

Submitted Text of "Rights and Wrongs of Reproductive Technologies", *Dialogue: A Journal of Religion and Philosophy*, 36:40-46 (April 2011). Check against published text.

The experience of infertility – desiring but being unable to have a child – is rarely physically painful but it is often deeply painful at an emotional and psychological level. It is, however, not often talked about. Sex education in school is usually all about not getting pregnant, with little or nothing said to prepare people for the fact that it can sometimes be very difficult or even impossible to conceive when you *want* to have a baby. And yet infertility is also more common than many realise. It may take the form of *primary infertility* where there has never been a child. It may be *secondary infertility* where there has been a successful pregnancy in the past but there are problems conceiving again. Strictly speaking, a couple will not be considered medically infertile until they have tried unsuccessfully for two years to have a child by natural means of unprotected sexual intercourse. It is estimated that 5% of couples seeking to have children fall into this category, although as many as 30% take more than six months and 15% over a year to conceive.

Faced with such a situation, the question is inevitably raised – what else can I do to have a child? Due to scientific and technological developments there are now a range of possible ways of intervening to try to overcome this problem and more are likely to be developed. Some of these are generally uncontroversial as they merely seek to enable the body of the woman (or, less often, the man) to do what for some reason it is not doing. This might mean the provision of drugs to enable the woman to ovulate (release an egg that can then be fertilised). It could involve surgery in order to unblock a woman's fallopian tube and so allow passage of the egg or to enable a man's sperm to be ejaculated. In each of these cases, the intervention brings some form of cure for infertility by bringing healing to a damaged part of the body in order to allow conception to occur naturally through sexual intercourse. Even the Roman Catholic Church, which as we shall see is opposed to other interventions, accepts these as valid forms of assisted conception.

There are, however, a range of other techniques which are also sometimes referred to as forms of assisted conception but more helpfully called Artificial Reproductive Technologies (ARTs). Each of these – because reproduction now takes place in some sense artificially through the use of technologies and not simply naturally through intercourse - raises ethical questions for some people. Some of these questions are whether a particular technique is ever a morally acceptable way for anyone to have a child. Other and often deeper ethical questions are, however, arising because the techniques developed to help solve infertility are in turn raising wider new moral and legal dilemmas not simply for the couple seeking a child but for society as a whole. These lead some to claim that we are not only changing the physical way we, literally, conceive children but altering how intellectually we conceive children and families in our society.

In making ethical judgments about these techniques there are, as often in ethical disagreements, two central forms of concerns. Some people (those who would generally be considered deontologists) raise questions about the techniques in themselves and consider some to be always wrong. Others (such as utilitarians and consequentialists) point to either uncertain or possibly damaging consequences of the techniques as reasons why they should not be used.

Different ways exist of distinguishing and categorising the ethical issues raised by the variety of reproductive technologies. There are, however, three key decisions which raise ethical questions. Some techniques raise only one of these, others raise two or all three. The first question is whether it is wrong even to attempt to create life using artificial techniques which involve control over human gametes (ie sperm or eggs) and bypass natural intercourse. The second question is whose

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gametes can legitimately be used in any ART. The third question is whether the artificial creation of human embryos is ever justified and this in turn opens up other questions relating to our treatment of such embryos.

The three techniques which will be referred to in relation to these questions are:

- (1) Artificial Insemination (AI) or Intra-uterine Insemination (IUI). In this technique sperm is artificially inserted into the woman's body. It can be the sperm of the man in the couple. This was traditionally called Artificial Insemination by Husband (or AIH) and is also sometimes called homologous insemination. It can, however, be the sperm of a donor. This is variously called Artificial Insemination by Donor (AID), Donor Insemination (DI) or heterologous insemination.
- (2) Gamete Intra-Fallopian Transfer (GIFT). Here both sperm and egg are placed together in the woman's fallopian tubes. These may be the sperm and egg of the couple seeking a child or one or both may be donated. In practice this is rarely used because of the third technique -
- (3) In Vitro Fertilization (IVF). This is currently the most common and most morally interesting and contentious technique. Here eggs are fertilized with sperm in the laboratory (*in vitro* is Latin for "in glass", so also "test tube babies") in order to create embryos. Embryos are then placed in the woman's womb.

Should we ever use human gametes in our techniques?

Probably the least controversial form of ART is artificial insemination when the sperm used is that of the husband. It is also one of the earliest techniques, with the first claimed human conception using it being as early as 1790. Sperm is collected from the man and placed inside the woman's body artificially. Today the technology is such that the fast-moving sperm can be separated and placed in the woman's womb about the time she is expected to ovulate, thus increasing the chance of natural fertilization. When the sperm is that of the husband then many would see no ethical problems about this procedure as it simply enables a married couple to conceive who cannot do so through intercourse. The Roman Catholic church, however, remains opposed to it and its reasoning highlights the first ethical challenge raised against ART.

The Roman Catholic rationale is found in the 1987 *Vatican Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* (commonly known as *Donum Vitae*). Its fundamental objection arises because it rejects any procedure that bypasses the physical sexual union of husband and wife in order to generate human life. In the words of Agneta Sutton, explaining the official teaching of the church,

What distinguishes morally justifiable methods from AIH, AID, GIFT, IVF and related procedures that do not involve the normal sexual act is that the former do not interfere with the natural process of generation in which conception takes place in the female body as the result of a man and a woman having sexual intercourse. That is to say, what makes most techniques now used unacceptable is that they do not facilitate the natural process but bypass it altogether. Procreation is separated from intercourse. Hence, the child is not

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begotten by a couple in or through their bodily union but is a product of the actions of third parties.¹

The moral logic here is the same that explains Roman Catholic objection to contraception. They believe that God intends procreation through a sexual act which has both a *unitive* significance, bonding the couple together, and a *procreative* significance, being open to the gift of new life. Anything which seeks to separate these is to be rejected. Contraception seeks the unitive good while preventing the procreative good. Artificial insemination seeks the procreative good apart from the unitive one.

A further morally problematic aspect for some is that the sperm would normally be collected through masturbation which some view as always immoral. Other means are, however, available, with some Roman Catholics even arguing it could be permissible to collect sperm from a condom used during intercourse (although the condom would, of course, also need to be split so it was not acting as a contraceptive!).

As the quotation from Sutton makes clear, this strong sense of a divinely ordained natural order for the creation of new human life which we must respect and never bypass leads to a rejection of all forms of ART as wrong.

Whose gametes can we use?

Most people have no objections to either AI or GIFT when the sperm (and egg in GIFT) are those of the couple seeking a child. However, the same techniques raise new moral questions when donor gametes are used. This brings a third (and possibly fourth) party directly into the process of providing the couple with a child. As a result there is a distinction between what is called the *biological parent(s)* who provides the genetic material and the *social parent(s)* who acts as father or mother to the child when born. Indeed, by the use of surrogacy – the agreement to carry a child for someone else – it becomes possible for there to be five people involved in what is usually the work of two people seeking to become parents: two social parents who want the child, two biological parents who each donate gametes, and the biological mother who carries the child of the two biological parents for the two social parents.

The first example of gamete donation is the infamous first known case of DI in 1884. Apparently Dr William Pancost told medical students he was treating a couple whose infertility was due to the husband being sterile and asked what should be done. Demonstrating the sort of original thought and sober judgment for which medical students are renowned it was suggested the best looking student supply some sperm! Dr Pancost took the suggestion seriously and, when supposedly just examining the sedated woman, he inserted a student’s sperm into her body without her consent to see what would happen. Nine months later the first child born by donor insemination was born, although the woman always believed it was her husband’s child conceived naturally.

Using gametes without consent from all parties is generally considered not acceptable. Indeed, in a famous case in the UK in the late 1990s, Diane Blood was refused IVF using her dead husband’s

¹ Agneta Sutton, *Infertility and Assisted Conception: What You Should Know*, The Catholic Bishops’ Joint Committee on Bio-Ethical Issues, London 1993, pp30-31. Online at http://www.catholic-bioethics.org.uk/documents/infertility_assisted_conception.pdf

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sperm because his explicit consent to donate sperm had not been given before he fell into the coma from which he never revived. Although she was allowed to receive fertility treatment abroad, having two sons in 1998 and 2002, it required a change of the law in 2003 before she could register her dead husband as the posthumous father. Another interesting question relating to consent is who are considered the relevant parties – can a woman use donor sperm to become pregnant simply on her own decision or does her husband/partner and so prospective social father also have to give informed consent to the procedure?

The **first** issue is whether sperm and egg donation is wrong in principle, whatever the consequences. For some people, using donor gametes is wrong because they in some sense violate the bond between the couple by bringing – like adultery – another party directly into one of the most intimate aspects of the marriage relationship and in a way that is then embodied in the life of another human being. So, when in 1945 the British Medical Journal carried a report on four cases of DI a commission set up by the Archbishop of Canterbury called (unsuccessfully) for the procedure to be criminalized in England. In 1958 the Lambeth Conference of Anglican bishops said that it 'cannot see any possibility of its acceptance by Christian people'. With changing patterns of marriage and family life and the growth in blended (or step-) families with parents accepting children born with another partner or spouse, there is now much less social objection to using donor gametes although the purposeful creation of a child by this means is morally distinct from similar practices such as adoption and held to be wrong by some. Other important questions also arise.

Second, there is the question of who donates and who knows what about them. Sperm and eggs are quite different from other organs that may be donated. They are much more tied to human personhood and the uniqueness of each human individual. Far from simply enabling the recipient to flourish as normal (as with say a kidney transplant) they create a totally new human life whose personal characteristics are being significantly determined by the gift being made.

The simple fact is that none of us knows how we were conceived. We rely on social assumptions and honesty from our social parents. So, should those conceived with donor gametes be told their social parent is not their biological parent? If so, at what stage in life, and how? There are horror stories – sadly not all apocryphal – of children traumatically discovering this about themselves through reading parents' emails or from comments made by those who knew and did not realise they did not know.

For many years sperm donors were assured of anonymity. As a result, parents knew little more than the basic physical characteristics needed to make a good "match" and children born through DI never knew who their biological father was. That situation has now changed in the UK as it is held that children have a basic human right to know about their genetic identity. As a result, since 2005 all children conceived through donor gametes are legally entitled to identify their genetic parents once they reach 18. This does not, however, apply retrospectively, so most children born with donor gametes are still unable to discover who their biological parent (usually the father) is.

This raises a **third** set of questions which concern the consequences of using donor gametes and so are particularly important within a utilitarian ethic. What impact does using donor gametes have on the relationship of the couple who bring up a child where one of them has been unable to contribute to its genetic make-up? Perhaps more significantly, what is the impact of using donor gametes on the person conceived? Can the technique be said to cause them harm?

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There is some evidence that those born as a result of donor sperm where the donor remains anonymous face difficulties as a result. A US survey in 2010, entitled "My Daddy's Name is Donor", studied a sample of 485 adults between 18 and 45 whose mother used a sperm donor to conceive them. It concluded

We learned that, on average, young adults conceived through sperm donation are hurting more, are more confused, and feel more isolated from their families. They fare worse than their peers raised by biological parents on important outcomes such as depression, delinquency and substance abuse. Nearly two-thirds agree, "My sperm donor is half of who I am." Nearly half are disturbed that money was involved in their conception. More than half say that when they see someone who resembles them they wonder if they are related. Almost as many say they have feared being attracted to or having sexual relations with someone to whom they are unknowingly related. Approximately two-thirds affirm the right of donor offspring to know the truth about their origins. And about half of donor offspring have concerns about or serious objections to donor conception itself, even when parents tell their children the truth.²

A **fourth** set of ethical questions arises in relation to who is able to use donor gametes and who makes such judgments. Once the creation of a child is abstracted from a physical union of a male and female body and becomes the bringing together of sperm and egg by human techniques there is no longer any given limit to who can have a child. John Robertson and others have spoken of "procreative liberty" – the freedom to have children or to avoid having them. Robertson argues that "although often expressed or realised in the context of a couple, it is first and foremost an individual interest".³ With donor gametes available (whether freely or bought and sold in some form of market), it becomes possible for a single woman to have a child without any relationship that would provide a father. Since laws relating to a child's need for a father were relaxed in 2008 there has reportedly been a tripling in the number of single women using IVF. The use of donor gametes also allows same-sex couples to have children. This has for some time been relatively easy for a lesbian couple using donor sperm but, as the recent famous case of Elton John and David Furnish demonstrates, it is now possible for gay men to father a child using a surrogate and donor egg.

In conclusion, the use of donor gametes therefore raises new ethical questions. There are *questions of principle* – should donor sperm and egg be used at all? Should children know who donated the sperm that enabled them to exist? There are *questions of practical consequences*, notably whether there is evidence that separating biological and social parenthood harms the child, especially when the former is anonymous. There are *social, legal and political questions* of what limits there should be on the use and availability of gametes: when, if ever, is it right to deny someone a child using donor gametes and are forms of ART bringing about a significant reconfiguration of what we mean by "family"? There is also here the beginning of another deeper question which becomes even more pressing in relation to IVF - are we sometimes in danger of making children into a new form of consumer commodity?

² "My Daddy's Name is Donor", pp 5 -6, full report at www.familyscholars.org/assets/Donor_FINAL.pdf

³ John Robertson, *Children of Choice: Freedom and the new reproductive technologies* (Princeton University Press, 1994), p 22.

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What about embryos?

Once it was possible to collect and store human gametes, the question inevitably arose as to whether they can be used to produce a new human life. In 1968 scientists Robert Edwards and Barry Bavister were the first to fertilize a human egg successfully in the laboratory. It was not until ten years later - on July 25th, 1978 – that the first "test-tube baby", Louise Brown, was born. Since these developments there has been a whole set of new ethical questions. These are now focussed on the widespread availability of in vitro fertilization (IVF) which has produced over one million children worldwide. Clearly all the issues raised already can also arise with IVF but there are other questions which are new.

The **first** ethical issue is how we are to view the embryo created *in vitro* and whether it is to be treated significantly differently from human gametes. For some people, especially many Christians, a fertilized egg, containing a new, unique genetic code is a new, unique human person made in the image of God. This makes an embryo qualitatively different from human gametes and requires it to be treated as we would treat any other human being whose life should be nurtured and protected and who therefore should not be harmed or destroyed. Others, however, argue that the embryo at its earliest stages of development is not to be given the same status as fully developed humans. It is not a human person with potential but, at best, a potential human person. Here the 1984 Warnock Report has been highly influential both in relation to UK law but also more widely. It argued that, rather than focussing on 'conception', the decisive point is at the end of the second week of development with the formation of the primitive streak – the start of the nervous system and spinal cord. This is when the cells have differentiated into embryo and placenta and twinning is no longer possible.

This question is relevant to IVF because, although it would be possible only to create as many embryos as it was intended to implant, in practice this does not happen. For a variety of reasons, including cost and possible future treatments, the normal practice is to create more than the one or two embryos usually implanted and this leads to the next ethical challenge.

The **second** issue in IVF is that of 'spare embryos'. Given more embryos will be created than are transferred to the woman's body, what is to be done with those not implanted? These will be frozen but ultimately decisions will have to be made about what to do with them. One option here is for the couple to use them in another IVF treatment. This may be because they wish another child after a successful treatment or it may be because the first (and perhaps second or third) attempt at pregnancy failed to lead to a live birth. It is estimated that 29% of IVF cycles led to a live birth for women aged under 35 but this success rate falls quite quickly as the woman ages so that it is only 11% for women aged 40-42, 5% for women aged 43-44 and less than 1% for women aged over 44. Another option is for the embryos to be donated to another couple, what might be considered the earliest stage of adoption. The more ethically controversial options involve destroying the embryos either directly or indirectly through experimenting on them in order to try to increase our knowledge and assist in treating infertility or curing genetic diseases. These can be difficult decisions for those who have always sought a child and now have frozen embryos that, even if they do not view them as children, are potential children. Decisions are even more difficult when parents die or separate.

The **third** ethical and legal issue in IVF is therefore ownership of frozen embryos. Here we again face the challenge noted earlier of the commodification of children but in a much more material sense.

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IVF is a re-productive technology which makes a definite product – human embryos – whose ownership can become contested. At the more bizarre end of the scale, there was the case of Marion and Elsa Rios, who, after receiving IVF treatment died in a plane accident making their frozen embryos potentially heirs to their great fortune. This led to many offers to adopt these particular embryos, until a court ruled that, even if brought to term, they would not be able to inherit. More tragic are situations where the couple split and one wishes to use the embryos but the other refuses. The legal situation is that one party has a veto though the pain this can cause and the ethical challenges some see it raising are vividly summed up in the words of divorced Lorraine Hadley who lost her legal battle: "An embryo is not a possession to be divided up in the divorce proceedings. It is a baby in the making. I fully accept that men have rights too. But I find it abhorrent that we should be able to create these little human beings - and then flush them down the toilet on a whim. Why should one of us have the right to say the embryos should be destroyed simply because it doesn't suit them any more?"

This example of how something which so often produces good outcomes can produce bad outcomes raises the **fourth** question of the risks and possible negative consequences of using IVF. The whole process itself can be very emotionally difficult, particularly for the woman and especially when repeated attempts fail to produce the desired child. One way to increase success rates is to transfer more embryos to the woman. That, however, can lead to carrying twins, triplets or an even larger number of children. This creates added emotional and financial burdens and sometimes the need to decide whether to carry out selective abortion to reduce the number of embryos in the womb. There have therefore been ethical criticisms of IVF and ART more widely from a feminist perspective, critiquing the subjugation of women and male control over women's bodies

Given the oldest IVF baby is only in her early 30s and there are a range of different techniques now used in relation to IVF, we still know relatively little about whether or in what ways certain forms of IVF might increase health risks for those conceived by it. In 2003, Lord Winston, a leading figure in the area, expressed concern that more research was needed and warned that "Whilst the early reports of IVF were wholly reassuring in terms of the abnormality rate, there is now a lot of data out there in the public arena which suggests that some procedures actually, under certain circumstances, might be quite dangerous".⁴ In 2006, it was reported that a recent study found that children born after their parents sought fertility treatment were four times more likely to have autism than those born to fertile parents. There were also rises in childhood cancers and attention deficit hyperactivity disorders.⁵

On the other hand, IVF can also be used in order to reduce the likelihood of seriously ill children but this raises the **fifth** significant ethical question – the place of embryo selection. Because IVF enables parents and doctors to choose which embryos to transfer, questions inevitably arise about whether there are ethical constraints on such a choice. At its simplest, can a couple choose to have a boy rather than a girl? More seriously, if the couple know they risk passing on a serious deformity or

⁴ Quoted in Independent, 11th Sept 2003 - <http://www.independent.co.uk/news/science/winston-warns-of-risks-to-testtube-babies-in-later-life-579544.html>

⁵ Report in The Guardian, 26th Oct 2006 - <http://www.guardian.co.uk/science/2006/oct/26/lifeandhealth.medicineandhealth>

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medical condition such as cystic fibrosis, should they use pre-implantation genetic diagnosis (PGD) to ensure that all embryos transferred are free of the problem? Ethicists such as John Harris who work from a utilitarian or consequentialist perspective would argue that such decisions should be made. Some view it as immoral and blameworthy for parents to refuse to do this and fail to prevent their child from suffering. Others, however, vehemently object to this and view it as a form of eugenics where the eradication of diseases occurs by the elimination of those humans – albeit as embryos – who suffer from them.

The moral challenge becomes even more stark when there are competing conceptions of health and disease: was it right for a deaf couple to turn standard procedure on its head and choose an embryo they knew would be deaf? Most recently there has been debate about 'saviour siblings' created in order to provide compatible tissue or other material to treat an existing sick child. As expressed in Jodi Picoult's *My Sister's Keeper* and the film of the book, this practice – now legally permissible in the UK - raises a range of ethical issues and would be seen by some as violating a Kantian ethic based on refusing to treating people as means and not ends in themselves.

Conclusion

The various forms of ART are all seeking to achieve the good of a healthy, wanted child and to respond to the pain and suffering that comes from infertility or the danger of passing on a serious genetic condition to one's children. A utilitarian or consequentialist ethic based on seeking good outcomes will therefore have a very strong presumption in their favour although questions can arise as to whether they also harm those they appear to benefit. For others, some of the techniques used violate God's order and human dignity or undermine fundamental principles which need to be upheld as they protect human life and good family structures within society. These techniques therefore need to be resisted as a temptation even if they apparently offer some good consequences. Perhaps most interesting and challenging of all, is the question of the deeper impact of ARTs as they arise out of and shape an individualistic, economically consumerist and politically liberal and rights-based society. Whatever their justification in any particular case, might ARTs provide the means to transform the desire for a child into a perceived right to have a child? Here wider ethical questions arise as to whether children flourish better in certain structures of relationship and whether ARTs, having initially provided solutions for infertile couples, may now be redefining our whole way of understanding parenting, families and children.

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