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In vitro fertilisation: the major issues – a comment

G D Mitchell

The paper by Professor Singer and Mr Wells is an interesting one for it presents views that are likely to obtain a great deal of support from medical scientists and medical practitioners. But it is interesting also for what it fails to do in considering the ethics of *in vitro* fertilisation. It may be noted in passing that the authors do not limit themselves to *in vitro* fertilisation, which they rightly say is ethically controversial, nor could they, for all forms of artificial reproduction need to be considered together. However, let us firstly, ask what we mean by ethics.

The Oxford English Dictionary describes ethics as 'The science of morals' (1602), but a later definition describes ethics as 'the rules of conduct recognised in certain limited departments of human life' (1789). Now rules of conduct must be essentially social, even private acts are subject to the judgment of society even if the sanctions applied to offenders against the rules are informal and manifested in mild disapprobation. Thus the rules of conduct, subject to circumstances and situations, are general and of universal applicability. To be sure they apply to the individual's conduct in relation to himself, but much more in relation to others, and this in the interests of the general welfare of all. All action is fundamentally social action and no individual can live apart from society. For this reason we must examine conduct, including behaviour associated with IVF and other forms of artificial reproduction in terms of their effects on the society of which the individual is a constituent part.

It may be objected that this approach loads the debate and that the place to start is the source of authority for rules of conduct, which is what various ethical systems do. Thus there are ethics of a stoic, Christian or Kantian nature, which all appeal to a source of authority, and there is utilitarianism, which probably is the most effective influence on modern thinking. The source and criticism of values may be reason, God, or some inner light which distinguishes good from evil and right from wrong. Yet there is also a venerable tradition, largely Aristotelian, which argues that as men are made by nature to live in communities, their communal purposes are the ultimate values from which the rest are derived, or with which their ends as individuals are identified. In short we cannot determine individual conduct unless we have some

clear notion of the society, or *polis* in which the individual exists, and of what is required for the society's well-being.

It follows that the ethics of *in vitro* fertilisation cannot be discussed apart from other forms of artificial reproduction, and that artificial reproduction cannot be discussed aside from the part played in society by normal forms of human reproduction. Let us pause to consider the fact that society has always controlled reproduction, but it has done so indirectly by determining who may reproduce. It has therefore traditionally regulated reproduction through the institution of marriage and has upheld rules against incest, adultery and unlawful sexual intercourse as between those under a certain age. This means reference must be made to the institution of marriage, which is a public declaration about responsibility for the issue of a union, and the family in which marriage is embedded. Marriage and the family are important parts of human society, being ubiquitous, albeit taking various forms from time to time and from place to place according to cultural differences. The reason why marriage is important lies in the social ends it serves. Firstly, society has to be maintained over time in a structured way; secondly, those who are engaged in the reproductive process must be supported and sustained; and thirdly, those who are produced as offspring need to be cared for.

Instead of approaching their subject in this way Singer and Wells ask if IVF is natural. They distinguish between descriptive and teleological views, and they plump for the latter, which looks at the ends of human kind. But, even so, in arguing that we are most truly human when exercising our specifically human capacities, and IVF certainly can be said to do this, they conclude that what is natural is good. This, of course, is true also of the production of nuclear weapons. Surely, what is important teleologically is to ask to what end IVF as a technique is to be employed and who benefits from it – the individual at the expense of society, or not and, if individuals, which individuals?

If IVF like AIH (Artificial Insemination by Husband) is to help a husband and wife have a child of their own using his sperm and her oocyte, then it is difficult to see any reason for not employing these

techniques. It could be argued that reproduction might perpetuate infertility in the child, but this is not a major argument against the practice. If, however, there are to be donations of semen or oocytes, or the use of a surrogate mother to produce an embryo for transplantation, then there are major social issues to be considered.

One unexamined assumption of the authors' paper is the right of a person who desires a child to have one. It is not obvious why desire should give rise to a human right, especially a desire which leads to the creation of a new individual who also has rights. The principal consideration is not the adult's desire but the child's welfare. This is fully accepted by the courts of law and this must be our starting point, remembering that we are considering conduct which leads to the creation of a child. This is very different from the situation where a child already exists and something has to be done to provide for him or her. Thus the institution of adoption is designed to meet this need, but adoption is very different from the practices we are considering, although it may give us some useful pointers.

There are two main reasons why receiving donated sperm and oocytes is deleterious to society. Firstly, a donation is frequently shrouded in secrecy and of a kind that leads members of families to be deceitful. Secondly, it gives rise to births of children who are denied adequate, or at least normal, knowledge of their genetic origins. The first objection is of direct relevance to social welfare, for families are the means whereby basic social values are instilled. Among these values are truthfulness and trust, which are essential for everyday life. We have only to pause for a moment to see how truth and trust inform our daily commerce in the groups within which we live and work and in our business and professional life. Where there is secrecy over donations of semen or oocytes this must lead to distrust not only in families where children have been born as a result of such donations, but in children born to families in the normal way. Thus, for example, as AID becomes more widely practised and people are more aware of it, children in normal families may well ask themselves if their fathers and mothers are 'really' their fathers and mothers, ie they may question their genetic origin. However, knowing that AID families almost invariably refrain from telling the child or anyone else, children in normal families can never be sure of the truth of any answer they are given. They cannot go to other kinsfolk for assurance, for the fact of AID is usually kept from them as well as from the child. Indeed, the deceptions tend to multiply, for priests, teachers and sometimes general practitioners are kept in the dark, and these are those to whom a child may go for advice and help.

The second objection lies in the deprivation of the child so conceived. We may well ask if children should be born whose origins cannot be disclosed to them. Now, of course, some children are the result of an illicit union outside wedlock, but the question as to whether they should be born is not difficult to answer if it is the

welfare of children that we have in mind. Yet the child in the circumstances we are considering is the result of a conception which has been planned, he is a planned creation, planned not with the welfare of the child in mind but with the desire of an adult to have a child. The child born as a result of a donation, unless it has been undertaken openly and the child is aware of his genetic origin, is at a disadvantage compared with children born in the normal way. To begin with he is subject to a health hazard which other children may avoid, and it is not remedied if the doctor knows the state of the health of the donor at the time of conception, for the later medical history of the donor may be relevant to accurate diagnosis of disease and suitability of treatment. There is, however, another aspect. Knowledge of parentage normally entails a knowledge of genetic origin. This is knowledge which helps a child acquire an identity; he knows where he belongs. Not to have this knowledge may be said to deprive him of a natural right. So should we, as a society, and the profession of medicine in particular, connive at producing children who begin life with a disadvantage?

In their discussion of surrogate motherhood the authors argue persuasively in favour of it being carried out by volunteers rather than on a commercial basis, but again we have to ask to what extent will secrecy intervene, and if it is done openly will the child have any difficulty in acquiring his identity or will the two mothers find themselves the objects of divided loyalty. The distinction the authors make between commercialisation and voluntary surrogate motherhood is unimportant beside the issue of whether it is good in principle or not. After all it could be argued that if properly controlled and open to inspection a commercial organisation might be better than some private arrangement. The provision recommended for screening potential surrogate mothers and couples would be necessary, just as it is necessary carefully to screen adoptive parents. What are more important are the hazards of the process whereby a surrogate mother might want to keep her child. Is the contract to be enforced, and if not, which Singer and Wells allow may be the case, is that in the best interests of the child?

Again, we come to the nub of the matter. Is it right to support processes which may well lead to the creation of children suffering some kind of deprivation which children born in the usual way may not expect to endure? The fact is that the authors have little to say about the child and a great deal to say about the desire of adults for children. Are they prepared to say that a child has a rightful expectation to have a father and mother who are also respectively progenitor and progenitrix, and to be in no doubt about his identity as their child? If so, then AIH and IVF for married couples using their own sperm and oocytes is acceptable. To go beyond this is hazardous as has frequently been argued, and argued in this journal (1). Yet they do go beyond it and argue for medical impartiality as between married couples, single

women and lesbian couples, saying there should be no blanket prohibition by the State. But distinctions do need to be made between married couples and others (2). In short they reflect the prevailing medical ideology, which is highly individualistic, almost exclusively patient-oriented and which takes little account of society or the future generations who will constitute it. The authors' concluding argument that the State does not 'seek to prevent any fertile persons, whatever their marital status or private sexual predilection, from reproducing' is no argument for providing a service on demand. Moreover, it is not an argument for the profession of medicine, which is believed to set high standards, deliberately to connive with patients suffering a disability, (not, it should be noted, a disease), to reproduce regardless of the welfare of the child so produced or, for that matter, the welfare of the society the child is introduced into. To say it would be unjust is to emphasise the needs, natural or acquired, of adult individuals not the welfare of children to whom the practice may be an injustice.

Finally, a comment on the authors' discussion of resources, for they ask if resources going into IVF and other forms of artificial reproduction should not have alternative uses. They mention, for example, dialysis machines. This raises important issues which would require considerable discussion. But more immediately we may ask: should not these resources be better employed in research into male and female infertility in order to remedy the primary disability? What is needed is the treatment of infertility not a service to circumvent childlessness. It is difficult to discern the *medical* justification for providing a single woman with an AID child or IVF or a transferred embryo.

References

- (1) Dunstan G R. Ethical aspects of donor insemination. *Journal of medical ethics* 1975; 1, 1; 42-44.
- (2) Snowden R, Mitchell G D. *The artificial family: a consideration of AID*. London: George Allen and Unwin, 1981. Snowden R, Mitchell G D, Snowden E M. *Artificial reproduction: a social investigation*. London: George Allen and Unwin, 1983.

Response

Peter Singer

To begin by correcting some misinterpretations: Deane Wells and I did not 'conclude that what is natural is good'. We raised the issue of what is natural only in order to argue that the claim that *in vitro* fertilisation is 'unnatural' does not amount to a sound objection to it. We sought to do this by demonstrating that on one plausible view of what is 'natural', *in vitro* fertilisation is natural. We did not go on to say that therefore it is good.

Nor did we assume that a person who desires a child has a right to have one. We did not base our argument

on rights. Indeed I cannot find a reference to rights anywhere in the article. Admittedly, we do refer to the widely held view – which we share – that medical treatment should be available to all who need it, and in this instance, we said, the need for treatment can be established by the strength of the patient's desire for children. But this claim rests solidly on utilitarian foundations, without any need for an appeal to rights. Naturally, in making our utilitarian calculations, the interests of the potential child must also be taken into account.

Turning now to this crucial question of the interests of the child, I would not disagree with Professor Mitchell's assessment of the undesirability of secrecy in family relationships. But is this an inevitable concomitant of the use of donated eggs or sperm? I do not believe it to be. Attitudes about secrecy in adoption have changed very quickly in the past decade. It is now much more common for adopted children to know not only that they are adopted, but also the identity of their natural mother. With proper counselling, there may soon be less secrecy about AID and the use of donor gametes in IVF. Many AID practitioners think this is impossible because of the donors' insistence on secrecy, but a recent Australian study of AID donors has indicated that 61 per cent of donors interviewed were willing to have their identity made known to their AID children who had reached the age of 18 years, and to have provision made for contact with them (1).

Suppose, however, that in some cases children will be unable to trace their genetic origins. Professor Mitchell appears to believe that such children are deprived of a natural right. The right to have knowledge of one's genetic origins does not appear on any lists of 'self-evident' natural rights with which I am familiar, and so I can only regret that Professor Mitchell does not tell us how he deduced the existence of this right. Despite my doubts about this alleged 'natural right', I do not deny Professor Mitchell's claim that children born without the possibility of knowledge of their genetic parents 'begin life with a disadvantage'. I do, however, reject the suggestion that this disadvantage is so serious that society should not allow such children to be produced.

Consider the matter from the point of view of the child born to the otherwise infertile couple. There was never any possibility of this particular couple producing a child who would be their own genetic offspring and would thus know of its genetic parents in the normal manner. So for the particular child, the options are either no life at all, or life with the disadvantage of not knowing one's genetic parents. I have no doubt that most children born as the result of the use of donated sperm or eggs would unhesitatingly reply that their lives have been worthwhile, and they are glad they were born. The disadvantage they may suffer from is not such as to make their lives so miserable as not to be worth living. If Professor Mitchell can produce contrary evidence, I am prepared to change my mind; but it must be evidence that