesbian and single-parent families does not indicate that these children would be at risk for psychological problems… Because many donor insemination clinics refuse to accept lesbian or single heterosexual women, even when they are allowed in law to do so, a growing number are choosing self-insemination instead.

Some private providers did advertise services to lesbian and single women.

e.g. The London Women's Clinic

- The London Women's Clinic is often described as the fertility clinic of choice for single women and same sex couples.
- We have been treating lesbian couples and single women wanting to start a family for more than 10 years, and indeed we were one of the very first clinics in the UK to do so.
- In this time we have helped more than 2000 single and lesbian women in their wish to have healthy babies. Our caring and supportive medical staff are committed to offering all our patients the best chance of having a baby.

Human Fertilisation and Embryology Act 2008

The 2008 Act amended the 1990 Act.

Section 13(5) now reads:

- A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth.

Human Fertilisation and Embryology Authority *Code of Practice*

Para 8.11 When considering a child's need for supportive parenting, centres should consider the following definition:

- 'Supportive parenting is a commitment to the health, well being and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.'

Human Fertilisation and Embryology Authority *Code of Practice*

Para 8.10 spells out factors relevant to risk of harm:

i) previous convictions relating to harming children

ii) child protection measures taken regarding existing children, or

iii) violence or serious discord in the family environment

b) past or current circumstances that are likely to lead to an inability to care throughout childhood for any child who may be born, or that are already seriously impairing the care of any existing child of the family, for example:

i) mental or physical conditions

ii) drug or alcohol abuse

iii) medical history, where the medical history indicates that any child who may be born is likely to suffer from a serious medical condition, or

iv) circumstances that the centre considers likely to cause serious harm to any child mentioned above.

Human Fertilisation and Embryology Act 2008

- Can now have two female parents:
- Section 42(1) If at the time of the placing in her of the embryo or the sperm and eggs or of her artificial insemination, W was a party to a civil partnership, then subject to section 45(2) to (4), the other party to the civil partnership is to be treated as a parent of the child unless it is shown that she did not consent to the placing in W of the embryo or the sperm and eggs or to her artificial insemination (as the case may be).
- If not in a civil partnership, the 'agreed female parenthood conditions' (s.44) apply.

Human Fertilisation and Embryology Act 1990

Section 38(1) No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so.

Any activity? → objection to procedure (eg IVF)

→ *not* objection to people?

UK Equality Act 2010

Section 4 The following characteristics are protected characteristics—

- age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

UK Equality Act 2010

- **Section 13 Direct discrimination**
  (1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.
- **Section 19 Indirect discrimination**
  (1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.

Institutional autonomy?

- Cannot refuse to treat someone on the grounds of their sexual orientation or relationship status.
- Can refuse to treat someone if 'reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect'.

HFEA Code of Practice (8th edition)

Para 8.7: Those seeking treatment are entitled to a fair assessment. The centre is expected to consider the wishes of all those involved, and the assessment must be done in a non-discriminatory way. In particular, patients should not be discriminated against on grounds of gender, race, disability, sexual orientation, religious belief or age.

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Gifts with moral strings attached:
Should gamete donors have a right to exclude non-standard couples/persons as recipients?

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Conflicts of interest statement

I declare that I have no conflicts of interests with regard to the topic of this contribution.

Learning objectives

1. To understand the special nature of moral and legal rights.
2. To understand the conflict between a donor's claim to determine who should receive the donated germ cells and the recipient's right not to be discriminated.
3. To understand the different ethical implications of individual donation arrangements and impersonal donation schemes in the context of public healthcare systems.

What means „**should** donors **have a right to** exclude non-standard couples“?

- A right is an entitlement to do or to have something. - „I have the right to be frank.“ implies that I think that my action (to be frank), if I decide to perform it, will be protected by some moral, social or legal force.
- Rights are not always absolute. There are *prima facie* rights and *prima facie* duties (David Ross) that can be trumped.
- „... should ... have a right to ...“ asks for a **general entitlement** of gamete donors to exclude non-standard couples in a society.

Rights can be based on:

- **moral principles** (e.g. human rights, which are thought to be absolute),
- **ethical arguments** (e.g. animal rights, which are contested),
- **metaphysical beliefs** (e.g. blastocyst rights, which are shared by parts of the community),
- **shared practice** (e.g. gift recipients‘ right to give something back), or
- **law** (e.g. marriage rights, which are established by the legal system of a state).

What means „should **donors** have a right to exclude **non-standard couples**“?

- Nonstandard couples could be gay or lesbian same sex couples. In the case of gay couples, reproduction involves a surrogate mother. In the case of lesbian couples, reproduction only involves a gamete (sperm, egg) donor.
- Lesbian couples can have children also without ART. In the following I will focus **only on lesbian couples**.

Argument 1: individual donation agreements

If a lesbian couple asks a potential gamete donor to donate, she/he must have a right to refuse donation of egg or sperm. There are no duties to donate gametes to a couple in personal donation relationships, therefore there can be no restrictions to the rights of the donor to renounce an individual/personal agreement between couple and donor, even if the donor refuses to donate precisely *because* the couple is lesbian. This is a similar right to the right **to refuse** sex with a person who asks for it.

Argument 2: impersonal donation schemes

If a gamete donor donates egg/sperm within an impersonal donation scheme (e.g. sperm bank, ART clinic) the rights and duties of a donor are a matter of justice and include public reasoning and legal regulation. There is **biopolitics** involved: payments, identity and information disclosure, terms and conditions of donor's relationship to the child etc. need to be **fairly** regulated because the medical system helps to establish these parentship relationships.

The question, whether a donor should have the right to refuse donation of egg/sperm to a nonstandard couple, must be addressed on **this** level.

Argument 3: inclusion of same sex couples

The exclusion of lesbian couples could only be justified with concerns for the best interests of the future child (see argument 5). This would however lead to an exclusion of lesbian couples from reproductive services **in general**, and not to a right of individual donors to choose to refuse donation to nonstandard couples within the system.

Argument 4: discrimination

If a donor would get the right to refuse donation to lesbian couples, this would mean that the medical system or the state protects his/her choice to discriminate lesbian couples to establish generative relationships.

This is **inconsistent** with a general policy against discrimination of same sex relationships and for the best intersts of the child.

Argument 5: welfare of the child

Children's well-being **positively** depends on the love and care of their parents, their support, stimulating environment etc., and **negatively** on conflicts in the family, violence, abuse etc. There is no empirical evidence that children growing up with a female single parent or in a „rainbow family" to be systematically disadvantaged. It is not the parents' gender that makes the difference to the child's best interests. The evidence speaks otherwise. Children may however be challenged by discrimination of their parents.

If this is correct, it is unfounded to assume that the gender-pattern of lesbian parents will systematically disadvantage their children.

However, children and parents might be burdened when they are treated as „abnormal" family. Tensions with the sperm/egg donor might be a factor to cope with. But similar tensions can also arise without gamete donation also in heterosexual relationships.

Conclusions (1)

1. Hence, within an **impersonal** donation scheme gamete donors **should not** have a right to exclude lesbian couples as recipients.
2. Medicine should not help to establish reproductive relationships by gamete donation given as a gift with moral strings attached excluding lesbian couples as recipients. However, a potential donor has no obligation to donate gametes to a lesbian couple in **individual** donation agreements.
3. Medicine and society share responsibilities to organize reproductive services in a way that the well-being of the future children **and** the interests of couples are equally fostered and harmonized.

Conclusions (2)

4. There is no evidence for the child being systematically disadvantaged by the fact that its parents have the same sex, threfore, the case for explicit discrimination of same sex families in ART-services rests on shared prejudices and natural right considerations (metaphysics), not on the best interests of the child.
5. Open issue: How far can societies tolerate discrimination of same sex couples by **private** providers of ART who connect donors and recipients who share the same overall beliefs about marriage and parenting, without infringing the state's commitments to equal basic rights?

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- Basic Semen Analysis Course in Greek Language
  4-7 September 2012 - Athens, Greece
- Basic Genetics for ART practitioners
  7 September 2012 - Rome, Italy
- Regulation of quality and safety in ART – the EU Tissues and Cells Directive perspective
  14-15 September 2012 - Dublin, Ireland
- Basic Semen Analysis Course in Spanish language
  18-21 September 2012 - Galdakano,Vizcaya
- GnRH-antagonists in ovarian stimulation
  28 September 2012 - Hamburg, Germany
- The best sperm for the best oocyte
  6-7 October 2012 - Athens, Greece
- Basic Semen Analysis Course in Italian language
  8-11 October 2012 - Rome, Italy
- Accreditation of a preimplantation genetic diagnosis laboratory
  11-12 October 2012 - Istanbul, Turkey
- Endoscopy in reproductive medicine
  21-23 November 2012 - Leuven, Belgium
- Evidence based early pregnancy care
  29-30 November 2012 - Amsterdam, The Netherlands

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