Right to Access Reproductive Technologies – A Right or A Wrong?

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Received Date: May 18, 2016, Accepted Date: July 11, 2017, Published Date: July 21, 2017.

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Abstract

The advents of new Reproductive Technologies (RT) have changed many lives by helping thousands of women to conceive. Advancements in medical science have not only provided remedy for infertility and also provided a chance of parenthood for single mothers, homosexuals, post-menopausal women with or without the direct involvement of a male partner. Development of reproductive technologies opens delicate legal questions and bioethical dilemmas: should unrestricted access to reproductive technologies be made readily available to all eligible singles/couples and what are the eligibility criteria? To what extent should children’s interest be of concern when determining access to RT? This article will look into legislative framework on access to reproductive technology, relevant case law, technological advancements in the treatment of infertility and other issues arising out of uninterrupted access to reproductive technologies, as well as some controversy surrounding it. The aim is to assess whether there is a solid argument for unrestricted access to RT and legal conditions for exercising this right.

Keywords: Reproductive technologies; Infertility

Introduction

The argument for and against the uninterrupted access to reproductive technologies (RT) for individuals can be understood as a clash of ideologies among libertarian advocates and utilitarian thinkers.

The concept of autonomy in the reproductive process has its roots in the belief that individuals should be in full control over their lives, their choices, their convictions and their beliefs. Even persons with severe mental illness or retardation are protected against compulsory sterilisation or contraception. In Re A (Male Sterilisation) [2000], the Court of Appeal held that “Sterilisation of a mentally incapacitated patient on non-therapeutic grounds could only be carried out if it was in the best interests of the patient. The concept of best interests relates to the mentally incapacitated person and was not limited to best medical interests, but encompassed medical, emotional and all other welfare issues [1]. Autonomy contravenes the idea of state interference except, when others are harmed in the process of exercising one’s right to access reproductive technologies. This notion is highlighted in the following quote:

“… The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. The only part of the conduct of any one, of which he is amenable to society, is that which concerns others. In the part which merely concerns himself his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign”.  
JS Mill [2]

The realisation for reproductive freedom came in the twentieth century when it was violated the most – by forced sterilisation in many countries, by forced child-bearing under the Nazis, by forced abortions in China, and by forced sex in marriage [3]. The freedom from coercion in reproduction is now an integral part of reproductive autonomy. The advent, development and spread of reproductive technologies gave a fillip to the otherwise sexually constrained women, who now found newer ways to restrict as well as induce pregnancy through technology. The contraceptive products helped people avoid reproduction without inhibiting their basic sexual instinct. Similarly, in-vitro fertilisation (IVF) technique helped hundreds and thousands of women conceive which seemed a remote possibility due to multiple medical factors [3]. Furthermore, various techniques for assisted reproduction offer not only a remedy for infertility but also offer the fertile single woman or lesbian couple the chance of parenthood without the direct involvement of a male partner [4].

The aim of this article is to highlight some major issues pertaining to access to reproductive technologies and to consider whether this is a universal right of access to these technologies, by taking an international law and human rights perspective, analyzing the case law of the European Court for Hunan Rights, and examining the legal framework in the UK. For the sake of brevity, this article is divided into five sections.

The first section looks into the controversy on the right to access reproductive technologies. The second section explores the legislative framework that regulates the access to the latest reproductive technologies. The third section reviews at the technological advancements in the treatment of infertility and how access to the latest technologies for all capable adults can pose serious social and legal issues. The fourth section highlights the problem of limited public funding available with the National Health Services, UK (NHS) to ensure free access to reproductive technologies. The last section discusses about certain legal, ethical and privacy issues that are a by-product of unrestricted access to reproductive technologies among the capable adults. The author concludes by submitting that granting autonomy in the matters of reproduction has some dangerous consequences, especially for the welfare of the child.

The Controversy

The idea of respect for individual choice and reproductive autonomy was supported by several other thinkers, including Ronald Dworkin, who defined the right to procreative autonomy as being the “right [of people] to control their own role in procreation unless the state has a compelling reason for denying them that control”. He further described this right as being “embedded in any genuinely democratic culture” [5]. In this context, procreative autonomy is a negative right.

Negativity is reflected by the idea that it is a right against State interference in the reproductive freedom of a person. It does not confer any positive right to the individuals to demand from the State the provision of resources or means by which to have, or avoid, having children.
However, it can be argued that the right of prison inmates to reproduce may be restricted, albeit on grounds of security, etc [6].

Jackson and Harris also supported the idea of State’s non-interference and unfettered access to reproductive technologies. They are of the opinion that “interference with access to reproductive technologies is a violation of procreative autonomy, and that the real or perceived dangers of possible harm are insufficient to justify constraints” [7]. In order to overcome criticism of his contentions, Harris posits that infertility may be considered as a disability, which warrants full and free access to reproductive technologies. Viewing the regulation of access to reproductive technologies as discriminatory, Harris asks if fertile women are not prevented from having children just because they are ill, addicted, immature, incapable or unlikely to be committed parents, why should there be any conditions on the access to reproductive technologies? [7] Articles 8 and 12 of the European Convention on Human Rights also guarantee respect for family life and the right to found a family.

By corollary, these articles support the concept of autonomy in access to reproductive technologies, as a family is considered complete by procreation and any restriction on access to reproductive technologies to the competent adults can be considered as violation of the basic human rights and dignity.

For instance, in Dickson v UK [8], the European Court of Human Rights held that UK’s refusal to allow the applicant prisoner to have facilities for artificial insemination breached his and his wife’s rights under Article 8 of the European Convention on Human Rights [9]. Rejecting the UK Government’s contentions, the Grand Chamber stated that “an inability to beget children is not an inevitable consequence of imprisonment and providing access to insemination facilities would not create a security issue or any significant financial demand on the State” [8]. The Court further observed that it to be legitimate that the policy should be concerned with the welfare of a child; “however, that cannot go so far as to prevent parents who so wish from attempting to conceive a child” [8].

However, unfettered access to reproductive technologies is not a right that has bipartisan support. The challengers include O’Neill, who support legitimate regulation and argues that factors, such as long term dependency of children born and the parental capabilities of prospective parents need to be fully considered before granting procreative autonomy [3]. The visions of reproductive autonomy, according to O’Neill, are neither convincing nor attractive because they misconstrue having children as a form of self-expression that demands individual autonomy [3]. The welfare of the child is the central theme of O’Neill’s arguments against granting unfettered access to reproductive technologies to the competent adults.

Children’s rights are protected on international level by the UN Convention on Rights of the Child. The Convention is among the most ratified international legal documents and enjoys widespread support globally, being referenced to in numerous policies and treaties concerning minors. The Convention places focus on child’s best interest and the surrounding family structure. It also guarantees a child’s right to know and be cared for by his or her parents, to preserve his or her identity (Articles 7-8), freedom of expression (Art. 13), right to access best possible medical care (Art. 24), social security (Art. 26), to participate in cultural life (Art. 31), as well as for respect and protection of their rights by the government, parents and other adults acting in their best interest (Article 4) [10].

Some writers have argued against unfettered autonomy on the health and safety grounds. For instance, Robertson raised a number of concerns against unrestricted access to Assisted Reproductive Technologies (ARTs), including risks of lower birth weights and major malformations in births using IVF procedure; child-rearing ability, age, disability, health status, marital status or sexual orientation of the individual; risks associated with providing ART services to persons who could transmit infectious or genetic diseases (e.g., HIV, cystic fibrosis); risks to offspring from inadequate parenting arising out of ARTs provided to persons with mental illness or serious disability, use of ARTs in unique family settings, such as surrogacy, posthumous uses of gametes and embryos, or with single parents or same sex couples [6]. Another issue raising concern in this line, would also be misuse of genetic material, without donor’s permission or for goals other than parental and child-bearing purposes, such for experimental cloning, advanced genetic selection and other forms or genetic and embryo alterations.

The Legislative Framework

The Warnock Committee, in its preliminary discussions, dwelt at length the issue of access to infertility treatment [4]. During the discussions, the Committee, inter alia, resolved that the legal status of marriage cannot be the basis to deny infertility treatment to anyone [4]. The Committee further resolved that as a general rule, it is better for children to be born into a two-parent family, with both mother and father, irrespective of the duration of such relationship [4]. This, the Committee was of the view that treatment would be inappropriate in the case of lesbian or bisexual couples or in the case of any person not in a stable heterosexual relationship.

In order to address the ethical and safety issues surrounding the use of reproductive technologies, the Human Fertilisation and Embryology Act was brought into effect in 1990 ("1990 Act"). This legislation comprised of certain prohibitive and permissive elements concerning the reproductive procedures, including among others, Gamete Intra-Fallopian Transfer (GIFT) and Intra Uterine Insertion (IUI) [11]. These regulations have amended the 1990 Act by introducing new legal requirements for licensed organisations involved in the donation and procurement, testing, processing, storage and distribution of gametes and embryos. However, in 2005, due to technological advances and perceived changes in ethical and societal attitude, the House of Commons Science and Technology Select Committee investigated the legislative framework of this legislation, which culminated into the Human Fertilisation and Embryology Act 2008, and which amended the 1990 Act, the Surrogacy Arrangements Act 1985 and provides for parenthood provisions.

One significant aspect of the 1990 Act was the introduction of the Welfare Principle within the legislative framework. Section 13(S) of the 1990 Act provides that 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). The amended Section 13(S) reads thus: “A woman shall not be provided with treatment services, other than basic partner 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”[11]. Thus, although 1990 Act contains no statutory prohibition for the treatment of any competent adult (either single or lesbian or postmenopausal women) through access to reproductive technologies, yet the ‘welfare of child’ is given due consideration.

The Welfare Principle was applaudied by some prominent personalities, including Lord McGregor, who said: “the Welfare Principle was a happy extension of a principle, which has now
been part of English law for more than half a century”[12]. Similar sentiments were expressed by MP, Jo Richardson, who was the advocate of client’s needs, when he agreed that the clinician ought to take account of the welfare of the child[13].

Prior to 1990, the clinics offering donor insemination were free to treat, or refuse treatment to, any individual, including single women, lesbians, or couples where the husband was aged [14]. However, with the inclusion of the word ‘father’, the welfare of the child was given prominence and a question mark was raised on the free access to reproductive technologies for all competent adults.

Another pertinent question concerning welfare of the child arises: what yardstick should the clinician adopt in determining the welfare of the child while deciding whether to offer treatment to a particular couple or individual? Jackson is of the view that the access to infertility treatment can be denied only when such circumstances can be envisaged under which non-existence would be preferable to the life that would be led by children of these would-be parents [15]. The Parliament, however, reasoned that the clinicians should look into the factors, such as the would-be parents’ commitment to having and bringing up a child; their ability to provide a stable and supportive environment; their future ability to look after or provide for a child’s needs and the possibility of any risk of harm to their child [11]. Jackson further advocated the need to have the parental aptitude assessed before conception, for anyone who cannot conceive naturally [15].

The Welfare Principle, as a decisive factor in allowing access to reproductive technologies, however, was rejected by Jackson when she observed that such an assessment will be unfair because firstly, we cannot expect fertile people to prove their parental adequacy prior to conception; and secondly, the clinicians cannot be provided with enough information to make such a complex judgement as to the parental adequacy of fertile people; and thirdly, the law generally favours existence to non-existence [15]. Although future predictions of parental aptitude may seem unconvincing in absence of clear proofs to the contrary, it is certain that continual psycho-social support to prospective parents can have positive effects on raising children conceived with assistance of RT. It is therefore advisable to include measures of parental support after biomedical conception of a child, to assure better parental competences, given circumstances of child’s conception.

On the other hand, it should be seen as contrary to human rights standards to allow access to RT, when it is improbable that a child would enjoy a set of welfare standards attributed by the international and domestic legal standards. This would include social surroundings and settings in which parents’ homosexual orientation is heavily seen and treated as a psychosocial disorder, or where same-sex marriages ban is still holding strong. Other indicators incompatible with access to RT should include parent’s history of child abuse, diagnosis of violent or other types of anti-social behaviour among parents. In these cases it would often and to a high degree be inadvisable to allow for access to RT, because of foreseeable social stigmatization of the child and possible accompanying disorders in duced by child abuse, bullying and other forms of external behaviour that would endanger child’s social and emotional wellbeing.

The restrictions imposed on the access to reproductive technologies have found favour in the recent judgement of the European Court of Human Rights [16]. In the instant case, two married couples challenged the provisions of Austria’s Artificial Procreation Act prohibiting heterologous techniques for in vitro fertilisation. Ovum donation is prohibited under all circumstances, while sperm donation is only possible when the sperm is directly placed in the womb of a woman. In upholding the validity of the legislation, the Grand Chamber observed, “the Court’s task is not to substitute itself for the competent national authorities in determining the most appropriate policy for regulating matters of artificial procreation... concerns based on moral considerations or on social acceptability must be taken seriously in a sensitive domain like artificial procreation”[16].

This is an example of the so-called margin of appreciation doctrine developed in court practice of the European Court of Human Rights, which leaves discretionary power to states to make best choice decisions in areas in which diverse cultural and legal traditions and diverse societal norms exist, while fulfilling their obligations under the Convention [17]. The main argument for allowing such discretionary power to states is that national authorities are better positioned to make decisions in situations where there is not inter-state or regional consensus on legal issues due to different psycho-socio-cultural values, customs and traditions that exist in different societies. However, states need to prove that they exercised a careful and detailed analysis of the situation prior to making a decision that effects human rights. The application of this doctrine in area of reproductive technologies shows that a broad margin of appreciation is left to public authorities when deciding in which way and manner they regulate access to reproductive technologies, because approach to this subject matter significantly varies socially, culturally and legally among different states. It also implies that determinations would have to be made on case-to-case basis and backed up by plethora of indications that government took into account when deciding on whether to grant access to RT or deny it.

**Technological Advancements**

Over the years, technological advancements in the field of reproduction have generated a lot of excitement, especially among people with infertility. For instance, in-vitro fertilisation (IVF), in-vitro maturation (IVM), IUI, GIFT, surrogacy, etc. have been gaining popularity among infertile couple to have children. Although such technologies are much in demand and are rampanty used in infertility clinics, yet several cases of medical negligence have been observed, which is again a by-product of ease access to reproductive technologies.

In *Evans v UK* [18], a curious case was decided by the European Court of Human Rights. The primary issue involved in this case was the presumption of a continuous consent between a man and a woman at every stage of reproductive process. In this case, the woman was detected with ovarian cancer, and she was offered IVF treatment before commencing her cancer treatment, as the latter could lead to infertility. On successful fertilisation of her eggs using her partner’s sperms, she was told to wait for a period of two years before the implantation of embryos in her uterus. However, the couple separated in the meantime, and her partner withdrew his consent and asked the clinic to destroy the stored embryos. The woman challenged the validity of the provision of the Human Fertilisation and Embryology Act 1990, which allows either of the couple to withdraw their consent at any time before the embryos are implanted in the woman’s uterus. The High Court, the Court of Appeal, and finally, the European Court of Human Rights ruled in favour of the legislation. In effect, the courts held that the woman’s right to a family life, as guaranteed by Article 8 of the European Convention of Human Rights could not override her partner’s withdrawal of consent.

This has been a controversial verdict, as highlighted by Michael Wilks of the British Medical Association Ethics Committee, who sought extension of the period of 5 years for storage of embryos.
after one partner withdraws consent, so that there was less of a “ticking clock” [19]. Another viewpoint in opposing the judgement was expressed by Josephine Quintavalle of the pro-life group, Comment on Reproductive Ethics, when she said that her partner “had become a father” when the embryos were created, and the court should have compassion for the woman”[19].

Thus, even though the couple were given unfettered access to reproductive technologies, a situation was created wherein though the courts followed the law, yet justice was not delivered to the woman, whose last hopes of bearing a child were dashed by withdrawal of consent by her partner. In this situation the European Court of Human Rights took the egalitarian approach and pronounced that right of access to reproductive technologies is a natural right of a man’s right as it is a woman’s right. This pronouncement has important practical implications in realization of access to RT.

Public Funding

Unrestricted access to reproductive technologies also raises another important question – how far is it justified to publicly fund the reproductive treatment? Undoubtedly, reproductive treatments are very expensive and require multiple sessions/sittings, making the costs rise exponentially. Even the NHS often finds itself at a loss at times when it is difficult to consider infertility treatment as an “illness” requiring public funding. Unless the condition of the patient falls under the statutory definition of “illness”, he/she cannot claim treatment at the public expense. National Health Service Act 2006 imposes duty on the Secretary of State to provide “...services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service [20].” In order to address the situation, the National Institute for Health and Care Excellence (NICE) updated the guidelines of the Royal College of Obstetricians and Gynaecologists in February 2004. Accordingly, three cycles should be available to the woman when she is at an optimal age for fertility treatment, i.e., between 23–39 years, when there is a recognised cause of infertility of any duration, or alternatively unexplained infertility of at least three years’ duration. However, despite the updates, a survey in 2006 showed that some Primary Care Trusts were not funding any IVF treatments, and that the vast majority were funding not more than 50% of the treatments, and that the rate of such treatments is on a lower side. There are multiple problems that may result in unhealthy baby, people with a history of sterilisation, obesity, smoking, etc.

In R v Sheffield HA, ex p Seale [22], the Sheffield Health Authority refused to provide IVF treatment to the woman due to a policy adopted by the Authority wherein the access to infertility treatment shall be provided to only those women who are between 25-35 years age group due to scarce financial resources available at the disposal of the Authority.

Other Issues

While it is understandable that reproductive technologies are beneficial for the infertile patients, it is equally true that the success rate of such treatments is on a lower side. There are multiple factors at play, which influence the success of these treatments, viz., advanced maternal age (over 35 years), other medical complications that may result in unhealthy baby, people with a history of sterilisation, obesity, smoking, etc.

For instance, in R v Ethical Committee of St Mary’s Hospital (Manchester) ex p Harriott [23], the IVF treatment was refused to a couple because of multiple factors, including their previous rejection for adoption by adoption agencies; the woman’s criminal record for offences relating to prostitution and the running of a brothel; and an alleged poor understanding of the role of a foster parent.

Unrestricted access to reproductive technologies also raises a host of ethical and legal issues. For instance, posthumous reproduction is one such challenging area. The Warnock Committee Report [4] discouraged the posthumous use of gametes and embryos on the grounds that this might lead to psychological problems in the child and the mother. Another possibility in case gametes and embryos are used posthumously is the non-closure of administration of estates following such births.

The courts in the UK were presented with one such rare opportunity to deal with a case of posthumous use of embryos and gametes (Blood case). In the instant case [24], the Court of Appeal upheld the refusal of HFEA to permit the wife of the deceased person to be inseminated with her dead husband’s sperms, on the ground of lack of written consent of the dead husband with respect to the storage of his sperm, which was contrary to the provisions of 1990 Act.

Privacy is another important issue that often gets compromised if unfettered access to reproductive technologies is granted to every capable adult. The general rule under the 1990 Act is to maintain high levels of confidentiality from the service providers with respect to the personal details of gamete and embryo donors. However, the regulations related to Section 31 of the 1990 Act empowers the children born as a result of donated tissue to request the HFEA to confirm their origins; e.g., when they intend to marry, enter into a civil partnership or planning to have an intimate relationship with someone; so that they can know if they are genetically related to their intended spouse [25].

In Rose v Secretary of State for Health [26], acknowledging the right of the donor-conceived individual to access information about the donor, it was held that respect for private and family life under Article 8 of the European Convention of Human Rights required that every person should be able to establish details of their identity as human beings, including their origins, and the opportunity to understand them.

Thus, autonomy in the matters of access to reproductive technologies encompasses the access to donor’s information as well. However, not all the donors will come forward if they know that their information will be revealed to the donor offspring, as it may create complicated situations later in their lives. Nevertheless, privacy issues of this kind suggest that parental freedom of procreation as well as donor’s right to anonymity need to be carefully balanced with the child’s right to personal autonomy, including right to know its origin and biological history.

Conclusion

The advancement in the reproductive technologies has undoubtedly opened newer vistas for infertile people. This article has shown that a desire to have a child is among aspects of realizing one’s personality, right to family life and right to optimal mental and physical health and that personal autonomy, including autonomy of choice to conceive a child, has a long-standing tradition among libertarian authors. However, no matter how appealing the argument for rights of born adults to make autonomous choices regarding that family life, parenthood and descendants, rights of the unborn children should also be taken into account when considering access to RT. The access to these technologies poses a serious challenge to the health authorities and law makers, as well
as serious ethical and societal question about the welfare of the child. This is especially the case in terms of unrestricted access to RT to all competent adults, including lesbian couples, homosexual male couples, single parents, parents with history of genetic disease, persons with anti-social biographical elements etc. English law is at a transitional stage in responding to these questions surrounding access to assisted reproduction.

So far, there is no international consensus concerning regulation of access to reproductive technologies, and there are no enforceable, international obligations for states to allow access to reproductive technologies in their healthcare systems in each and every case or to provide public funding to aid access to these technologies. It is certain that careful balancing of interests in each case will be required in order not to infringe the European Convention and still satisfy children’s rights standards. Legal authorities should interpret the provisions on access to RT to encompass cultural, social, ethical and legal implication pertaining to each individual case and broader social context including ethical, sexual and reproductive norms that exist within society. It would be ethically acceptable to allow such access according to the Welfare Principle, in cases in which a conceived child would enjoy a quality of life, welfare standards and protection of its rights in the existing society equal to other naturally conceived children, considering social norms and customs. To conclude, the state of law, including an international legal standard does not lend itself to the conclusion that universal human right to access RT exists, even when it is not otherwise possible to naturally conceive a child. Further bio-medical and legal research is needed to determine in which situations access to RT is justified at national level in a given society. Legal intervention must reply to fast development and which situations access to RT is justified at national level in a given society. Legal intervention must reply to fast development and similarly cases of assisted reproduction. Similarly, in situations of advanced reproduction in medicine and science in this filed, but only in a way that accommodates human rights and interests of both parents and their intended children.

Conflict of Interest

The author of this article has no conflict of interest with any person or agency in context with this research and article.

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