When surgery works (or fails us) : Ethical aspects

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Aims and objectives (+no conflict of interest)

- Understand the relevance of ethics to ART surgery
- Be able to use clear principles to perform an analytical appraisal of relevant ethical concerns in all cases
- Understand the interconnection between legislation and ethics
- commercial relationships : none
- activities that might be perceived as a potential conflict of interest : none

Setting the scene

Surgery (for both female and male) : consent

Female surgery (failure): the surrogacy option

Male surgery : alternatives to testicular biopsy, a case study

When sperm fails us: sperm donation

The couple : joint decisions, in the real world

The Guardian | Wednesday June 6 2007

National

Tenfold rise in fertility treatment for over-40s

Steady increase in overall success rate

Watchdog's warning on delaying children

James Randerson
Science correspondent

The number of women undergoing fertility treatment in their 40s has increased tenfold in the last 15 years, according to figures released yesterday by the government's fertility watchdog. In 1991, fewer than 600 women were being treated to help them conceive, but by 2006 the number had risen to 6,000.

The statistics, published by the Human Fertilisation and Embryology Authority, show that although treatments for older women are less successful, the overall success rate has risen steadily from 14% in 1991 to 21% in 2004. Between 1991 and 2006, the number of women over 40 seeking treatment jumped from 9% of the total seeking treatment to more than 15%. In the same period, the proportion of women aged 35 or below undergoing treatment dropped from 58% to 40%.

Sam Abdalla, director of the assisted conception unit at the Lister hospital in west London, said that the reasons for the shift were social rather than medical. Angela McNabb, chief executive of the HFEA, said women needed to be aware that their chances of conceiving drop as they get older. "It's a matter, I think, of concern," she said. According to data collected from all 85 fertility clinics in the country, a woman aged under 35 who embarks on IVF has a 26% chance of having a healthy baby at her first attempt. The same figure for a woman aged 40 to 42 is 9% and by 44 or older it drops to 1%.

"Some women are waiting longer for various reasons to have a family," said Sheena Young, head of business development at Infertility Network UK, a support organisation for IVF patients. "But you should keep in mind that many people are not having access to treatment at the optimum age." Access to fertility treatment on the NHS is patchy around the country and even if it is available, couples may have to wait for treatment.

In an apparent riposte to comments made in the Guardian last week by the fertility expert Lord Winston, Shirley Harrison, the HFEA's chair, said: "I don't subscribe to the view that we have large numbers of clinics run by the greedy or the corrupt."

Lord Winston had said: "It's very easy to exploit people by the fact that they're desperate and you've got the technology which they want, which may not work."

Ms Harrison conceded that patients approach the HFEA with concerns over the cost of treatment. "The cost of treatment is the single biggest issue for patients and more than a third of private patients pay more for their treatment than they expected," she said. One IVF cycle typically costs £4,000-£8,000. She said the HFEA favoured the introduction of costed treatment plans which lay out what fertility procedures will cost from the start.

SocietyGuardian.co.uk/health »

A few words about bioethics: 3/4 principles

- **Autonomy:** consent for investigations and treatment; information is "**key**"**; accurate, evidence based, including "equipoise"**
- **Beneficence V maleficence**: safety: "innovative therapy" eg test icsi till recently in The Netherlands
- **Justice** and access to healthcare (mostly socio-political problem)
- Consider then context (psycho-social dimensions)

Information= key to autonomy: our duty

How much information is enough?..thorough discussions , especially in poor prognosis cases...

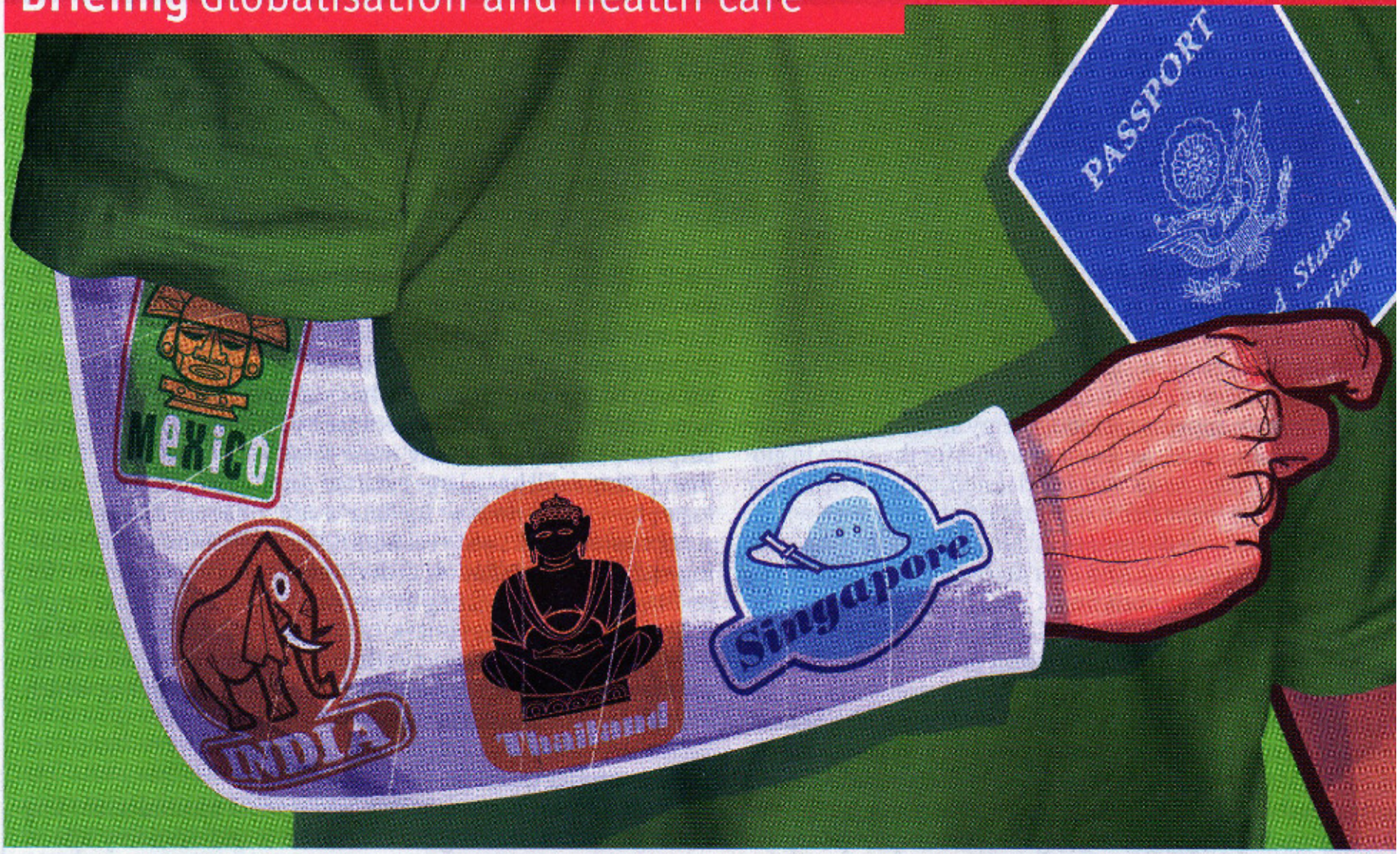
... The lesser the chance, the more information is needed : **proportionality** (in this case "**inverse proportionality**")

ART specific ethical aspects

- **Welfare of the child**: minimal v max threshold eg parental health , multiple preganancy (TF13, H R 22: 2585-88 (2007))
- **new techniques** ...(adopted). without the necessary evaluation of their efficacy, effectiveness, safety and social and economic consequences.; their use without **safeguards** re health of the children premature introduction of drugs without proper research
- **Genetic counselling** may be necessary (Klinefelter; AZFc concerns); min discuss risk for that pregnancy (often older woman)

ART ethico-political aspects: “macro” ethics

- **Justice and access**: financial pressures when little funding; single women, women in lesbian couples ; in UK many PCT refuse funding for sterilisation reversal failure (no IVF, no IVF/ICSI)
- Access **barriers** to treatment: in UK all care > 40 is in private sector; other criteria BMI, FSH levels
- All can lead to **cross border reproductive care** (autonomy, safety, justice, welfare of the child)



Operating profit

have undermined this trend.

However, globe-trotting patients c
ever occupied a niche. What is getting p
ple excited today is the promise of a bo
in mass medical tourism, as a much big

Justice and access

- **<u>Equity of access to assisted reproductive technology</u>**
- Medical interventions, both to have a child and to avoid a genetically affected child, should be **funded at least partially** in relatively affluent societies.
- Funding of medically assisted reproduction should be considered in a structured way including **efficiency**, safety and equity to **avoid unjustified discrimination.**

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Table 1: Percentage of patients crossing borders to the six treating countries first 4 countries (where questionnaires number is >100, and next 3 (Q1>50))

	Country of treatment							
Country of Residence	Be	CZ	DK	SLO	SPA	SWZ	TOTAL	
	%	%	%	%	%	%	N	%
Italy	13.0	2.6	0.3	1.0	31.7	51.4	391	31.8
Germany	10.2	67.2	11.9	0.0	10.7	0.0	177	14.4
Netherlands	96.6	0.0	0.0	0.0	3.4	0.0	149	12.1
France	85.0	7.5	0.0	0.0	7.5	0.0	107	8.7
Norway	0.0	1.5	98.5	0.0	0.0	0.0	67	5.5
UK	7.6	52.8	11.3	0.0	28.3	0.0	53	4.3
Sweden	0.0	5.7	92.4	0.0	1.9	0.0	53	4.3
Total n	365	252	154	65	193	201	**1230**	---
%	29.7	20.5	12.5	5.3	15.7	16.3	100.0	---

Mc Kelvey, David, Jauniaux and Shenfield , BROG

How IVF tourists and their multiple babies overload the NHS

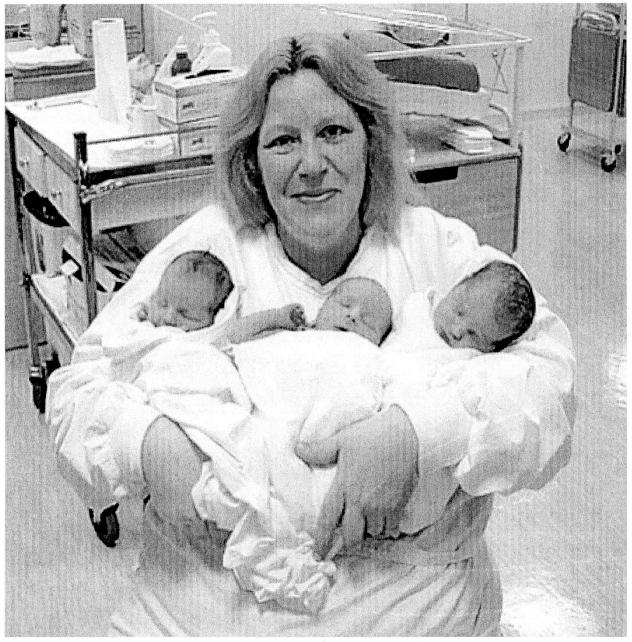
By Jenny Hope

Last updated at 12:35 AM on 20th September 2008

Doctors have revealed for the first time the burden on the Health Service caused by women who have multiple births after going abroad for fertility treatment.

New evidence shows that one in four women having triplets or more as a result of IVF treatment had conceived outside the UK.

They travel overseas for IVF because it is cheaper and they are likely to get a higher number of embryos used in treatment, according to fertility specialists who carried out a study at a leading London hospital.



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Epidydimo-vasostomy v sperm retrieval

- Autonomy: information re success rates and risks
- Beneficence: better success rate in equipoise cases depends on female age
- v maleficence: more imposition on one gender rather than another
- Justice: is one funded while another is not (eg UK, no public funding if past sterilisation)

Other specific cases, and gender differences

- Men and women: an equal situation?
- The privilege of gestation comes at the price of more pelvic interventions
- Sperm donation ? Harder to accept than oocyte donation
- Surrogacy
- Some countries lawful to treat single or same sex couples; also trans sexuals (surgical implications+)

Identifiable v anonymous gametes donors

- UK Regulations at: http://www.opsi.gov.uk/si/si2004/20041511.htm
- http://www.hfea.gov.uk (all HFEA publications)
- HFEA (Disclosure of donor informatiion regulations) 2004: affects new donors from 1 April 2005, with transition period till 1st April 2006 for old donors (except); now all identifiable

POLÉMIQUE AUX ÉTATS-UNIS :
DES FEMMES FONT CONGELER LEURS OVULES

UN BÉBÉ POUR PLUS TARD ?

Parce qu'elles se consacrent à leur carrière ou qu'elles n'ont pas trouvé le père idéal, des Américaines font congeler leurs ovules pour différer leur grossesse. Des entreprises ont flairé la bonne affaire. ENQUÊTE ISABELLE DURIEZ

A la terrasse d'un café californien, elle sirote son thé glacé l'air de rien. Pourtant, cette jeune femme à l'allure de poupée Barbie vient de lancer une petite bombe sur le marché de la fertilité aux Etats-Unis. Elle est en train d'investir des millions de dollars dans une nouvelle technologie qu'elle estime « aussi révolutionnaire que la pilule » : la congélation des ovules. « Nos mères ont passé leur vie à essayer de ne pas tomber enceintes. Notre génération, elle, n'arrive pas à faire des bébés. Eh bien, promet-elle, finie la tyrannie de l'horloge biologique. » Selon Christy Jones, fondatrice d'Extend Fertility, les femmes peuvent avoir un enfant quand elles le souhaitent, même après 40 ans, à condition de faire congeler leurs ovules tant qu'elles sont jeunes. Et de préférence dans l'une des sept banques d'ovules qu'elle vient d'ouvrir aux quatre coins des Etats-Unis.

Christy Jones n'est ni médecin ni chercheur, mais une redoutable femme d'affaires qui sait à qui elle s'adresse : aux milliers de trentenaires célibataires qui, comme elle, ont peur de rencontrer trop tard l'homme de leur vie. « Quand j'avais 20 ans, raconte-t-elle, j'imaginais que j'allais faire des études, rencontrer l'homme de ma vie, me marier et avoir des

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privilege

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Surrogacy: ethico legal aspects

- ***Who can have surrogacy in the UK?***
- medical case, not social
- surrogacy arrangement is complete when a parental order is granted to the intended parents, intended parents must use one of their own gametes, update 2008 to fit in with non discrimination law
- **potential surrogate mother :** good overall health, minimum amount of risk

Risks to the surrogate

- Disproportionate payment given to surrogate women risks coercion of vulnerable women, and has the potential to lead to commercial exploitation, in particular recruitment of women of underprivileged background
- Familial coercion may be powerful
- Single ET is advisable
- **FIGO**: unacceptable for social reasons; respect the autonomy of surrogate
- The commissioning couple and surrogate potential must have full and separate implication counseling independently prior to their agreement, and be encouraged to address the question of eventual disclosure to the child before entering into the intended procedure

Other possible concerns for surgeons

- When to cryo preserve material?
- Leading to

1. posthumous use (Taskforce
2. cancer patients future fertility considerations

All cases may be analysed with the same

1. general ethical calculus
2. + specific ART considerations (starting with Welfare of the child)

Conclusions

- What is common in the clinic?
- **Patients**: need evidenced based information, truth about unknowns
- Practitioner: duty to **patients**' interest , Welfare of the child ; clarity of success rate and complications risks
- **Patients** centred approach: Success, access and justice; Multiple pregnancy is still the commonest risk of all

References

- Taskforce Ethics and law considerations:

  Equity of access to ART 14, Human Rep 23, 772- 774 (2008); Welfare of the Child 13, H R 22: 2585-88 (2007); Gametes donation; Surrogacy (all available on eshre.eu website

- Shenfield F, Sureau C, eds, Ethical dilemmas in Reproduction, Parthenon, London and New York, 2002

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