

## WMA STATEMENT ON ASSISTED REPRODUCTIVE TECHNOLOGIES

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### PREAMBLE

1. Assisted reproductive technology encompasses a wide range of techniques designed primarily to aid couples unable to conceive without medical assistance. Since the birth of the first so-called 'test-tube baby' in 1978, more than 1.5 million children worldwide have been born following IVF treatment.
2. The term 'assisted reproductive technology' includes techniques such as in-vitro fertilisation (IVF) and intra-cytoplasmic sperm injection (ICSI). It can be defined as including all treatments that include medical and scientific manipulation of human gametes and embryos in order to produce a term pregnancy. Although some legislatures have considered artificial insemination, whether using donor semen or semen from the patient's partner, as different, many of the issues about regulation in relation to obtaining, storing, using and disposing of gametes and embryos are closely inter-linked. In this statement treatments such as artificial insemination are excluded.
3. Assisted reproductive technologies raise profound moral issues. Views and beliefs about the moral status of the embryo, which are central to much of the debate in this area, vary both within and among countries. Assisted conception is also regulated differently in various countries. Whilst consensus can be reached on some issues, there remain fundamental differences of opinion that cannot be resolved. This statement identifies areas of agreement and also highlights those matters on which agreement cannot be reached. Physicians faced with such situations should comply with applicable laws and regulations as well as the ethical requirements and professional standards established by their National Medical Association and other appropriate organizations in the community.
4. Physicians involved in providing assisted reproductive technologies should always consider their ethical responsibilities towards any child who may be born as a result of the treatment. If there is evidence that a future child would be exposed to serious harm, treatment should not be provided.
5. As with all other medical procedures, physicians also have an ethical obligation to limit their practice to areas in which they have relevant expertise and experience and to respect the rights of patients. These rights include that of personal bodily integrity and freedom from coercion. In practice this means that valid or real consent is required as with other medical procedures; the validity of such consent is dependent upon the adequacy of the information offered to the patient and their freedom to make a decision, including freedom from coercion or other pressures to decide in a particular way.

6. Assisted conception differs from the treatment of illness in that the inability to become a parent without medical intervention is not always regarded as an illness. While it may have profound psychosocial, and thus medical, consequences, it is not in itself life limiting. It is, however, a significant cause of major psychological illness and its treatment is clearly medical.
7. Obtaining informed consent from those considering undertaking treatment must include consideration of the alternatives, including accepting childlessness or pursuing adoption, the risks associated with the various techniques, and the possibility of failure. In many jurisdictions the process of obtaining consent must follow a process of information giving and the offer of counselling and might also include a formal assessment of the patient in terms of the welfare of the potential child.
8. Patients seeking assisted reproductive technologies are entitled to the same level of confidentiality and privacy as for any other medical treatment.
9. Assisted reproductive technology always involves handling and manipulation of human gametes and embryos. Different individuals regard this with different levels of concern but there is general agreement that these special concerns should be met by specific safeguards to protect from abuse. In some jurisdictions all centres handling such materials require a licence and must demonstrate compliance with high normative standards.

#### **SUCCESS OF THE TECHNIQUES**

1. The success of different techniques may differ widely from centre to centre. Physicians have an obligation to give realistic information about success rates to potential patients. If their success rates are widely different from the current norm they should disclose this fact to patients. They also have an obligation to consider the reasons for this as they might relate to poor practice, and if so, to correct their deficiencies.

#### **MULTIPLE PREGNANCIES**

1. Replacement of more than one embryo may raise the likelihood of at least one embryo implanting. This is offset by the increased risk, especially of premature labour, in multiple pregnancies. The risk of twin pregnancies, while higher than that of singleton pregnancies, is considered acceptable by most people. Practitioners should follow professional guidance on the maximum number of embryos to be transferred per treatment cycle. If multiple pregnancies occur, selective termination might be considered on medical grounds to increase the chances of the pregnancy proceeding to term where this is compatible with the national law and code of ethics.

#### **DONATION**

1. Some patients are unable to produce usable gametes. They require ova or sperm from donors. Donation should follow counselling and be carefully controlled to avoid abuses, including coercion of potential donors. It is inappropriate to offer money or benefits in kind (for example free or lower cost treatment cycles) to encourage donation but donors may be reimbursed for reasonable expenses.

2. Where a child is born following donation, families should be encouraged to be open with him/her about this, irrespective of whether domestic law entitles the child to information about the donor. Keeping secrets within families is difficult and can be harmful to children if information about donor conception is disclosed inadvertently and without appropriate support.

### **PRE-IMPLANTATION GENETIC DIAGNOSIS (PGD)**

1. Pre-implantation genetic diagnosis (PGD) may be performed on early embryos to search for the presence of genetic or chromosomal abnormalities, especially those associated with severe illness and very premature death and for other reasons, including identifying those embryos most likely to implant successfully in women who have had multiple spontaneous abortions. Embryos carrying the abnormality are discarded; only embryos with apparently normal genetic and chromosomal complements are implanted.
2. Neither this powerful technique nor simpler means should be used for trivial reasons such as sex selection for reasons of gender preference. The WMA holds that physicians should only be involved with sex selection where it is used to avoid a serious sex-chromosome related condition such as Duchenne's Muscular Dystrophy.
3. PGD can also be combined with HLA matching to select embryos on the basis that stem cells from the resulting child's umbilical cord blood could be used to treat a seriously ill sibling. Views on the acceptability of this practice vary and physicians should follow national laws and local ethical and professional standards if confronted with such requests.

### **USE OF SPARE GAMETES AND EMBRYOS AND DISPOSAL OF UNUSED GAMETES AND EMBRYOS**

1. In most cases, assisted conception results in the production of gametes and embryos that will not be used to treat those from whom they are procured. Such so-called spare gametes and embryos may be stored, cryo-preserved for future use, donated to other patients or disposed of. One alternative to disposal, in countries that permit embryo research, is donation to a research facility. The available options must be explained clearly and precisely to individuals before donations are made or retrievals performed.

### **SURROGACY**

1. Where a woman is unable, for medical reasons, to carry a child to term, surrogacy may be used to overcome childlessness, unless prohibited by national law or the ethical rules of the National Medical Association or other relevant organization. Where surrogacy is practised, great care must be taken to protect the interests of all parties involved.

## RESEARCH

1. Physicians should promote the importance of research using tissues obtained during assisted conception procedures. Because of the special status of the material being used, research on human gametes and especially on human embryos is, in many jurisdictions, specifically regulated. Physicians have an ethical duty to comply with such regulation and to help inform public debate and understanding of the issues.
2. Due to the special nature of human embryos, research should be carefully controlled and should be limited to areas in which the use of alternative materials will not provide an adequate alternative.
3. Views, and legislation, differ on whether embryos may be created specifically for, or in the course of, research. Physicians should act in accordance with national legislation and local ethical advice.

## CELL NUCLEAR REPLACEMENT

1. The WMA opposes the use of cell nuclear replacement with the aim of cloning human beings.
2. Cell nuclear replacement may also be used to develop embryonic stem cells for research and ultimately, it is hoped, for therapy for many serious diseases. Views on the acceptability of such research differ and physicians wishing to participate in such research should ensure that they are acting in accordance with national laws and local ethical guidance.

## RECOMMENDATIONS

1. Assisted reproductive technology is a dynamic, rapidly developing field of medical practice. Developments should be subject to careful ethical consideration alongside the scientific monitoring.
2. Human gametes and embryos are accorded a special status. Their use, including for research, donation to others and disposal, should be carefully explained to potential donors and subject to local regulation.
3. Embryo research should only be carried out if local law and ethical standards permit it and should be limited to areas where the use of alternative materials or computer modelling does not provide an adequate alternative.
4. Physicians should follow professional guidance on the maximum number of embryos to transfer in any treatment cycle.
5. It is inappropriate to offer money or benefits in kind (for example free or lower cost treatment cycles) to encourage donation but donors may be reimbursed for reasonable expenses.

6. Families using donated embryos or gametes should be encouraged and supported to be open with the child about this.
7. Sex selection should only be carried out to avoid serious, including life threatening, medical conditions.
8. Physicians have an important role in ensuring that public debate about the possibilities of assisted conception, and the limits to be applied to its practice, is informed.
9. Physicians should comply with national legislation and should demonstrate compliance with high normative standards.

RESCINDED