EDITORIAL

Ethics in assisted human reproduction

In recent years, reproductive issues constitute a major part of bioethical studies and discussions in most study centres of the world. No other ethical subject matter may elicit more heated controversy at all levels of society. This is not surprising as reproduction constitutes the most private and intimate aspect of the life of individuals and consequently the most sensitive and fundamental concern of our society. In the past, abortion and sterilisation were the foremost reproductive ethical issues which generated controversy and debate throughout the world. At present, topics of Assisted Reproduction and Prenatal Diagnosis have emerged as important reproductive ethical issues in the developed world.

The philosophy of Assisted Reproduction or Assisted Procreation is often erroneously referred to as "Artificial" Reproduction. From a scientific view-point, there is nothing "Artificial" about this technology. Assisted Reproduction technology relies completely on the principles of normal anatomy, physiology, biochemistry, pharmacology, endocrinology and genetics of human reproduction.

Since the birth of the world's first "test-tube" baby, Louise Browne, in Manchester, United Kingdom in March 1978, there have been considerable developments in new technologies relating to the theme of Assisted Reproduction. We have In-Vitro Fertilisation (IVF), Gamete Intra-Fallopian Transfer (GIFT), Pronuclear Sperm Transfer (PROST), Zygote Intra-Fallopian Transfer (ZIFT) and Direct Intra-Peritonial Insemination (DIPI), all denoted by appropriate acronyms. The rapid development of these Assisted Reproduction procedures within the short span of a decade, has been made possible by numerous technological advances relating to sperm collection and preservation, ova maturation, collection and preservation, in-vitro fertilisation procedures, embryo storage, embryo transfer, embryo donation, surrogate motherhood, and more important, to the reproductive endocrinological advances related to all these procedures.

It must also be appreciated that for successful implementation of the research and clinical service aspects of the various facets of the new Assisted Reproduction technologies, there must be high quality ethical surveillance to safeguard the legal, religious and social norms prevailing within our society. Pioneer programmes especially those in developed countries already face the issues and problems created by rapid technological advancements outpacing existing medical laws. Doctors and scientists are now urgently seeking professional guidelines or new laws to ensure that rapid advances in research on human embryos do not progress into areas that may be considered repugnant by the community.

Legal answers have yet to be formulated for many pertinent ethical questions. The controversial question of what should become of the "remaining" fertilised eggs (embryos) was debated in Vienna, Austria by the First Internatinal Congress of In-Vitro Fertilization in 1983.[1] In view of the need for legal guidelines to regulate the development of in-vitro fertilisation programmes, the United States Congress held several hearings on the various implications of "artificial" human reproduction. In Australia, France and the Netherlands, special committees

have been set up to study all aspects of in-vitro fertilisation. In the United Kingdom, the British Government acknowledged the report of the 16-member Warnock Commission of doctors, scientists, lawyers and lay persons which studied and made specific recommendations on this issue.[2]

To-date, there are no specific laws or regulations governing artificial insemination and in-vitro fertilisation in Malaysia, except for the Medical Act of 1971 on the rules and regulations of medical practice. However, the Indecent Advertisements Act 1953 (revised 1981) could have legal bearings on the publicity and activities of these procedures. Even though a Human Tissues Act of 1974 exists in Malaysia, there is no provision under this Act to effectively control the handling of embryos or human tissues under the in-vitro fertilisation programme.[3]

The issues of in-vitro fertilisation and embryo transfer (ET) involve more a question of medical and religious ethics. And these matters are usually dealt with by national medical and religious councils. In Malaysia, the various medical and religious councils and the Ministry of Health have to date, not laid out any standard code of ethics, guidelines or legislation relating to such matters. Considering the benefits that Assisted Human Reproduction can confer on a significant proportion of subfertile couples, estimated at between 10 to 15 per cent of married couples in Malaysia,[4] the National Population and Family Development Board (NPFDB) of the Prime Minister's Department has taken the lead to undertake research into this new area of family development. And to formulate guidelines on such procedures and propose subsequently, to monitor the development and expansion of such centres and services in Malaysia.

Various religious councils have given their full support in the preparation of Guidelines for the Assisted Human Reproduction Programme. Such modern technologies are welcomed in enabling married couples to fulfill their procreative responsibilities. The support is specifically given for procedures that involve legally married couples in stable union. That is, the biological and social parents of the child would also be the natural parents and that the child would be given all loving care.

The Board also proposes that there be no ethical objections to Assisted Human Reproduction as for the treatment of subfertility, which can enable some subfertile women to conceive and have their children within marriage. A publically assisted programme would carry this philosophy further by bringing down the cost of treatment and ensuring deserving but otherwise non-privileged couples to have access to such medical innovations (optional). An IVF procedure costs between $4,000 to $6,000 in a private centre in Malaysia whereas a public sector sponsored programme – for example that at the NPFDB – costs only half as much. Capital outlay for clinical and laboratory personnel, operation theatre and reproductive endocrinology set-ups are already available at Government institutions.

Medical practitioners, scientists and other allied personnel are urged to cooperate and help formulate the national guide in order to promote family health and welfare in our country.

References

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