Chapter - V

Ethical-Moral and other Issues in Assisted Reproductive Technology

5.1 Introduction

When societies change rapidly, their prevailing ethical norms are challenged both by the biases of new knowledge and the conflicts created by the new practices that threaten prevailing norms. Ethics is the notion of what is good and right in society that guides human action. In the period of transition, the emergence of new ethical practices is guided by it. This is not a linear process but a trajectory interspersed with conflicts of ideas and interests in various arenas of technology society inter-face. Public health added social responsibility and justice to ethics of medical practice and research. Assisted reproductive technologies introduce ambiguities into traditional ways of defining basic concepts – parenthood, family, individual etc. As the use of technology expands the range of possibilities for procreation, new parties enter the reproductive process and blurs long-established categorical boundaries. Complex questions are further complicated through the uses of ART, such as what is “reproduction,” what is meant by “mother” and “father,” or when “life” begins. Not only are issues in assisted reproduction important for our understandings of order in the natural world, they are also centre to our conceptions about how we order the social world. As assisted reproduction confuses conventional categories of commodity and of family, normal ways of defining what is social and what is natural do not work well in the context of assisted reproduction. Thus, in trying to accommodate ART into society, bioethicists have used bioethical frameworks to establish new ways of redefining social and natural order. This chapter will focus on the complex ethical, moral, social and health related issues related to assisted reproduction and also discuss the religious response towards different ART procedures.

5.2 Ethical Issues in Assisted Reproduction

In the area of assisted reproduction, the idea of individual autonomy has shaped political and ethical debates. Ethical discussion of reproductive technologies began in the early 1970s, when techniques such as in vitro fertilization became a real possibility. Many of these early commentators were medical practitioners, so the first ethical concerns involved worries about illegitimate human experimentation. Leon Kass, an American scientist and public intellectual, noted in a 1971 article that in vitro fertilization procedures were executed on human embryos, with the possibility of
harming the potential child, there was no ethically acceptable way to perform the procedure. A scientist could not morally choose unknown hazards for the child and then give him a life in which he would have to face those consequences. At the university of Chicago he argued that “this blind assertion of will against our bodily nature-in contradiction of the meaning of the human generation it seeks to control-can only lead to self-degradation and dehumanization. Paul Ramsey, an American Christian ethicist, went even further to argue for a complete prohibition on IVF experimentation, believing that the moral hazards of experimenting on a possible future human being were unacceptable. He pronounced, “Men ought not to play God before they learn to be men, and after they have learned to be men they will not play God.”¹

On the other hand, John C. Fletcher, a leading biomedical ethicist, argued for the procedures, declaring that technology liberated human reproduction from what he termed, “reproductive roulette”. However, governments in many countries officially began to research the ethical implications of these technologies only shortly before the birth of the world’s first IVF baby, Louise Brown in 1978. In that year, the Ethics Advisory Board of the U.S. Department of Health, Education and Welfare undertook a study of IVF, primarily focusing on procedural safety and efficacy to ensure that scientists were minimizing the risks to potential offspring. Following the media fanfare accompanying Brown’s birth, numerous countries, including Spain, Netherlands, Australia and the United Kingdom issued more than a dozen reports on the topic within six years. In 1982, the United Kingdom established the Committee of Inquiry into Human Fertilization and Embryology, headed by the philosopher Mary Warnock, to examine the social, ethical, and legal implications of new and potential developments in human assisted reproduction².

Currently, ethical issues around assisted reproductive technologies encompass a wide range of questions including the “naturalness” of the technique, the moral status of the early human embryo, the relationships among relevant parties, and the economics of ART. Because couples substitute lab processes for procreation, some argue that the separation of reproduction from sexual intercourse is ethically dubious because it is “unnatural.” Others question whether an embryo can be regarded

² Ibid.
as a human being and if it deserves the full range of respect and protections guaranteed to citizens. In cases where ART challenges traditional boundaries of parenthood, the relationship of the genetic or birth parent to the social parent and child is unclear. There are additional problems of ART commercialization and access. Should sperm or ova providers be paid; in the case of surrogacy, how much should surrogate mothers be compensated and do the risks to the surrogate’s health outweigh the benefits of payment? These debates represent different approaches to interpreting reproduction so that individuals who have no other options can choose assisted procreation in a way that is morally agreeable to society. They assume the individual to be the unit of society with the ability to make free and self-determined choices. Successful ART regulation should allow for the maximization of individual interests within the confines of society.³

The separation between sex and reproduction was too fundamental to replace by technical means; that creating children outside the body would eventually undetermined the very definition of life. Feminists, meanwhile, split into two contentious groups. Some, led most famously by Shulamith Firestone in her Dialectic of sex, embraced IVF as the first step towards liberating women from their reproductive biology. Others painted IVF as the self-serving creation of men and commerce. Like option and hormones and tubal surgery, they argued, it was just another “hubristic and harmful technology,” born of a conspiracy between the “collective be male ego and the corporate and medical and pharmacological purses.” By promoting the idea that a woman could find happiness only in motherhood, it “perpetuate[d] the cycle of depression, despair, hope… [and] promote[d] a fetus-centered ideology.”⁴

Chastened by such critics, governments in the United States, the United Kingdom, and Australia launched high-profile inquires into the implication of IVF, promising to arrive at an appropriate set of guidelines. In all three countries, the inquires dragged on for years, becoming intimately intertwined with debates over abortion, fetal research, and state funding. In the end, the three countries reached widely disparate yet similarly inspired conclusions. The British ultimately decided that in vitro techniques, including the freezing and donation of embryos, could “be

⁴ Supra note 1 at 6
regarded as an established form of treatment for infertility.” Children born as a result of these techniques as to be considered fully legitimate in the eyes of the law, and a new state agency, the Human Fertilization and Embryology Authority was established to regulate both fertility research and fertility services.\textsuperscript{5}

In Australia, state parliaments arrived at their own set of conclusions and recommendations. In South Australia, for example, clinics were permitted to treat only patients who were considered medically infertile, and a new regulatory agency was given sweeping powers to govern reproductive technology. In Victoria, treatment was limited to infertile heterosexual couples and a separate agency was established to license fertility centers and approve fertility specialists. In effect, therefore, the Australians, like the British, decided to permit in vitro fertilization but regulate its practice.\textsuperscript{6}

In the United States, by contrast, the political system was still reeling from the 1973 \textit{Roe v. Wade} decision. Faced with fervent—occasionally even violent—opposition to abortion or fetal research, the federal government had suspended funding for fetal research in 1974, pending the recommendations of a soon-to-be-created National Ethics Advisory Board. During the days of the Nixon administration, oversight for these policies fell to Health, Education and Welfare (HEW) Secretary Casper Weinberger, whose conservative views on reproductive matters were well known. In 1976, responsibility moved to Joseph Califano, President Carter’s secretary of health and human services, another public opponent of abortion. Califano established a revamped commission and launched his own round of hearings, which most in the field of reproductive medicine regarded as an extended excuse for an eventual ban. Surprisingly, though, Califano’s commission reported positively on IVF, recommending in March 1979 that the government end its moratorium on funding. Even with this report, however, Califano and the National Institutes of Health were reluctant to act. “It was a political hot potato,” recalls one leading fertility specialist. “No one would touch it.” And so, amazingly, the “short-term” moratorium stayed in place. No federal funds in the United States flowed to IVF research.\textsuperscript{7}

\textsuperscript{5} Id at 27
\textsuperscript{6} ibid
\textsuperscript{7} Id at 28
Now arguably the language of health care rights has lead to an opening up of issues such as the right to found a family\(^8\), and the demand to be treated to be able to do so. There is now available a whole gallery of possibilities. As Morgan and Nielsen point out:

The development of reproductive technology presents contradictory choices, especially for women. Technically, some of the development have increased the capacity of women to take control of their own bodies; with same versions of cloning and parthenogenesis it has even been argued that the notion that reproduction belongs to women would take on a new dynamic with the ability to reproduce without the need for the patriarchal genetic.\(^9\)

However, in India, in the last few years, advocacy groups have also engaged with the government’s plan to regulate the ART industry. Sama-Resource Group of Women and Health has played an important role in this campaign, starting by putting together a picture of the industry and its impact on women and society. It has also held a series of consultations with women and health groups on the government’s plans and has developed detailed analyses and critiques of the ICMR’s guidelines for ART clinics and the draft ART (Regulation) Bill and Rules 2010. At the first such consultation, participants discussed a number of issues raised by these technologies: the public health context and social impact of infertility; the growth of the ART industry; the use and misuse of technologies; the quality of regulation; the concerns of feminists, disability rights activists and the sexuality movement; emerging genetic technologies, and the new eugenics. The consultation highlighted the need to promote greater public discussion on the social and ethical implications of ARTs and influence the development of regulation and monitoring in this field. This consultation, and other meeting that followed, enabled groups to share their views on the flaws in the bill and suggest modifications before the legislature. Activists have been coming together to look at the industry, its growth and diffusion, to discuss the implications in relation to the women’s and health movement, and to press for appropriate regulation that protects women’s health and rights.\(^10\) We can enlist some of the ethical issues in the following points:

---

\(^8\) European Convention on Human Right, Art, 12
5.2.1 Unnaturalness

One criticism is that assisted reproduction is unnatural. It is ‘playing God’ and interfering in nature’s most precious activity: the creation of life. As one group of catholic bishops put it: ‘increasingly, children are seen as the object of “consumer choice”, rather than as new human beings to be accepted unconditionally. Jacqueline Laing and David Oderberg argue that assisted reproduction commodifies life.11

Objectors to the whole notion of artificial reproduction techniques set great store in the existence of the natural order of biological processes. Naturalness has there been equated with something that is untainted with modern human intervention. The unnaturalness may also be seen as stemming from the introduction of a third party into what is considered an intimate relationship. AID (Artificial Insemination by Donor) can be considered a form of adultery. As Pope Pius XII argued, ‘To reduce the shared life of a married couple and the act of marital love to a mere organic activity would be like turning the domestic home into a laboratory’.12

Before it is considered that this argument is staying outside the legal realm and intro the realms of theology, consider the case of Maclennan v Maclennan13, which considered such a ‘third-party’ objection. It was held that a women who goes through a process of AID does not commit adultery, because there has been no sexual contact between the women and the male sperm donor. What may have been argued, however, is that a married women’s decision to undergo AID without the consent of her husband could be regarded as constituting unreasonable behavior for the purposes of divorce proceeding.14

The objection really resolves itself into one about the morality of artificial forms of infertility treatment per se. It also questions the selection of the ‘best’ embryos for implantation with some of the techniques. It is wrong to ‘make’ children, the argument goes like ‘IVF is a form of domination over another human life, whereas in authentic parenthood the child is a partner in the common life expressed in the procreative act of married union.15

13 (1958) SC 105.
14 Supra note 12, at 240
15 ibid
5.2.2 Anonymity of the Donor

An issue of great controversy is whether children born using donated sperm should be able to discover the identity of the sperm donor. Until recently such children only had access to the most limited information: a child could discover whether she or he was born as a result of donated gametes and whether he or she was related to a person she or he intended to marry. However, the Human Fertilization and Embryology Authority (Disclosure of Donor Information) Regulations 2004 have provided children with access to a far greater range of information. Though the regulations only apply prospectively: to all donations from 1 April 2005. Children born as a result of donations after that date can apply, once they have reached the age of 18, to discover identifying information including:

a) The donor’s name (and name at birth, if different) and address,
b) The donor’s date of birth and the town or district of birth,
c) The appearance of the donor,
d) A short statement about the donor.

The regulations will not render a sperm or egg donor a parent in the eyes of the law, nor will they mean that they become liable for child support or take on other financial responsibilities. All they mean is that her or his identity can be discovered by a child.\(^\text{16}\)

In USA, some clinic have been offering AID services which include detailed descriptions of donors, allowing the ‘purchaser’ of such services to exercise choice of donor. Early in 1998 The Times reported the development of an illicit market in sperm, available through the internet. The Human Fertilization and Embryology Authority noted that these catalogues of apparently physically attractive donors were resulting in charges of about 280 euro for each sperm sample. What is seen as most disturbing is the fact that these donors seem prepared to forgo at least some of their anonymity; a number will forgo anonymity completely, but other will allow a video of themselves to be shown to the child when it reaches 18.\(^\text{17}\)

5.2.3 Infertility Treatment and Privacy

One of the difficult balancing acts in relation to infertility treatment is to consider the conflict between the need to maintain the privacy of the couple involved in the treatment and the need to improve information flow and protect the welfare of

\(^{16}\) Supra note 11, at 372
\(^{17}\) Supra note 12, at 241.
children who are the product of such techniques. It was noted above that the child may well want to know of its genetic origins, but the parents who have brought it up may well want to keep the fact of donation from it. Added to this it is argued that to gauge the success or otherwise of infertility treatment regimes there need to be empirical research on the children of this reproductive revolution. What of the parents who do not wish this information to become available for risk of altering the child to its origins or the fact that one or both of them were infertile? There is also a serious potential conflict between infertility clinics and the couple’s own doctor.  

5.2.4 Legal Status of the Child Born As a Result of Donation

The Warnock Committee were faced with the inevitable conclusion that the child born as a result of AID was illegitimate at law. The potential seriousness of this conclusion was that the husband of the women who bears the AID child would have no parental rights and duties with regard to the child so produced, though, as a matter of general family law, the label of illegitimacy now carries with it fewer implications than it once did. The report recommended that the child should be treated at law as the child of the mother and her husband where they have both consented to the treatment.

In India, the ICMR Code refers to the necessity for the parents to adopt the child. This implies that the child born of a surrogate mother belongs to the surrogate mother herself and not to the couple, even if the surrogate mother is only a gestational surrogate and the couple has provided both sperm and egg. This is declared to be a “universal consensus”. The ART Guidelines also state that a third-party donor and a surrogate mother must relinquish all parental rights in the child.  

5.2.5 Potential Liability of the Donor

What is the situation of the AID child who suffers from a genetic defect passed on from the donor male? Can the donor be found responsible for a failure to communicate his knowledge of the defect, or can the law find the donor negligent for a failure to discover the existence of the defect before becoming a donor, or the doctor in during the treatment?  

18 Ibid.  
19 National Guidelines for Accreditation, Supervision and Regulation of ART clinics in India. Indian Council of Medical Research, National Academy of Medical Sciences (India), (2005), New Delhi: Ministry of Health and Family Welfare, Government of India para 3.5.5.  
20 Supra note 12 at 243.
5.2.6. Harm to the Embryo

Many forms of ART involve the creation of a number of embryos from which two are normally selected and implanted. Where the treatment is successful, or the couple decide to stop the treatment, this leaves spare embryos, which if not used, are destroyed. This is strongly objected to by those who regard embryos as having a right to life or having a profound symbolic importance. Of course, it would be possible to meet this concern. Regulations could permit only the creation of single embryos which would then have to be immediately placed in a woman. However, that would greatly reduce the chances of the procedure working. Alternatively, all spare embryos could be made available for donation to other couples.\(^{21}\)

5.2.7. Child Welfare

There are those who are convinced that children born as a result of ART will suffer harm in a variety of ways. There is medical danger for IVF children, most of which born as a result from multiple births when assisted reproduction is used. There is also, it is said, the danger that children will suffer psychological damage when they discover the unusual circumstances of their conception. It is sometimes said to be harmful for children to be born with no clear familial identity or sense of kinship. In fact, it is far from clear what the danger of IVF are, but the rather limited data to date does not prove that children born using ART suffer psychologically or physically.\(^{22}\)

5.2.8 The Cost of Failure

The public image of IVF is the joyful production of a new ‘miracle baby’. There are official figures on the number of children born using assisted reproduction, but none of the number of couples for whom of the experience has produced only false hopes, huge expense, deeply invasive procedures, and unbearable sadness. It must not be forgotten that the rate of success of assisted reproduction are not high. Indeed the Medical Research Council has accepted that we need much more research than we have to date on the effectiveness and safety of ART.

Even where successful there is the risk with ART of multiple pregnancies and with it the extra risks to women and children. Of children born using IVF, 22.7 per cent are twins or triplets. Although they no doubt being delight, the burden on parents raising multiple-birth children is considerable. In particular, multiple births have higher rates of miscarriage, abnormality, prenatal death, and prematurity. This

\(^{21}\) Supra note 11 at 349.  
\(^{22}\) Id at 350
produces greater strain on the couple, neonatal services, and expenses for the NHS. The HFEA has launched a ‘one at a time’ strategy which aims to reduce the number of multiple births to 10 per cent over three years. All clinics should have a policy in place which seeks to reduce the number of multiple births. The HFEA code now says that only one embryo should be transferred if couples have a good chance of success. There is a delicate balance here between increasing the chances of success of the treatment, and decreasing the chances of multiple births.23

5.2.9 Availability of Infertility Treatment

Infertility treatment, particularly IVF, is costly, time consuming, still not particularly effective, but nevertheless subject to increase demand. Should infertility treatment be available to all or should it be regarded as a form of elective medical intervention and therefore of limited availability? Those opposed to treatment for infertility point to the fact that while there is an ageing population and a growing one, the health-care system will be under financial pressure. To give infertility priority is a form of double jeopardy; the treatment devotes resources better spent saving life, and if successful increases the population.24

In India, Almost 60–70 per cent of the public sector doctors reported treating infection of the male genital tract, providing induced ovulation and prescribing fertility drugs and 50–60 per cent offered diagnostic services and counseling for couples. The public sector did not have any facilities for sperm banking and do not deal with donor materials. Most providers, both public and private think that the high cost of treatment is the strongest impediment to effective infertility treatment for patients followed by low educational levels of couples, low rates of success, varying infrastructure and facilities and lack of specialised training. Most public sector providers were of the opinion that services for infertility are lacking and, if at all, they are available at some tertiary level facilities. But, tertiary facilities are difficult to access for people living in small towns and villages. The problems faced by public sector doctors are: poor infrastructure and management, low salaries, career prospects, lack of or dysfunctional equipments, inadequate staff, medical supplies and hygiene at the PHC and CHC levels. Many of them felt that infertility treatment is time consuming and there are no protocols. There are only a few medical education

23 Id at 351.
24 Supra note 12 at 244.
programmes enhancing infertility programmes and management and counseling skills.\(^{25}\)

Perhaps one of the most obvious ethical challenges surrounding ART is the inequitable distribution of access to care. The fact that significant economic barriers to IVF exist in many countries results in the preferential availability of these technologies to couples in a position of financial strength. The cost of performing ART per live birth varies among countries. The average cost per IVF cycle in the United States is USD 9,266. However, the cost per live birth for autologous ART treatment cycles in the United States, Canada, and the United Kingdom ranged from approximately USD 33,000 to 41,000 compared to USD 24,000 to 25,000 in Scandinavia, Japan, and Australia. The total ART treatment costs as a percentage of total healthcare expenditures in 2003 were 0.06% in the United States, 0.09% in Japan, and 0.25% in Australia. Some have maintained that the cost for these cycles pales in comparison to the social advantages yielded by the addition of productive members of society. This is especially true in societies that have a negative or flat population growth rate coupled with an aging population. The funding structure for IVF/ART is highly variable among different nations. For example, no federal government reimbursement exists for IVF in the United States, although certain states have insurance mandates for ART. Many other countries provide full or partial coverage through governmental insurance. In many instances, long waiting times for IVF through these government programs encourage couples to seek treatment in private fertility centers that accept remuneration directly from the patients. In the United Kingdom, for example, only approximately 25% of all IVF cycles performed are funded by the National Health Service.\(^{26}\)

The ICMR code also says:

1. The setting up of a modern ART clinic and running it satisfactorily is an expensive affair, requiring a dedicated staff that would render longterm service. The setting up of ART clinics in the public sector, which do not exist as of now, must be explored.\(^{27}\)

---


\(^{27}\) Supra note 19 Para 7.1
2. The concerned Ministries must take a look at the reason for the high cost of ovarian stimulation hormones, and encourage and support local pharmaceutical industries to start manufacture of human menopausal gonadotropins indigenously so that the treatment of our infertility patients is not dictated by the commercial motives of the multinational pharmaceutical companies but by national needs.\textsuperscript{28}

5.2.10 Ethical Issues in Surrogacy

Another topic of ethical, social, and legal debate surrounds the use of surrogacy and gestational carriers. Some also are concerned that the use of surrogates and gestational carriers is a form of “child selling” or the “sale of parental rights”. Additionally, the rights of the surrogate or gestational carrier to not relinquish the infant following deliver are not well described. The human organ donation was given a non-commercial status by the Human Organ Transplant Act- 1994, however, temporary lending of uterus on payment has not been objected to by the state. This irrational distinction between human body parts donated and rented, and equating of goods and living beings in commercial surrogacy, is undermining the sacrifice and autonomy of surrogates. The expert providers see it as an industry where cheap Indian “labour” of the surrogate makes it a profitable venture for them. Their logic made the distinction between the product of social human labour (consumable commodities) and the product of woman’s procreative labour (a human baby).\textsuperscript{29} Another central concern surrounding the use of surrogates and gestational carriers is the possibility that financial pressures could lead to exploitation and commodification of the service. The mean compensation for a gestational carrier in the United State in 2008 was estimated at approximately $20,000. In contrast, a gestational carrier in India receives an average of $4,000 for the same service. Regulation of surrogates and gestational carriers varies widely from nation to nation and even within regions of individual countries. Due to these financial and legal considerations, international surrogacy has emerged as an emerging industry, especially in developing nations. This practice has exacerbated the already difficult ethical and legal issues surrounding gestational carriers. At the present time, issues surrounding issues of individual rights,

\textsuperscript{28} Id, para 7.2.
\textsuperscript{29} Imrana Qadeer, “New Reproductive Technologies and Health Care in Neo-Liberal India: Essays” Centre for Women’s Development Studies, (November 2010), at 30.
commodification, exploitation, citizenship of the offspring of international gestational carriers, and even fair trade are largely unresolved internationally.\textsuperscript{30}

Commercialization of surrogacy however, creates several social conflicts rather than resolving some. It generates family pressure on poor women to oblige. Given the extreme vulnerability of almost one third of the Indian women due to poverty, exclusion from, and marginalization in labour and job markets, patriarchal social and family structures and low educational levels, the financial gain through surrogacy becomes a key push factor. This is substantiated by the fact that most surrogate mothers are from not so well-off sections and the motive primarily is monetary. This makes their economic exploitation easy for the agents working for commissioning parents. Much debate has centered on whether surrogates should be paid for their services, whether surrogacy contracts should be enforced, and how to resolve custody disputes when one or more parties to a surrogacy agreement change their mind.

5.3 Feminist Perspective on medically Assisted Reproduction

A basic assumption of feminist theory is that women have the right to reproductive freedom and control over their bodies, and that this freedom-right-control is essential if they are to have full and equal opportunity in society. Although their concern is as much for the high birth rates in the developing nations as for the basic rights of women, those who are active in the family planning movement are also increasingly calling for reproductive freedom for women. Consequently, the declarations from both the 1974 U.N. World Population Conference and the 1975 U.N. International Women's Year Conference state that individuals have the right to determine the number and spacing of their children.\textsuperscript{31}

Control of reproduction means much more than being able to bear a desired number of children at desired time intervals; it is not just a question of knowledge and birth control technology. In order to be assured of control over reproduction, women must have economic independence, the freedom to bear or not to bear children regardless of marital status, and control over the means of controlling reproduction.\textsuperscript{32}

Reproduction and motherhood have been at the core of the feminist and women’s movements ever since their emergence. And from the start, reproduction

\textsuperscript{30} Supra note 26 at 5.
\textsuperscript{32} Id p. 57.
and motherhood have been highly contested issues – both within the feminist movements and beyond. Yet, over the past few years, ART has fundamentally altered the ways of reproduction and the perception of it, as ART has gained in importance not only for individual procreation, but also for population development. ART has opened up the possibility of childbearing to groups of women and men who did not have this option before, such as sub-fecund and infertile women, to women and men with other health problems, to gays, lesbians, and transsexuals, and to women beyond menopause.

Although most of all children in the world are still born without the use of ART, ART is spreading rapidly. Some techniques, such as ultrasound and amniocentesis, have become standard procedures in prenatal care in many countries, financed and often required by public health care. Likewise, many public health care systems recognize infertility as “illness” and subsidize its treatment, although mostly only for selected groups of women and men. While acknowledging the benefit which some women (and men) have from this development, feminist have tried to assess the impact which ART has on the social and economic situation and the cultural and legal recognition of all women. Most feminists view ART with criticism or at least ambivalently. They point to the factual changes in conception, pregnancy, and birth which ART has generated and to the shifts in the cultural, legal, and medical perception of women, reproduction, and motherhood. Reviewing the conditions of both fertile and infertile women, they doubt that ART contributes to empowering women and to granting them more control over their body, reproduction, and motherhood. Many warn against the consequences of the ART-induced dissociation between reproduction and motherhood, and about the split of the maternal body into different “deliverers” of products and services. They maintain that these developments have not reduced society’s power over women, but have induced new and global power structures at the gender, the social, and the economic level. The feminist answers to these trends demonstrate the challenge which the development of ART and its consequences poses to the feminist struggle and the feminist discourse. Many feminists call for stops to or restrictions of ART and its commercialization, and for the re-allocation of funds from ART to reproductive and health services which benefit all women. They argue for a stronger integration of ART issues in the discourse about human rights, for a more equal inclusion of feminist advocates in ART debates, and for a general politicization of ART to subject its development and
application to more democratic procedures. The development of ART has posed unsettling questions to many feminist principles and approaches. The medical practice of ART and subsequently the legal systems have drawn new boundaries and instituted previously unknown power imbalances between different biological motherhoods, between the embryo and the mother, and between different biological mothers and a father. The fact that one does not know the long-term consequences for women treated by ART and for their children has further aggravated cleavages between social motherhood and the various forms of biological motherhood. Feminists find themselves in a situation where they must strive to bind the social back to the biological, to re-define “nature” in a way that grasps all forms of fractured motherhood and to make claims on such re-definitions without supporting perceptions of reproduction and motherhood which they have fought against for so long.33

When ARTs were first developed in the West, they were perceived both by the medical profession and the public in general as a ‘miracle cure’ for an aberration caused by nature. While this continues to be the common understanding about ARTs, there were varied opinions amongst feminists about these technologies. At the two extremes are (a) those who claim the technologies to be emancipatory in nature; and (b) those who see them as an instrument in the hands of capitalism and patriarchy, reducing women’s role to reproduction and thereby furthering their subordination and exploitation.34

Members of the former group welcome these technologies as scientific and technological progress, holding that it is the context in which these technologies are used that makes them good or bad. They base their support for these technologies on the notion that they satisfy the legitimate needs of some women. Shulamith Firestone, a prominent radical feminist, feels that these technologies have the potential to liberate women from the burden of motherhood and hence act as an instrument through which women’s emancipation can be achieved. For supporters of these view, ARTs provides solutions for individual women in a context where infertility and childlessness result in social ridicule. Moreover, they empower women by giving them “choice” and “control” over their own reproduction.35

---

34 Supra note 10, at.23
35 ibid
Chapter V Ethical-Moral and other Issues in Assisted Reproductive Technology

Among the responses to these assertions is a body of feminist analysis that examines these concepts of choice and control, the terminologies used, and questions of ethics, the medical and social implications of these techniques for women’s identity, and motherhood.

Feminists like Gena Corea have argued for a total rejection of modern contraceptive and parental diagnostic technologies because they reinforced existing unequal social relations rather than enhance women’s reproductive choices. This stand is exemplified by the Feminist International Network of Reproductive and Genetic Engineering (FINRRAGE), formed in 1986. FINRRAGE argues that reproductive technologies are ‘…a manifestation of patriarchal domination and exploitation of women’s bodies by men who envy women’s procreative power.’

Some writers stress the role of patriarchy in oppressing women through New Reproductive Technologies; while others stress the interaction between patriarchy and capitalism. Regardless of theoretical orientation, feminists share a common concern with the fact that these technologies have undermined hitherto taken-for-granted relationships between biology, women’s identity, and the meaning of motherhood.

Another important issue that alarms the feminists is the commodification of the female body and the processes of reproduction. In the word of US-based feminist scholar Marsha Darling, the concept of women’s bodily integrity is threatened by the extent to which women’s biological and reproductive organs, tissues, cells, including ovum and genes, are quickly becoming ‘spare parts’ in a medical industrial complex. At the very same time that reproduction is imagined as an industrial process by the biotech industry, women are sought after as consumers of the very technologies that will weaken women’s right to bodily integrity.

Such commodification has been brought about by the commercialization of ARTs and feminists feel it is important to highlight their social consequences. Surrogacy is a perfect example of such commercialization. Feminists have referred to

surrogacy as “commercial breeding” and “reproductive trafficking”. Linda M. Whiteford, writes,

“Commercial surrogacy exploits socioeconomic class differences, using financial need and emotional need and currency. The exchange of money transforms surrogacy from an altruistic gift between sisters or friends into baby selling or womb renting”.

Feminists draw attention to the fact that often it is poor women who act as surrogates because of their financial need and their limited opportunities for earning a livelihood. On the practice of surrogacy, Professor Janice Raymond, who specializes in women’s study and medical ethics, says: “surrogacy makes women into mere incubators or receptacles for male sperm.”

In other words, surrogacy draws a line of demarcation between pregnancy and motherhood—two seemingly inseparable phenomena—by assuming that the women does not develop any emotional attachment with the foetus.

Starting in the late 1980s, Indian activists and scholars started analyzing the onslaught of new reproductive technologies in India. Malini Karkal looked at the significance of in vitro fertilization (IVF) in developing countries and the emergence of practices such as surrogacy. Lakshmi Lingam argued that, “New Reproductive Technologies raise several moral and ethical issues and they capitalize on the social stigma attached to infertility; the value attached to biological motherhood.” An important document from within the women’s movement is We and our fertility by Chayanika et al., which identified conceptual and programmatic links between fertility and population control technologies. The document contends that contraceptive and contraceptive technologies are part of one continuum and both technologies are designed to intervene in the hormonal cycle, either by promoting fertility or controlling it. Furthermore, the author argue that the institutions of marriage and family define women’s live as limited to their role as procreator, and describe women’s experiences in fulfilling these roles. Jyotsna Agnihotri-Gupta also look at

the interface of technology, health and women’s lives in Indian society, and the implications this has for women’s agency.\textsuperscript{41}

Furthermore, ARTs have also been seen as urban-centric and expensive, and therefore inaccessible to most women.\textsuperscript{42} Even though other social issues in India have taken precedence over ARTs, various movements have been vocal in pointing out the damage done by ARTs on a number of fronts. The ever-changing definition of infertility has also aggravated the labeling phenomenon. Earlier, infertility was defined as childlessness despite at least five years of sex without contraception. Today, the time frame is only one year: if a woman does not conceive within one year of marriage, she can be labeled “infertile”. This expanded definition also multiplies the number of people who may, and who do, seek ARTs, thus ensuring the expansion of the ART industry.\textsuperscript{43} A section of the lesbian, gay or queer movement is strongly critical of ARTs, on the grounds that this technology reinforces hetero normativity—the tendency to exclude everything that does not fit into the norms of heterosexual behavior.\textsuperscript{44} The promotion of ARTs is justified by the notion that they give women a choice, and that such a choice is important for women to have.

5.4 Economic Aspect of Medically Assisted Reproduction

Debora Spar has put her finger firmly on the pulse of the ART business when she calls it the “Baby Business” in her book with the same title. As with any other business, the process of making babies has a number of components. A couple looking for a baby may be in need of one or more of the three necessary components—sperm, ovum and womb. Fertility clinics provide the service of matching the technology with the need. They market their services through the media in various forms, just like any other business would do. Mostly, these clinics are in partnerships with established hospitals and doctor who visit them to carry out procedure of egg retrieval or embryo transfer once every three to four months. Also, “patients” are referred from smaller clinics to those offering more sophisticated technologies in bigger cities. There is, thus, a phenomenon of “local globalization” with regard to ARTs operating within the country.\textsuperscript{45}

\begin{thebibliography}{9}
\bibitem{41} Supra note 10 at 29
\bibitem{42} Id at 29
\bibitem{43} Id at 31
\bibitem{44} Ibid
\bibitem{45} Supra note 10 at 45
\end{thebibliography}
The most contentious part of this chain is the market for wombs. Because it involves a nine-month long confinement, it may involve complex legal arrangements, and very large payments. Given the very high cost of hiring a womb (a surrogate mother) in the developed North, the business of hiring womb has crossed borders. According to journalist Reena Martins the annual number of new surrogate pregnancies in India doubled in the last three to five years. A commissioning couple spends approximately Rs 10 lakh in India compared to Rs 25-35 lakh in the US. According to another press report, doctors states that though relatives usually comes forward to act as surrogate mothers, women who conceive for a fee will charge Rs 8-10 lakh for the entire contract. Doctors have also been quoted as saying that 70 percent of the clients for surrogates are non-resident Indians.

Reproductive technologies have grown in leaps and bound both in domestic and the global market. Tied as ART is with medical tourism, it has all the necessary linkages that help it to thrive in the market economy-educated people and the medical fraternity buying into it and promoting it and the State not being interested in any kind of regulation… and while women’s groups continue talking about sex tourism India actually have reproductive tourism that has come along with sex tourism.

A cost-benefit analysis is invalid for health issues, because the inputs and outputs cannot be quantified. When financial constraints determine public health priorities rather than epidemiological resources, the assumption is that the technology is necessary, effective and safe. And when the technology in question is far from the above, its promotion is not only unjustified, but also unethical.

On January 3, 2008, Judith Warner published “Outsourced Womb” in a blog in *The New York Times*. Warner raises ethical questions about the complexities of transnational gestational surrogacy, a growing segment of reproductive tourism industry. Increasingly women and couples from the United States and Europe have begun traveling to India to hire women at discount rates to gestate and deliver babies for a fraction of what it would cost in the United States. They are, like companies that outsource labor to other countries, traveling to purchase a cheaper source of reproductive labor. Gestational surrogacy is a form of industrial labor that has not been previously considered by economists or economic sociologists in their

---

46 Id at 48.
47 ibid
48 Id at 37.
discuss discussion of outsourcing yet it represent a growing segment of the reproductive tourism or medical tourism market.\(^49\)

5.5 Health Issues Relating to Medically Assisted Reproduction

Even without going through the issues of surrogacy, ova sale and ethical problems around these, if we simply look at the complications reported due to ART procedures, the range is alarming. It is reported that even in the so called take home babies, mortality is four times higher. Risk of ectopic pregnancy in ART is five times higher, miscarriage is 2-3 times higher than normal pregnancies and the rate of Cesarean section is 43.9 percent. Complications range from major congenital malformations, prematurety, multiple pregnancies to gestational complications such as 1st trimester bleeding, abortion, induced hypertension, diabetes, and premature deaths. In addition to these are the less reported problems even though these are so common that they are treated as “normal” for the procedure by doctors and “safe” for the women. These are strong emotional upheavals considered violative of the integrity of the body, depression and grieving caused by the poking and prodding of the body and the drugs injected. These side effects are now getting known in the western countries because women are beginning to talk and complain that they are given no feed backs. Drugs like Letrozol and clomiphene citrate are used for harvesting oocytes. These can cause hyper-stimulation syndrome that other than releasing large number of ova also causes ovarian rupture, vaginal bleeding, kidney and lung failure.\(^50\)

Although, ICSI has revolutionized the treatment for male infertility, its widespread use has raised medical concerns about the transfer of genetic defects to future generations. There is a higher than normal frequency of sex chromosome abnormalities in children born of ICSI procedures compared with the normal population. Besides, infertile men carrying Y chromosome microdeletions pass this defect to ICSI-born sons. During ICSI, the process of fertilization is dramatically changed. For example, there is no fertilization occurring in vivo, and the physiological maturation of sperm, its selection and penetration through oocyte investments, and its influence on embryonic spatial patterning are bypassed. Because ICSI bypasses a part of the process of natural selection and certain early


\(^{50}\) Supra note 29 at 18.
developmental mechanisms, concerns are expressed on the possible reproductive health risk(s) to the offspring.\textsuperscript{51}

In India, it is estimated that about 15\% of married couples are sub-fertile or infertile. Treatment of male-factor infertility in the country has improved dramatically with the introduction of ICSI, which is currently being practiced rather extensively in various major ART clinics in the country. It is, however, extremely important that this approach to treating male-factor infertility is carried out with caution, in view of the possible risk of vertically transmitting defective (spermatogenetic) fertility gene(s) to the male progeny, when the etiology of infertility is genetic in origin. Thus, ICSI may fall below the general expectations of the Helsinki Declaration. ART clinics accredited under the present programme must therefore take due note of the above before resorting to ICSI, and counsel the couple for whom ICSI is being recommended, appropriately. Inspite of what has been said above, in some case, ICSI may still be the preferred choice of treatment for infertility.\textsuperscript{52}

There is a growing interest in embryonic stem cells because of their potential use for developing spare organs or replacing defective tissues such as parts of the brain destroyed due to Alzheimer’s disease, or pancreatic cells in diabetic patients. The range of their potential use is limited only by one’s imagination. ART clinics are the only source of embryonic stem cells. Spare embryos are either frozen or returned to the infertile couple for replacement during a later cycle, or donated to another infertile couple, or discarded after five years using a suitable protocol.\textsuperscript{53}

Recently, the USA banned all federal support for embryonic stem cell researches. Germany has banned all research on embryos produced in that country but permits the use of embryos brought from abroad. The stand taken by the foreign governments on embryo research opens up the possibility of embryos from developing countries that do not have appropriate national guidelines in this area, being commercially exploited and sold to foreign countries. Therefore sale or transfer of human embryos or any part thereof, or of gametes in any form and in any way – that is, directly or indirectly – to any party outside the country must be prohibited. Within the country, such embryos or gametes could be made available to bonafide

\textsuperscript{51} Supra note 19 Para 1.6.11.2
\textsuperscript{52} Ibid.
\textsuperscript{53} Id, para 3.11.
researchers only as a gift, with both parties (the donor and the donee) having no commercial transaction, interest or intent.\textsuperscript{54}

ART procedures carry a small risk both to the mother and the offspring. These risks must be explained to the couple and appropriate counselling done. ART procedures are to be initiated only after patients understand these risks and still want to undergo ART. Some of the most commonly encountered risks are mentioned below:

5.5.1. Multiple Gestations

The reported incidence of multiple gestation ranges from 20 to 30\%. Incidence of twin pregnancies in the range of 10-20\% may have to be accepted as inevitable, but specific efforts must be made to reduce the incidence of triplets and multiple births of higher order. Therefore, not more than three oocytes should be transferred for GIFT and not more than three embryos for IVF-ET at one sitting, excepting under exceptional circumstances which should be recorded; the remaining embryos, if any, may be cryopreserved and, if required, transferred at a later cycle.\textsuperscript{55}

In the United States, while physicians are required to report the number of embryos transferred in an IVF cycle, there are no laws that state the allowed number of embryos transferred. The transfer of multiple embryos in a single cycle increases the rates of multiple births. Because of the increased social costs and health risks associated with multiple births, legislation or guidelines from professional societies have been introduced in many countries restricting the number of embryos that may be transferred per IVF cycle in an effort to limit the incidence of multiple gestations. Indeed, a study in the United Kingdom found that the total health care system costs following a singleton birth were £3313, £9122 following a twin birth and £32,354 following a triplet birth. Additionally, the health risks, both to the mother and the infant, increase dramatically with increasing number of infants. In the United States in 2007, the number of embryos transferred per cycle ranged from 2.2 in women under 35 to 3.1 in women over 40 years of age (CDC). Multiple birth rates in the United States in 2007 ranged from approximately 35\% in women under 35 to 15\% in women over the age of 40. In Europe, the approximate number of embryos transferred in the year 2006 was one (22\%), two (57\%), three (19\%), or four (1.6\%). In 2007, 79.2\% of

\textsuperscript{54} Id para 1.6.11.3.
\textsuperscript{55} Id para 2.4.1.
European births were singletons, with a twin rate of 19.9% and a triplet rate of 0.9%.

However, the practice of transferring multiple embryos has raised ethical questions about whether it is acceptable to do so with the knowledge that aborting some of the fetuses may later be medically indicated. Also of concern is whether it is ethical for patients to refuse selective reduction when they are aware of the attendant risks of carrying multiple fetuses to term. In 2006 the American Society of Reproductive Medicine issued guidelines that no more than two embryos should be implanted for women under 35, no more than three for women who are 35 to 37, no more than four for women who are 38 to 40, and no more than five for women over 40. Clinics, however, are not required to follow the guidelines. Some countries have imposed limits. In the United Kingdom, for example, the Human Fertilisation and Embryology Authority has set a limit of two embryos for women under 40 and three embryos for women over 40, but it is examining whether it should change its rules to make one embryo the norm. In Italy, by contrast, a maximum of three embryos may be created at a given time and, barring exceptional circumstances, all embryos created must be implanted simultaneously. A likely response to the Catholic Church’s teachings that embryos should not be intentionally destroyed due to its belief that human life begins at fertilization.

5.5.2. Ectopic Pregnancy

Ectopic pregnancy rates could be as high as up to 8% for ART procedures. The choice of an appropriate procedure as per guidelines mentioned earlier, especially in persons with tubal disease, may reduce the chances of an ectopic pregnancy.

5.5.3. Spontaneous Abortion

Spontaneous abortion rates range from 20 to 35%. Abortion rates rise with increasing age of the mother and in multiple pregnancies, especially with three or more foetuses. In cases where more than two foetuses are present, selective embryo reduction should be advised. It is essential that the advantages of embryo reduction (better chances of the survival of other foetuses and the fact that they are likely to be born nearer term and with better birth weight) and disadvantages (the possibility that there might be an increased risk of abortion following the procedure) must be

56 Supra note 26 at 2.
57 Jessica Arons, Future choices: Assisted Reproductive Technologies and the Law, (Center for American Progress, December 2007), at. 11.
58 Supra note 19 para 2.4.2.
explained to the couple, and their informed consent taken before embryo reduction is attempted.\textsuperscript{59}

5.5.4. Preterm Birth

There is a higher risk of premature/low birth weight delivery following ART, especially in the presence of multiple foetuses.\textsuperscript{60}

5.5.5 Ovarian Hyperstimulation Syndrome

The use of superovulation for ART entails a risk of hyperstimulation in some women. The extent of this risk is determined by the hormonal profile of the woman, the estradiol values, the dose required for triggering ovulation, the ability to aspirate all the follicles at the time of oocyte retrieval, and several other factors.

5.5.6 PGD (Pre-implantation Genetic Diagnosis)

The usual procedure for couples having IVF is to create a number of embryos and implant them two at a time into the women. The question we shall consider here is whether it is permissible to select from the embryos created which will be implanted. There is generally no objection to a selection being made on the basis of which embryos are most likely to survive to birth; but more controversially a couple who are at risk of having a child with a genetic disability may wish to select an embryo which does not carry that disability. This require an assessment of the different embryos to see if they carry the desirable or undesirable characteristics. This is known technically as PGD (preimplantation genetic diagnosis) and requires a licence from the HFEA in U.K. the Human Fertilization and Embryology Act, 1990, sets out the circumstances in which PGD is permitted. This includes ‘to establish if an embryo has an abnormality that might affect its capacity to result in a live birth’ and ‘to avoid a serious medical condition’. The practice is controversial and the HFEA will only allow it for a strict set of reasons. The Code explains:

Preimplantation genetic diagnosis (PGD) can be carried out for a heritable condition only in two circumstances:

(a) where there is a particular risk that the embryo to be tested may have a genetic, mitochondrial or chromosomal abnormality, and the authority is satisfied that a person with the abnormality will have to develop a serious disability, illness or medical condition, or

\textsuperscript{59} Id para 2.4.3
\textsuperscript{60} Id para 2.4.4.
(b) where there is a particular risk that any resulting child will have or develop a
gender related serious disability, illness or medical condition. A condition is
gender related if the Authority is satisfied that it affects only one sex, or
affects one sex significantly more than the other.

In the first situation, PGD may be carried out to establish whether the embryo
has the suspected abnormality; in the second, PGD may be carried out to establish the
sex of the embryo. As at January 2009, sixty genetic conditions had been licensed for
PGD.\textsuperscript{61}

IVF introduces a refinement in the form of Pre-implantation Genetic
Diagnosis. A cell of the fertilized embryo is examined for genetic or chromosomal
errors and only those embryos free of these conditions are used for the IVF procedure.
In the US, where there is no regulation of the procedure, PGD is used to test for a
range of conditions from serious illnesses that affect children to more treatable
conditions, and also those that develop in adulthood. In countries where son-
preferences is high, its use extends to sex-determination and selection of the embryo.
If PGD is not regulated, it will increasingly be used for non-medical purposes.
Already research is focusing on the genetic basis for characteristics such as skin
colour. The assumption underlying such practices is that certain qualities are desirable
and others are not, that there is a “normal” and an “abnormal”, that all characteristics
are generally determined and therefore the undesirable can be eliminated through
genetic engineering.\textsuperscript{62}

The ICMR guidelines also states:

There is a growing volume of information that is now available showing that
many forms of infertility are caused by genetically transmittable disorders. The
genetic disorders include trisomy, translocations, inversions, deletions and
microdeletions. All this new information suggests that great care must be exercised
with ART because infertile couple may be carriers of such disorders; when one tries
to force fertilization, the question arises whether one is transmitting genetic disorders
to the offspring. This raises many moral and ethical issues.

One way to get around this problem is to institute top-class genetic diagnostic
facilities that will be able to carry out diagnosis of genetic defects in single cells
obtained from embryos. This is a very expensive and labor intensive project and

\textsuperscript{61} Supra note 11 at 380.
\textsuperscript{62} Supra note 10 at 24.
therefore there is a need to establish just a few well equipped centers in the country and later expand them if there is a need. These centers could serve as referral centers and should be used judiciously. The establishment of such centers will go a long way in placing ART practice in India on a firm, healthy and ethical footing. 63

5.5.7 Saviour Sibling

The emotive term, ‘saviour sibling’, has come to be used for cases where parents of a sick child wish to have another child whose tissue can be used to provide a treatment for the condition of their sick sibling. In U.K. the 2008 Human Fertilization and Embryology Act has made it clear that embryo testing to ensure an implanted embryo may be a ‘saviour sibling’ is permitted. Paragraph 1ZA (d) of Schedule 2 allows a testing where:

A person (‘saviour sibling’) who is the child of the persons whose gametes are used to bring about the creation of the embryo (or of either of these persons) suffers from a serious medical condition which could be treated by umbilical cord blood stem cells, bone marrow or other tissue of any resulting child, establishing whether the tissue of any resulting child would be compatible with that of the sibling.

There, are however, limitations on the use of PGD for the use of selecting ‘saviour siblings’. First, the statute make it clear that it can only be used in the case of siblings. An ‘embryo’ who would be the cousin of a child with a serious medical condition could not be selected. Second, paragraph 1ZA(1)(d) makes it clear that selection cannot be made if it is planned that a whole organ (eg a kidney) is to be donated. The plan must be to use the umbilical cord blood stem cells, bone marrow, or other tissue, from a child. That is not to say that a child cannot donate an organ to a sibling, it is simply that they cannot be selected at the embryo state for such a purpose.

Critics of ‘saviour sibling’ claim that it involves bringing a person into being for the sole purpose of assisting their sibling. This infringes the principle that people should not be used solely as a means to an end. Supporters could reply to this in two ways. One would be to argue that in fact to save the life of one’s sibling is beneficial to the donor, or at least not harmful to them. Alternatively, they could argue that it is extremely unlikely that parents would treat the savior sibling simply as a source of tissue. It would be hard to believe that parents would ‘discard’ a saviour sibling once treatment of the existing child had been effective. The child is being created to be

63 Supra note 19 para 6.1.
loved in her or his own right as well as assisting the sibling. A slightly different argument is that the child, when older, might perceive her or himself as having been created as merely a means to save her or his sibling. This could cause psychological problems, particularly so if the matching had not worked out. Again, these are only possible dangers and we do not know how likely they are to be realized. The ‘saviour sibling’ might just as well feel delighted that she or he were able to save or attempt to save another life, and regard it as having enriched her or his own life. John Harris has argued that guesses about possible emotional harms for the ‘saviour sibling’ do not justify denying treatment which would save a life. Another issue which the courts may need to address at some point is the legal liability that could arise if a ‘saviour sibling’ is created but does not provide a cure.\(^6^4\)

The first case in India involving a “saviour sibling” was done in Life Cell in Chennai in 2009. This involved parental testing. A child with thalassemia was treated with stem cells from the cord blood and bone marrow of a sibling who was conceived for the purpose of providing a tissue match. There is a reason to believe that parental testing will soon give way to PGD for this purpose in India, to produce matched tissue donors for a sibling. However, there has been no discussion of the implication of creating a child in order to be a donor.\(^6^5\)

In addition to these specific complications of ART, couples undergoing various ART procedures incur the risks associated with the operative and anaesthetic procedures involved in ART.\(^6^6\)

### 5.6 Religious Aspect of Medically Assisted Reproduction

Ever since the beginning of human history and society, religion and science have been two very important coordinate of the human evolution, They have always been interrelated and both have exerted a great influence, thus when it comes to assisted reproduction we must take into consideration the religious point of view. Social factors, religious pressure groups and legislation differs from one state to another when it comes to dealing with controversial issues like: the genetic material donation, the use of surrogate mothers, the reproductive age-limitation, genetic diagnosis of the embryo, the selective embryo reproduction and even cloning.\(^6^7\) In spite now a day’s society tendency towards separation from churches old practice,

\(^{6^4}\) Supra note 11 at 386.

\(^{6^5}\) Supra note 10, at xxiv

\(^{6^6}\) Supra note 19 para 2.4.5.

civil groups are still manipulated by the various religious influence groups when it comes to important issues related to human reproduction such as contraception, abortion, and infertility therapy.68

The recent development of assisted reproductive technology raised serious questions related to reproduction which not always has the clearest answers. Bioethics has been created to deal with the different religious groups’ attitude towards the new fields of assisted reproduction but it cannot set the border line between ethical and unethical when it comes to assisted reproductive technologies.69 It is of a great importance for those who are confronted with infertility issues, both the scientists and the couple who deals with this medical problem, to acknowledge the importance of the religious aspects of the medical approach of infertility, to understand and to make a choice whether it is one which respects the practices of their religion or not.

5.6.1. Islamic Views

Islamic world has been enclosed to modern techniques for many years, delaying thus the implementation of modern reproductive technologies due to the prejudice that Islamic teachings would disapprove assisted reproduction. Islamic laws are extremely strict when it comes to sexual intercourse; sex is the privilege of the married couples, premarital and extramarital sex is strictly forbidden.70 Sex must be avoided with all costs during menstruation, after the birth, after diseases or disabilities. Homosexual intercourse is strictly forbidden.71 Adultery is still severely punished, starting with house detention, public dispraise and verbal humiliation.

The Islamic belief associates marital sex with family values and procreation, therefore it supports only the sexual act which involves man’s penis penetrating woman’s vagina, as it is the only sexual act which can lead to pregnancy, moreover oral and anal sex as well as masturbation are strictly forbidden.72 With the passage of time Islam offers its support to assisted reproduction, when natural procreation fails, the treatment is seen as the couple’s duty and the Islamic laws forbid adoption. Assisted reproductive techniques are only permitted between husband and wife, a

71 Supra note 69.
third party, the donor is not accepted whether it is a sperm donor, or a surrogate mother, an embryo, or an oocyte donor. In the case of divorce or the death of the husband, artificial insemination cannot be made with husband’s sperm. Any medical procedure which involves donor is considered adultery.\textsuperscript{73}

As long as it is the husband’s semen that is used to impregnate the wife, intrauterine insemination ("IUI") is permissible.\textsuperscript{74} Permissibility, however, is conditioned upon insemination occurring while the marriage remains intact. Thus, the husband's frozen semen cannot be used after divorce, or after the husband’s death.\textsuperscript{75} IVF, with its various modifications, i.e., GIFT (Gamete intra-fallopian transfer), ICSI (intracytoplasmic sperm injection) etc., has been declared Islamically permissible,\textsuperscript{76} only if the following conditions are satisfied. First, the IVF must involve a married couple. Second, the sperm must be from the husband, and the eggs from the wife. Third, this must occur within the context of a valid marriage. Fourth, the procedure must be conducted by a "competent team" in order to reduce the chances of failure. Further, there is a need for conscientious handling of the process so as to ensure that the gametes of the husband and wife are the ones actually being used in the procedure. Finally, no more than the appropriate number of fertilized eggs should be transferred to the uterus.\textsuperscript{77} If more than the appropriate numbers are used, the risk of triplets and higher order multiple pregnancies increase, and as a result, the risks of miscarriage and pre-term delivery are great. It is common to transfer only two to three fertilized eggs, although there are usually more fertilized eggs produced. Freezing the remaining fertilized ova is permissible as long as they are only used in subsequent cycles for the same couple, and the couple is still married. The fate of the unused eggs has not yet been decided upon; it will be permissible to use them for medical research with the consent of the couple and within the appropriate guidelines.

The Quran states: "Then has He established relationships of lineage and marriage...." The use of donor sperm, eggs, or embryos will result in the biological father or mother being different from the "married couple." In Islamic law, this is

\textsuperscript{74} Supra note 72 at 17.
\textsuperscript{75} Ibid.
\textsuperscript{77} “Council on Islamic Education”, available at \url{http://www.cie.org}. Visited 15 April, 2011.
similar to adultery in confusion of the lineage. 78 Unclear lineage may cause one to marry a brother, sister, or a close relative, even with the strictest guidelines in place to prevent this from happening. If donor gametes are used despite the prohibition, Islamically, the following applies: in the case of donated sperm, the "husband" would be considered the legal father, although he is not the biological father. Moreover, if a donated egg is used, the birth mother is considered the legal mother, although she is not the biological mother.

Under Islamic law, surrogacy is prohibited. Linguistically and Islamically, the Arabic word for "to give birth" is Walad, and for "mother" it is Walidah, or the "one who gives birth." 79 A verse from the Quran states that, "None can be their mothers except those who gave them birth." 80 Even if there is an agreement between the parties, the confusion of lineage, which is inevitable in these surrogacy arrangements and which is of major importance in Islamic law, prohibits surrogacy. If surrogacy is still done despite the prohibition, it is the consensus of Islamic scholars that the birth mother is the "real" mother. 81

5.6.2. Hinduism

Hindu religion agrees with most of the assisted reproduction techniques, but it demands that the oocyte and the sperm used in the procedure to come from a married couple, this religion also accepts sperm donation but sets the condition that the donor be a close relative of the infertile husband. Abortion is not prohibited and the adoption of a child which usually comes from a numerous family is also practiced. 82

According to the Hindu view, in the case of male infertility the wife can be authorized to have intercourse with a brother in-law or another member of the husband's family in order to conceive a male offspring (only after 8 years of infertility or after 11 years of delivering only female offspring). According to the above statement this may lead to the conclusion that sperm donation can be practiced according to the Hindu view, with the restriction that the sperm donor must be a close relative of the husband. 83 According to Hinduism, it is suggested that oocyte donation

---

79 Ibid.
82 Ibid.
can be practiced on the same grounds as sperm donation and there is no prohibition of
the practice of surrogacy.84

Hinduism does not view the soul at man as having a specific beginning or
specific end. Cryopreservation of pre-embryos may be permissible when it is to help
the infertile couple and it serves the dharma of the physician.

5.6.3. Buddhism

Buddhism emerged in India around 500 BC and it is based on the teachings of
Siddhartha. Buddhism allows the use of IVF without restricting the access to this
medical procedure to the married couples, sperm donation is also permitted.85 A child
conceived from donated genetic material has the right to meet his genetic parents as
he reaches maturity.

Traditionally, Buddhism has imposed strict ethics on priests, while it has taken
relatively lenient attitudes toward lay people. This means that Buddhist priests allow
laypeople to do whatever they want to do as long as they do others no harm in a
concrete way. This leads to the idea that we do not have to accept infertility as it is. If
medical treatment for infertility is available, we can make use of it. Generally
speaking, having no children will be a greater threat to a marital relationship than the
practice of modern infertility technology. According to Buddhism, treatment should
be given to unmarried as well as to married couples.86 According to Buddhism,
donation of sperm is not prohibited, but it is suggested to refrain from this procedure
as much as possible. IVF has been practiced in Japan since 1982 and is also practiced
in other countries with Buddhist and Hindu populations. The practice of IVF raises
another dilemma from the Buddhist points of view, since it involves the procreation of
more pre embryos than are implanted in the uterus. The oocyte donation can be
practiced on the same grounds as sperm donation. According to many Buddhist
scholars experimentation on is acceptable. They also accepts cryopreservation of pre
embryos.87

There is no Buddhist prohibition of the practice of surrogacy, but it may raise
complications regarding the family ties and legal and moral aspects. Special problems

85 Supra note 10 at 1.
85 Joseph G. Schenker, “Religious Views Regarding Treatment of Infertility by Assisted Reproductive
86 Abdulaziz Sachedina, “National Bioethics Advisory Commission”, Ethical Issues in Human Stem
87 Supra note 86.
can arise when the surrogate mother delivers a female offspring, since according to Buddhism; there is an obligation to provide a male offspring.88

5.6.4. Christianity

The Christian attitude related to assisted reproduction and infertility therapy differs inside its divisions. It divides in three churches and their thinking is different on issues relating to assisted reproduction.

5.6.4.1 The Roman Catholic Church 89

The main laws for good Catholic conduct are given in the wholly book, the Bible. Also tradition, which comes from church’ decisional boards, priests and dogmatic teachings establish certain limitations to the freedom of the believer. The catholic dogma contains three leading principles related to the status of the family, the child and reproduction. First principle commands the protection of the human being from the moment of its conception, thus strictly permitting abortion. The second principle is related to the duty of procreation, as, just as in Judaism in the Old Testament God commands Adam and Eve to have children. Morally a child is the fruit of marriage, premarital sex is not allowed, and the Catholic Church condemns having a child outside the institution of marriage. The new-born has to embody the love between a husband and his wife and is considered the symbol of their eternal union. A third principle, which is related to integrity and dignity norms, must be taken into consideration when it comes to assisted reproduction ethics.

The Vatican has a clear position against assisted reproduction, ever since 1956, Pope Pius XII, defined artificial fecundation as immoral and illegal, because it affects human lives by separating procreation and sexual normal function. The criteria of this negative evaluation are found in respect, in the desire of defending and promoting human being’s fundamental rights to life and dignity and that person’s moral responsibility to God. Therefore modern medical techniques used in assisted reproduction like: ET, surrogate mothers, and embryo cryopreservation are not accepted by the Catholic Church.90 Moreover Catholic Church offers its respect and protection to the human being starting with its first seconds of existence; it considers the zygote, pre-embryo, embryo and fetus as persons and strongly disapproves

88 Supra note 84.
research on embryos, cryopreservation and abortion. Pope Benedict XVI has publicly re-emphasized the Catholic Church's opposition to in vitro fertilization (IVF), saying it replaces love between a husband and wife. In addition, IVF is disregarded because it might cause disposal of embryos; in Catholicism, an embryo is viewed as an individual that must be treated as a person.

5.6.4.2 The Eastern Orthodox Church

It was created in 1054 C after the Great Schism which divided Christianity in two: the Roman Catholic Church and the Eastern Orthodox Church. Eastern Orthodox Church is not as strict as the Roman Catholic Church, allowing the medical or surgical treatment of infertility but it is against and other assisted reproduction techniques, surrogate mother, donor sperm insemination-considered adultery, and embryo donation.

5.6.4.3 Protestant and Anglican Church

Basing its life-guiding principles on the old Christian Church and the creeds and teachings of the Apostles, the Anglican Church, allows assisted reproductive techniques, IVF and ET and allows the doctors to use sperm obtained after masturbation, however it forbids gametes donation. Anglican Church is not offering a moral status to the embryo, according to this Church moral can only be given to an individual with a well established personality. The Protestant Church accepts traditional treatment of infertility. Assisted reproductive technologies are acceptable only if the gametes are from the married couple and the procedure avoids damage to the pre-embryo.

The Roman Catholic Church condemns AID for married, as well as unmarried, women. The Vatican's instructions demand a strict connection between procreation and intercourse. Artificial insemination involves separation between "the goods and meaning of marriage". Concerning AID the instructions suggest that the AID process damages personal family relations as well as the offspring. The practice of artificial insemination is also rejected on the grounds that it is based on masturbation and that the AID process is an adulterous act.

94 Supra note 84 at p 4.
The Greek Orthodox Church opposes the practice of AID on the basis that it is an adulterous act. For the Protestant Church AID is mortally illicit and, at best, morally questionable. The Anglican Church allows semen collection by masturbation for artificial insemination by husband and for IVF.95

According to Christianity, in reality the origin of a human is the "result of an act of giving." The Vatican's instructions do not accept the donation of gametes to an infertile couple as an act of generosity. They state that conception by gamete donation (oocyte) can damage personal family relations, as well as the offspring and society. Oocyte donation is forbidden by three main branches of Christianity: Roman Catholic, Eastern Orthodox, and Protestant.96

The practice of surrogate motherhood is not accepted by the Christian religion, i.e., Roman Catholic, Protestant, or Anglican. The objection is on the basis that surrogate motherhood is contrary to the unity of marriage and to the dignity of the procreation of the human.97

The freezing of embryos, even when carried out in order to preserve the life of the embryos, constitutes an offense against the respect due to humans, by exposing the embryos to great risks of death or harm to their physical integrity and depriving them, at least temporarily, of maternal shelter and gestation.98

5.6.5. Judaism

The Judaic view can be summarized by the first commandment that God gave to Adam and Eve: “Be fruitful and multiply”. The Hebrew law is characterized by a strict association between the religious dogmas and the practice laws.

The origin of the written law can be traced back in the Torah, the Jewish sacred book, which contains the first 5 books of the Scripture, an expression of God’s revelation both a humanitarian guide and a book of wisdom. Dominant life guidelines of the oral law are studied in the Jewish schools. The Mishnah includes the traditional interpretations of the Torah and the post-biblical life rules. Talmud is a monumental document which contains rules originated from Mishnah. Moreover Responsa has

95 Ibid.
96 Supra note 92.
97 Supra note 86.
98 Ibid
approximately 1000 volumes and contains laws which can be interpreted as assisted reproduction.  

Another argument can be found in a 2nd century Talmud statement which says that any man without children is a dead man. Mishnah speaks about the number of children required in order to fulfill the divine commandment of procreation. The marriage, called mitzvah is understood by the Jewish church as the legal and religious acts performed by a man and a woman out of religious duty, a useful union which prevents the sexual sins, and moreover must generate heirs. Hebrew laws recognize sex as an important part of the human life, for the Jews sex is healthy and their laws acknowledge the importance of sexual desire. Mitzvah Onah states that a man has 3 important duties to his life partner: he must provide food, clothing and fulfill his conjugal duties.

The Judaism allows doctors to treat infertility and the infertile married couple must be go through all the stages of the diagnosis and treatment as a single unit. Moreover the woman has to be investigated prior to the man, only if she is clinically appropriate to procreate than man will also be examined.

AID is indicated in cases of incurable male infertility or when the husband is a carrier of serious inherited disease or abnormality. It is used extensively throughout the world. All Jewish legal experts agree that AID, using the semen of a Jewish donor, is forbidden. It is the severity of the prohibition that is debatable. AID is commonly accepted, but only if the embryo is fertilized by the husband’s sperm. Donor sperm is accepted only as a legal option. According to Jewish law, is prohibited for a variety of reasons: incest, lack of genealogy, and the problem of inheritance. Semen donors for AID, as well as physicians, who use the semen, are violating the severe prohibition against masturbation. Insemination with the husband’s sperm is permissible if the wife cannot become pregnant in any other way.

There are various views regarding the legal relationship that exists between the semen donor and the child born as a result of AID. Some rule that no relationship exists with others that the child should be regarded as the donor's child, with all the legal complications of incest, inheritance, levirate marriage, etc. The majority opinion

---

100 Ibid
101 Supra note 86.
is that the donor has not fulfilled the obligation of procreation by fathering an AID child. The practice of AID is accepted by part of the Jewish population in Israel, and according to the regulations of the Ministry of Health it is allowed in special circumstances.\textsuperscript{104}

In the case of egg donation or embryo donation, the problem that arises is who should be considering the mother, the donor of the oocyte or the one in whose uterus the embryo develops the one who gives birth. In the case that one of the women is Jewish and the other is not, the problem of the status of the child whether or not he is a Jew will arise. Jewish law states that the child is related to the woman who finished its formation the one who gave birth.\textsuperscript{105}

The freezing of the pre-embryo raises the basic question of whether cryopreservation, which stops the development and growth of the embryo, cancels all rights of the pre-embryo father. With regard to the mother, the problem is simplified, since the embryo is transferred into her uterus later and will renew the mother-embryo relationship. With regard to the relationship to the father, whose main function is to fertilize the oocyte in order to form the pre-embryo, the period of freezing may cause a severing of the relationship between the child and his father. Freezing of sperm and pre-embryo is permitted only when all measures are taken to ensure that the father's identity will not be lost.\textsuperscript{106}

The Jewish religion does not forbid the practice of surrogate motherhood. According to Jewish law, if partial surrogacy is practiced and a strange woman is inseminated with the sperm of a man and she completes the pregnancy on agreement the child born should be handed over to the owner of the sperm. In the case of full surrogacy, when the embryo is transplanted into another woman, the question is not resolved, as discussed in the case of ovum donation. From the religious point of view, the child will belong to the father who gave the sperm and to the mother who gave birth.\textsuperscript{107}

Nowadays, assisted reproductive technology is a common practice in the treatment of infertility. The clinical achievements of this technology are due to the

\textsuperscript{104} Available at \url{http://in-vitro-fertilization.eu/different-religious-concepts-in-vitro-fertilization-assisted-reproduction/} visited on 12 April 2011.
\textsuperscript{105} Supra note 86.
scientific progress in the field of human reproduction. Different religious arguments of the different religions impose limitations on the therapeutic approach to infertility.\textsuperscript{108} The prolonged conflict between religion and science is based on the difference in religious belief and scientific theory.\textsuperscript{109} Religious authorities, in order to maintain their Strength, power, and efficiency, should undergo continual development, and change in the same way that science does. While religious principles may be unchangeable, they may, nevertheless, undergo significant changes in their implementation.

5.7 Conclusion

To conclude, we see that on the one hand, the use of ART has revolutionized the life of humans, on the other hand, it fulfilled the hope of the despaired infertile people, made it possible for them to have their genetically linked child, but on the other hand the use of ART raised the number of social, ethical, moral economic, religious, and health related issues which put a big question mark on the use of ART. The response of the judiciary is significant towards the various issues arising with the use of ART. So, in the forthcoming chapter the judicial pronouncements will be discussed in detail.

***************

\textsuperscript{108} Supra note 84.
\textsuperscript{109} Supra note 86.