

Ethical Issues in Reproductive Medicine

2013

1. Preamble

- 1.1. All individuals 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 includes services to manage fertility as well as infertility. Family planning services are used to control fertility and include contraception, termination of pregnancy, and sterilisation. Assisted reproductive technologies (ART) are used to manage infertility and include *in vitro* fertilisation (IVF) and artificial insemination and/or various methods of ovulation induction.^{1 2}
- 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 should not be coerced into undertaking (or not) any form of reproductive medicine.
- 1.5. A doctor (medical practitioner) who chooses to provide clinical services, or conduct research, in reproductive medicine should not be subject to discrimination or stigmatisation.
- 1.6. A doctor who chooses not to provide clinical services, or conduct research, in reproductive medicine should not be subject to discrimination or stigmatisation.
- 1.7. A doctor should not be expected to participate in clinical or research activities that conflict with his or her personal convictions. When a doctor faces these conflicts, they should inform their patients so that they may seek care elsewhere and should not impede access to care. In an emergency situation, doctors are required to continue care for the patient until their services are no longer required.
- 1.8. Clinical research into reproductive medicine should be freely conducted within the prevailing ethical, social, medical and legal frameworks.
- 1.9. 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 to services and consent

- 2.1.1. All individuals should be aware of, and have access to, affordable family planning information and services.
- 2.1.2. The ability to regulate and control fertility should be regarded as a principal component of the physical, mental, and social well-being of women of reproductive age. Family planning can contribute to the survival and health of mothers and children. Family planning services may include, but are not limited to contraception, sterilisation, and termination of pregnancy.
- 2.1.3. It is important to recognise that men of reproductive age have specific reproductive health needs.

¹ IVF may be used in the management of infertility. It involves medical and scientific manipulation of human gametes and embryos in order to produce a term pregnancy.

² This position statement may also be relevant to medical students.

2.1.4. Doctors have an important educational role in informing their patients about up-to-date family planning options, the 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 procedures with their partner.

2.1.5. People with impaired capacity should be included in the decision-making process regarding their family planning, to the extent possible.

2.1.6. Where young people have decision-making capacity, and wish that treatment to remain confidential, then doctors should respect and maintain that confidentiality. When appropriate, young people should be encouraged to make decisions regarding family planning in collaboration with adult family members or guardians.

2.2. Contraception

2.2.1. Contraception can offer numerous physical and psychological health benefits which should be weighed up against recognised side effects and complications.

2.2.2. Women should be aware of, and have access to, emergency contraception.

2.3. Sterilisation

2.3.1. Sterilisation should be considered an irreversible form of contraception. Any discussion must provide adequate information about the procedures, their implications, and alternatives must be provided.

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

2.4. Termination of pregnancy

2.4.1. Doctors have the right to hold differing views regarding termination of pregnancy.

2.4.2. While a doctor may refuse to be clinically involved in a termination of pregnancy because of his or her personal convictions, such a refusal should not impede the patient's access to care.

2.4.3. Where surgical termination of pregnancy is performed, the procedure and the associated anaesthesia should, as with any other medical intervention, be performed by appropriately trained doctors, in premises approved by a recognised health standards authority.

2.4.4. Medical termination of pregnancy should be made available as an alternative to surgical termination of pregnancy in cases where they are medically deemed to be the safest and most appropriate option.

2.4.5. Medical termination of pregnancy should only be performed when adequate services are available to manage the process and any complications that might occur in a safe and timely manner. Medical termination services should involve a multi-disciplinary clinical team under the leadership of a doctor.

3. Assisted Reproductive Technologies (ART)

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. Error! Bookmark not defined.

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.ⁱ Consent cannot be withdrawn once the donated gamete or embryo has been used.

3.1.3. Individuals should be fully informed of the risks and benefits, both physical and psychological, and realistic 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, 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 the production of gametes or embryos that are not used to treat those from whom they were procured. These 'surplus' gametes and embryos may be stored, cryo-preserved for future use, donated to other patients, disposed of, or donated for research. These available options must be explained clearly and precisely to individuals before donations are made.^{Error! Bookmark not defined.} Any patients considering ART should be aware of the significant ethical, legal, and social implications of gamete and embryo donation.

3.3. Pre-implantation genetic diagnosis (PGD)

3.3.1. PGD³ should be restricted to fatal or seriously and permanently disabling diseases. Genetic selection should not be undertaken on the basis of sex (except in order to avoid hereditary sex-linked disease) or on the basis of characteristics or traits that are unrelated to disease.ⁱⁱ

3.4. Artificial insemination and ovulation induction

3.4.1. Similar principles apply to artificial insemination and ovulation induction.

4. Surrogacy

4.1. Surrogacy may involve a 'traditional' surrogacy, where a pregnancy is conceived through insemination with sperm from a commissioning male or a 'gestational surrogacy', where the surrogate acts as a 'gestational carrier' of the embryo created using the commissioning parents' gametes.ⁱⁱⁱ

4.2. Once such a pregnancy has commenced, the doctor's ethical and medical obligations to the surrogate mother and child are the same as those owed to any pregnant woman and her future child. 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.^{iv}

4.3. The commissioning parents will have their own health care needs related to the surrogacy; for example, in relation to the process of gamete donation.

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

4.5. It is inappropriate to offer money or benefits in kind to encourage surrogacy but they may be reimbursed for reasonable expenses.^{Error! Bookmark not defined.}

³ PGD is defined as a technique by which embryos fertilised in vitro are tested for genetic characteristics, particularly for specific genetic disorders (eg., cystic fibrosis). From National Health and Medical Research Council. *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research*. June 2007.

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ⁱ National Health and Medical Research Council. *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (June 2007).

ⁱⁱ Australian Medical Association. *Position Statement on Genetic Testing 2012*.

ⁱⁱⁱ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. *C-Gen 16. Surrogacy*. Jul 2011.

^{iv} Australian Medical Association. *Position Statement on Maternal Decision-Making 2013*.