

Reproductive tourism as moral pluralism in motion

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Reproductive tourism is the travelling by candidate service recipients from one institution, jurisdiction, or country where treatment is not available to another institution, jurisdiction, or country where they can obtain the kind of medically assisted reproduction they desire. The more widespread this phenomenon, the louder the call for international measures to stop these movements.

Three possible solutions are discussed: internal moral pluralism, coerced conformity, and international harmonisation. The position is defended that allowing reproductive tourism is a form of tolerance that prevents the frontal clash between the majority who imposes its view and the minority who claim to have a moral right to some medical service. Reproductive tourism is moral pluralism realised by moving across legal borders. As such, this pragmatic solution presupposes legal diversity.

We see stories regularly in the media about strange or extreme applications of the new reproductive technologies. One of the first cases to get large media attention was that of the 59 year old British woman who went to Italy to become pregnant. Since then one case after another has been brought to our attention. The English couple who visited a clinic in Italy to have preimplantation genetic diagnosis for sex selection for non-medical reasons; a 62 year old French woman who went to the United States to be inseminated with her brother's sperm; a British woman who crossed the channel to Belgium to have a child with the sperm of her deceased husband; a couple of British male homosexuals who found a surrogate mother in the United States, and so on. In all these cases, people moved from one country to another to get the treatment they desired. Although most instances of "reproductive tourism" picked up by the media are sensational, these cases present a highly distorted picture of the phenomenon as a whole. Most movements are made for treatments such as oocyte donation and known or anonymous sperm donation. It can be predicted that this type of travelling will steadily increase. There are indications that most patients are prepared to go abroad to get the type of treatment they want.¹ The call for national and international measures to stop these movements becomes, however, ever louder. The United Kingdom health secretary said in reaction to the birth of twins to a 59 year old British woman that "we'll renew our efforts to have discussions with other countries as to the examples we set and they can establish ethical controls over some of the dramatic achievements of modern medicine".² The legal scholar Nielsen has also stated that both national and international measures are called for to prevent this kind of shopping.³

REPRODUCTIVE TOURISM

"Procreative tourism" was first named by Knoppers and LeBris in 1991 to describe the practice of citizens exercising their personal reproductive choices in less restrictive states.⁴ It is the travelling by candidate service recipients from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire. As such, it is part of the more general "medical tourism".

This type of travelling is not restricted to Europe. The same phenomenon occurs in the United States and Australia. In Australia, for instance, the differences in legislation between

the states concerning access to reproductive technology services results in differential access by single and lesbian women.⁵ As a consequence, women from Victoria have been travelling to New South Wales to benefit from the less restrictive law in that state.⁶ The United States have known this phenomenon for a long time, especially for abortions. There are large differences between the American states regarding access to treatment, type of treatment, procedures etc of medically assisted reproduction.⁷

Travelling to obtain a medical service does not necessarily mean that one has to cross national borders. This misconception follows from the term "tourism". Given the connotations of the term, which are negative when considered within a medical context, it would be better to replace it by "reproductive travelling" but it seems a bit late for that now. Tourism mainly refers to travelling for recreational reasons. Indirectly, this connotation devalues the desire motivating the journey: it implies that the fertility tourist goes abroad to look for something exotic and strange. Basically this is a form of travelling from a place where treatment is not available, because of the prevailing rules, to a place where it is available. These rules are not necessarily laws but may also be the personal moral convictions of the health care provider, institutional policy guidelines, and recommendations by committees. In countries without legislation on assisted reproduction, each doctor and clinic decides autonomously whether to provide a certain type of treatment and whether to offer a service to a certain type of patient. In Belgium, for instance, the policies concerning assisted reproduction differ considerably between secular hospitals and catholic hospitals. Patients who fear, or know, that they will not be accepted in a catholic clinic will request treatment in a fertility centre with another moral worldview even if this means that they have to travel to another city or to another part of the country. This option, obviously, only exists in the absence of a restrictive national regulation.

THE CAUSES OF REPRODUCTIVE TOURISM

Within the European Union, a few countries, such as Belgium and Italy, have no or very little legislation concerning medically assisted reproduction. By looking at the patient streams flowing to these countries, one can chart the legal restrictions in the rest of Europe. I will focus on Belgium since I am more familiar with the situation there. The latest national report, which presents the data of the Belgian register of assisted reproduction for 1999, indicates that 30% of the

patients receiving in vitro fertilisation (IVF) treatments come from abroad.⁸ Approximately 2700 oocyte pickups are performed in Belgium for foreign patients. The proportion is significantly higher when oocyte donation is considered: 60% of all patients requesting oocyte donation are foreigners. In one large centre for reproductive medicine, more than half of the oocyte recipients come from abroad.⁹ About 10% of these women come from France. These French patients come for two main reasons: i) the candidate parents want to increase their chances of success—in Belgium, contrary to the practice in France, fresh oocytes can be used (freezing of embryos reduces the success rate), and/or ii) because they do not accept the compulsory “personalised anonymity” which operates in France.¹⁰ Other streams of patients come from Germany, where neither oocyte donation nor IVF with donor sperm is allowed; from the Netherlands because of a maximum age limit for the recipient and because surgically obtained sperm cannot be used, and from France where lesbian couples and single women are denied access to assisted reproduction and where female recipients must be of “reproductive age”.

Generally speaking, the main causes of reproductive tourism can be summarised as follows: a type of treatment is forbidden by law for moral reasons; a treatment is not available because of lack of expertise or equipment (like pre-implantation genetic diagnosis (PGD)); a treatment is not available because it is not considered safe enough (for the moment); certain categories of patients are not eligible for assisted reproduction; the waiting lists are too long in the home country; and the costs to be paid by the patients are too high in their home country.

The last point is worth mentioning because the classical argument against reproductive tourism is the inequality of access. Only people with the necessary financial means can afford to look for treatment abroad. Although largely correct, this argument is selectively used. Most countries do not reimburse all costs for all IVF cycles and a large part of the infertility treatments are performed in profit based private hospitals. As a consequence, almost all countries discriminate against patients on the basis of income, even for those interventions that are accepted in their country. Those who use the justice argument should first eliminate the existing financial discrimination. Moreover, when the lower financial cost is precisely the reason for crossing the border, the justice argument is difficult to maintain. The real costs for medically assisted reproduction are significantly lower in Belgium compared to other countries.¹¹ Reproductive tourism in these circumstances reduces injustice and allows poor people to obtain treatment. Finally, this is a strange argument if used by those who impose the restrictions. They prevent people from getting treatment at home and then say that the movements are unfair because only the rich can go abroad.

There is another argument hidden beneath the previous one. Some people seem to blame reproductive tourists for using the escape route: they should suffer like all the others who do not have the money to travel.

“This raises the question of whether it is equitable, within the EU, that Member States may impose their regulatory choices only on those who cannot afford to “choose” another regulatory regime, by buying a service in another Member State, or to put it the other way, whether it is equitable that some people can in effect “buy their way out” of ethical or moral choices given legislative force in their own Member State.”¹²

The first question, however, is whether the state is justified in imposing a moral view on citizens who did not consent to these rules and principles. In addition, is it equitable when one member state denies its citizens access to a reproductive service that is considered perfectly acceptable in another member state?

POSSIBLE SOLUTIONS

The matter of legislation in the field of assisted reproduction raises a number of questions concerning the relationship between law and morality. What is the appropriate legal response of a postmodern society, characterised by different groups holding different moral outlooks, to moral conflicts and dilemmas? Under which circumstances should people abide by laws that express the substantive moral position of the majority? Given the complexity of the law/morality relationship, I will not try to give a general analysis of the issue here. I will instead focus on the possible legal ways to reduce or eliminate reproductive tourism. This perspective seems to presuppose that reproductive tourism is the *problem*. The phenomenon can be seen, however, as a *solution* to restrictive legislation. In the latter interpretation, the legal “solutions” reveal which type of legislation causes reproductive tourism.

A. INTERNAL MORAL PLURALISM

If the existing legislation or regulation in a country allows all people to obtain the medical service they desire, there is no need for reproductive tourism. The easiest way to eliminate such tourism is by abolishing all forms of restrictive and coercive legislation. The principle underlying this position is that the legislation in a democracy should take into account the moral view of the different groups in society.

Legislation, at least in a democratic society, reflects, and is supposed to reflect, a compromise between the diverse preferences and interests of the members of that society. . . . Hence, a legislative acceptable compromise can be attained only if some considerable degree of moral agreement can be achieved during the course of the political debate.¹³

The best balance would be to adopt a “soft” law which is mainly focused on safety issues and good clinical practice and does not impose strict prohibitions or obligations on anyone.¹⁴

Since our postmodern society is characterised by a multitude of moral and religious views, the law should not reflect the substantive moral position of one group.

When there is an intellectually irresolvable plurality of moral viewpoints, there will not be a common basis for coercive constraints justified uncontroversially in a particular common concrete view of the good life. . . . Therefore their legal prohibition should always be under moral suspicion in a secular pluralist society.¹⁵

Respect for the moral autonomy of the citizens implies that if reasonable people disagree one should not impose one alternative by law. The absence of a law, as practice in Belgium shows, means that other institutions, such as the fertility clinics make the rules. These small scale operations exist side by side and serve the patients who share their moral convictions. One clinic will serve lesbian couples and thus present a view which maintains and emphasises the right to procreate while the clinic next door will refuse to treat them on the basis of a different view to do with responsible parenthood. People who request treatments not provided by one institution can look for another clinic nearby.

This solution can also be seen as a form of harmonisation (see below). The number of reproductive movements will strongly diminish by aligning international law in a liberal direction. This can be done by introducing the rule that no member state should penalise or forbid a treatment that is allowed and practised in another member state.¹⁶ One could argue that this treatment is part of, and accepted by, at least one European culture. The result of this strategy would obviously be that all national legislation would be down regulated

to the level of the most liberal country. Legislation would then express the lowest common denominator.¹⁷ After analysing the Blood case, McGleenan predicted that the jurisprudence of the European Court of Justice regarding article 59 of the European Community treaty would generate a structural downward pressure so that any regulation would gravitate towards the most permissive laws. According to McGleenan, the freedom of movement to receive services “must lead to the conclusion that there should be a community wide policy on reproductive technology” which should include a minimum policy standard.¹⁸ The evaluation of reproductive tourism clearly depends, however, on the appreciation of moral diversity.

B. COERCED CONFORMITY

Three types of action can be distinguished: 1) only citizens are eligible for treatment; 2) restriction of the liberty of movement, and 3) control and criminal charges against offenders.

1. Citizenship or permanent residence

The amount of reproductive travel can be reduced by countries requesting citizenship or permanent residence as a condition for treatment. The HFE Act 1990 in the UK stipulates in section 30 (3) (b), concerning surrogacy, that: “the husband or the wife, or both of them, must be domiciled in a part of the United Kingdom or in the Channel Islands or the Isle of Man”. The condition of citizenship can be justified if the regulation foresees certain measures which would become impractical, uncontrollable or impossible if people moved back to their home country. This would be the case if access to the treatment were conditional on a regular follow up of the children. If no such measures are imposed, however, it is not clear why citizenship should be a condition. If requests by lesbian couples are accepted, then why should foreign lesbian couples be denied access? It is not up to the visited country to enforce moral rules imposed by a neighbouring country if these differ from its own. A possible exception to the unlimited admission of foreigners is the protection of the internal system by keeping the waiting lists within acceptable limits. This applies to oocyte donation where, because of the shortage of oocyte donors, the waiting time may exceed several years. In that case, a limit on the number of foreign applicants can be established to prevent indirect harm being done to one's own citizens.¹⁹ Since the tolerant society is not responsible for the influx of foreign candidates, its residents should not suffer as a result of this influx.

2. Restriction of the freedom of movement

The state can try to prevent people from crossing the border to obtain treatment elsewhere. Ireland wanted to bar Irish women from leaving the country to obtain an abortion in Great Britain. In 1992, a 14 year old rape victim was restrained from leaving Ireland for nine months but this injunction was later overturned. Although the ban on abortion was maintained, two amendments to the Irish constitution stated that the freedom to travel between states could not be limited and that the freedom to obtain and make available information relating to services lawfully available in another state could not be restricted.²⁰ Since the authorities generally do not know who is going where for what, the effective application of this rule would demand a complete closure of the borders except for the very young and the very old.

Articles 59 and 60 of the European Community treaty guarantee the free movement of services, including medical services and thus infertility treatment. This implies that people have the right under community law to go to another country and receive the service they desire.

3. Control and criminal charges

A more drastic violation of people's privacy, autonomy, and bodily integrity was adopted by Germany around 1990. German border guards forced gynaecological examinations upon women re-entering Germany at the Dutch border in search of evidence of extraterritorial abortions. Prosecutors also brought criminal charges against women who obtained abortions in other countries.²¹ The European parliament condemned these practices in 1991.

C. INTERNATIONAL HARMONISATION

The regulation of assisted conception can be categorised as to different approaches: the “private ordering approach” (United Kingdom); the “cautious regulatory system” (Denmark); the “prohibitive licensing system” (Austria), and the “liberal constitutional approach” (Canada).²² The existence of different legal systems renders international harmonisation particularly difficult.²³ When people talk about harmonisation, they seem to think of agreement on a number of acts and treatments which should be prohibited. This idea also underlies the much criticised European Convention on Human Rights and Biomedicine.²⁴ After studying the regulations in several countries, Knoppers and LeBris⁴ identified a number of issues on which a general consensus exists. There are, however, different definitions of consensus²⁵ and different levels at which the consensus might occur. A consensus might be reached if the principles are defined very broadly without checking whether people also agree on the implications of the principles in concrete cases. Everyone might agree that “respect for human dignity” and “inviolability of the human person” deserve safeguarding but that does not mean that the same conclusions will be reached when surrogacy and embryo research are discussed. The diversity that characterises the moral perspectives on medically assisted reproduction is downplayed for political reasons. Although the European institutions recognise the principle that matters of (bio)ethics belong to the jurisdiction and competence of the member states, the European Convention on Human Rights and Biomedicine is an indirect attempt to reduce diversity and to standardise legislation around a set of moral rules about which there was never a consensus to start with.

Consensus on a list of prohibitions is pointless as long as there is no global consensus. The globetrotters involved in reproductive cloning demonstrate this. A European list of prohibitions will merely change the destinations. Only a worldwide consensus would eliminate the problem and that is, to put it mildly, highly unlikely. The reaction to reproductive cloning nicely illustrates the purpose of national legislation in a world where location is a trifling fact. Some countries have broken law making world records trying to block reproductive cloning. The prime objective of these laws is not, however, to prevent reproductive cloning from happening since there is no way national legislation could do this. The first goal of the law makers was to keep their own hands clean, by preventing cloning from being performed on their territory.

INTERSTATE MORAL PLURALISM

In a democracy, political parties attempt to organise society according to their goals, values, and principles. The political programmes include ethical or religious convictions. Political parties try to put their moral stamp on the positions expressed in the societal institutions, among which is the law. However, “democracy is not based on the principle of consensus but on the principle of majority”.²⁶ The conflict between the parties and groups is decided by the majority rule in parliament. If the democratic process functions normally the view on the good life of the majority will prevail at the expense of the minority view. This problem will only disappear when the majority includes everyone and consensus becomes unanimity.

What is ethically right or good is not decided by which norms the majority supports^{27, 28} but the ethical rules that apply in social life (what is allowed, obliged or forbidden) are, at least partially, decided by the politicians who vote the laws. Neutrality of the state is impossible here. A nation without any regulation or legislation regarding bioethical issues supports the position that each citizen should decide according to his or her personal moral convictions whether a certain treatment is acceptable. This contradicts the view of those who want to prohibit certain applications of the new reproductive technologies. Allowing as well as prohibiting implies taking sides. It is not an option for policy makers simply to do nothing.²⁹ This political right should be balanced, however, against other values and principles to prevent the development of a dictatorial state that would fit every single part of our social life into one particular conception of the good life. Among these values we count autonomy, tolerance, and mutual respect. A state which uses excessive coercive power to promote majority values will end up permanently suppressing minority groups.³⁰ There is a difference between organising social life according to substantive moral principles and using all possible means to force each and every citizen to abide by these rules. Tolerance towards people with different moral positions, who express their disagreement in a peaceful manner, should be a characteristic of a pluralist society.

Imposing a moral opinion on persons who do not share this view creates the risk of conflicts which threaten peace and cooperation in society.³¹ Since position taking by the state is unavoidable, two stances to reduce the risk of moral warfare can be distinguished. In the first stance, the majority adjusts its position to incorporate some of the objections of the other groups. This leads to a compromise where, for instance, certain acts are allowed but only under certain conditions or certain acts are prohibited except under specific circumstances. Such a compromise, however, is not always possible and is not necessarily experienced as sufficient by the opponents. The second way to diminish conflicts is when the state demonstrates a degree of tolerance towards the dissenting agents who violate the rules. By allowing reproductive tourism, most states show a degree of tolerance. Three conditions should be present before we can talk of tolerance: the state disapproves of the conduct of the tourist (which it shows by forbidding what the tourist is going to do elsewhere); the state has the power to stop or punish the tourist, and the state chooses to allow the violation.³² The second condition is fulfilled since most states could impose much stricter measures to enforce their position. The examples given above from Ireland and Germany demonstrate this. But also on other points this type of reticence is demonstrated. The third condition is clearly illustrated by Sweden. Sweden thinks that every child born by means of donor insemination has the right to know the identity of its genetic father. This law caused one of the first European streams of reproductive tourism: Swedish couples going to Denmark where donor anonymity is guaranteed. Even though the Swedish government knows that most parents do not tell the child about the way it was conceived³³ (as a consequence, the child cannot ask for the donor's identity), it has, however, chosen not to introduce a measure that would effectively guarantee the child's right to know. The state could for instance state the name of the donor on the child's birth certificate. By not doing so, it tolerates wrongful behaviour on the part of the parents.

Two levels of tolerance are important for the topic of reproductive tourism: internal tolerance, such as the pragmatic tolerance found in the Netherlands³² and external tolerance, such as reproductive tourism. Internal tolerance allows the violation of the law within the territory by stating that offenders will not be punished under certain conditions while external tolerance allows citizens to escape from the law by travelling outside the territory without being punished or stopped. While internal tolerance can produce legal insecurity

for the citizens, external tolerance gives a clear message about what is permitted in the country. The final result of a policy of external tolerance is that a certain norm is applicable and applied in society as wanted by the majority while simultaneously the members of the minority can still act according to their moral view by going abroad. On deeply felt moral issues concerning life and death (such as reproduction, abortion, euthanasia etc), this policy prevents a frontal clash of opinions which may jeopardise social peace. Obtaining the desired treatment by travelling partially defuses the conflict and prevents the frustration and indignation of the minority group from accumulating. More positively, tolerance towards these movements also shows a healthy degree of relativism. The fact that reasonable people in one's home country and the majority in a neighbouring country opt for a different solution should raise a spark of doubt about the correctness of one's own position. Allowing people to look abroad demonstrates the absolute minimum of respect for their moral autonomy.

Within this context, diversity in legislation (combined with reproductive tourism) is beneficial for all. It could be argued that a pluralistic state should respect all positions but, as I mentioned earlier, this comes down to adopting a liberal perspective that ignores the view of those who think that a certain conduct should be prohibited. Harmonisation of a restrictive legislation would close down the option of travelling and thus increases the risk of a violent conflict within the society.

A DIFFERENT CONCEPTION OF LAW AND REGULATION

The diversity of regulation worldwide and the travelling of people across frontiers raises the question whether "any single jurisdiction can continue to enforce its own rules".³⁴ I would argue that legislation is still useful as a public statement of the moral conviction of the majority of the people of a jurisdiction. If, however, one hopes to achieve through the law that some interventions are no longer performed or that citizens will no longer use certain medical services, then prohibitions are no longer useful. Given interstate travelling, it is impossible to enforce laws that people do not consider morally justified. Those who do not share the moral standards reflected in the law will either go abroad or find other ways to sidestep the legal restrictions. In general, the ability to enforce laws is strictly linked to the territory. This fact already influences the way law makers presently look at new law proposals. The Swiss federal council³⁵ argued against a referendum initiative that wanted to prohibit most forms of in vitro fertilisation and the use of donor gametes, that the only consequence of such a law would be the flight of infertile couples to neighbouring countries. Instead of leading to fewer applications for the intended interventions, it would only lead to a relocation of the applications. Moreover, this would take away all possibility of control on the part of the state.

An interesting effect of the existence of alternatives for the citizens (diversity means choice) is that the law makers have to put much more effort into trying to convince the people of the acceptability or unacceptability of a certain action. The existence of different views stimulates reflection and obliges the holders of each position to offer rational arguments to convince those who hold the other position. Information campaigns and large public debates on ethical issues will be indispensable. A good illustration of the limitations of the law to change behaviour in the field of medically assisted reproduction is the Swedish law on donor insemination. After 15 years of a law which makes identifiability of the gamete donors mandatory, only 11% of the parents have told their children and this number does not even take into account the number of couples who went abroad during this period to avoid the law.³³ Apparently the parents are not convinced of the rightness of telling in the context of donor identifiability. In

this situation, the introduction of more coercive measures without an accompanying effort to convince people by information and debate would only lead to more reproductive tourism and to more frustration.

CONCLUSION

Reproductive travelling is a pragmatic solution to the problem of how to combine the democratic system which proceeds according to the majority rule, with a degree of individual freedom for the members of the minority. Although the majority has the political right to express their view of the good life in legislation, other values, such as tolerance and mutual respect, urge them to use this right moderately. It is preferable within a pluralistic society, when reasonable people disagree on the acceptability of a certain course of action, to look for a legal compromise that takes into account the positions of different moral communities and to avoid as much as possible radical prohibitions. Even if these recommendations are followed, however, moral conflicts will occur. In those cases, respect for the moral autonomy of the minority demands an attitude of tolerance. This minimally implies that the state refrains from taking active measures (such as restrictions on the freedom of movement of, and criminal charges against, offenders) to prevent citizens from seeking medical care in a state that holds a policy that better accords with their moral insights.

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