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Infertility, feminism and the new technologies

by Sally Keeble

Infertility, feminism and the new technologies

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Sally Keeble is writing a patient's guide to assisted conception to be published in 1995.

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New technologies

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If sex without procreation was the moral issue of the '60s, procreation without sex is fast becoming the poser of the 1990s.

Yet where the development of the pill and legalisation of abortion were welcomed by the women's movement as providing reproductive freedom and choice in social and sexual roles, the new reproductive technologies have yet to find an ideological champion. Most noticeable in the current debate has been the lack of any political response, leaving a policy vacuum in an area of major public concern which poses ethical, social and medical dilemmas that will not go away. It has also resulted in a controversial area of medicine being determined by market forces in a manner unprecedented in this country since the establishment of the NHS.

Three voices have been particularly strident in the debate. First has been that of popular morality, as evidenced in particular through the intense publicity surrounding the debates about the development of treatment of older women and use of foetal ovarian tissue at the start of 1994. The same backlash against the liberalism of the '60s that has seen the attack on single parents and the assertion of traditional values has also seen a tirade of criticism of the new reproductive technologies for overturning the so-called 'natural order'.

Most vociferous was the 'quality' press. Hardly had the nation recovered from Christmas' celebration of the first recorded virgin birth than on January 2nd in *The Sunday Times*' Focus section, there was an in-depth analysis of new reproductive technologies: "Designer babies are just a first step in science's ability to create...THE MASTER RACE". A week later, William Oddie in *The Sunday Times* called the techniques "grotesquely unnatural...an older woman could become mother to her own great-granddaughter, the macabre possibilities are endless". A *Daily Telegraph* editorial on January 8th talked of "bizarre, not to say ghoulish, proposals". The tabloids, unable to resist pictures of babies and human interest tales of celebrity families, were often more sympathetic. Sensationalist headlines such as "Exposed: Trade in Human Eggs" (*Daily Express*, February 18th) were balanced with soft focus pictures of nature-defying mothers and their babies: "I dreamt of this joy for 25 years" (*Daily Mirror*, February 10th).

Secondly was the voice of the medical establishment, typified by neutrality to many of the ethical issues involved. Rational, lucid explanations from the scientific community of the developments have been at a premium. Frequently

they have highlighted the gulf that exists between the possibilities of science and the general level of scientific knowledge in society. Assurances that use of foetal ovarian tissue to treat infertility patients was years away rested uneasily with a society that was dimly aware of the technology that lay behind bonny test tube baby pictures. Scientific imagination had so far outstripped general social awareness that the two sides could barely communicate about existing reality, let alone future potential.

The third voice has been that of the women's movement, part of a surprising coalition between a conservative popular morality and those who have more normally been associated with progressive thinking and whose influence in public policy has been substantial. A decade after the classic "Test Tube Women" put the case against the new reproductive technologies, Melanie Phillips argued in *The Guardian* against "artificially-induced motherhood", reducing medicine to "cannibalising dead foetuses to create living babies".

A political voice has been notably lacking. Two interventions stand out, both from women MPs. Dawn Primarolo, MP for Bristol and a member of Labour's frontbench health team, introduced a Ten Minute Rule Bill in 1993 seeking improvements in the provision of treatment. In February 1994, Dame Jill Knight, Conservative MP for Birmingham Edgbaston, tabled an amendment to the Criminal Justice Bill to ban the use of foetal eggs – a pre-emptive strike against the consultation process on the subject initiated by the Human Fertilisation and Embryology Authority. But neither of these amounted to anything approaching a comprehensive policy. Indeed, lobby groups complain that one of the biggest obstacles to winning more public resources for both research and treatment is the lack of a policy or support from any of the main political parties.

This, despite the fact that the new reproductive technologies touch on some key political issues: first, the relationship between science and society and second the role of women in society. Some of these questions have been around for a long time – for example the extent to which women are allowed to control either their own fertility or NHS priorities. Others are old questions that were once thought to have been resolved but which have been revived in our post-feminist times – in particular, the dominance of women's role as mothers and renewed interest in the two-parent family.

The new technologies raise fundamental issues about the role of the NHS, the main one being whether it should simply be about crisis intervention or about quality of life. In most areas of public service it has been accepted that any notion of equality must be about levelling up not down, about meeting people's aspirations and not just their basic needs. But when it comes to policy priorities and resource allocation in the NHS, the logic is rarely carried through.

This pamphlet seeks to fill that vacuum, looking at the current position and future scientific possibilities, setting out a basis for provision and dealing with the issues relating both to unease over the ethical position and the implications for women.

What treatment?

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In the media hype at the start of 1994, the various new technologies were lumped together under the derogatory heading "designer babies".

Jointly condemned were medical procedures which have been practised for many years, newer procedures which have become established in the last decade and areas of current research where application in treatment is still some years off. The world's first test tube baby, Louise Brown, was born in 1978. Although it was the British pair Patrick Steptoe and Robert Edwards who achieved the first live birth as a result of in vitro fertilisation, research into the new reproductive technologies was taking place throughout the world, and progress was rapid. A few years later in Australia came the first baby resulting from in vitro fertilisation using a frozen embryo – a major breakthrough, with a whole series of spin-offs, many of which have again produced a series of ethical dilemmas.

During subsequent years any number of treatments have been developed such as Gamete Intra-fallopian Transfer, Zygote Intra-fallopian Transfer – the medical journals are littered with the possibilities. Some are only minor variations on a theme. The two mentioned above involve transfer of either sperm and eggs or embryos into the fallopian tube rather than, as in conventional IVF, into the uterus, on the basis that research has shown that the fallopian tubes provide a better environment for conception.

Drugs

The basic procedure is of a drug regime to suppress the woman's natural monthly cycle, then introducing an artificial cycle that will stimulate her ovaries to produce a large number of egg-bearing follicles. Shortly before the follicles would normally release their eggs they are removed, usually under sedation rather than general anaesthetic. They are mixed with the man's pre-treated sperm – in a petrie dish rather than a test tube – and kept in the laboratory for two days. If the eggs have fertilised and the embryos have completed their early development normally, up to the British legal maximum of three are transferred back to the womb. Drugs are then provided to simulate normal hormonal conditions. During the next two weeks the embryos will either implant and produce a pregnancy – on average 18% of the time – or will be lost at the end of the normal monthly cycle – on average 82% of the time. Practitioners point to success rates of about 40% over three treatment cycles.

Originally hailed as the miracle treatment for women unable to have children due to damaged fallopian tubes, in vitro fertilisation has been developed to diagnose and treat many other causes of infertility or sub fertility and it has been combined with new techniques for the treatment of male infertility, with the sperm being injected directly into the egg to assist fertilisation. Developments in embryology are making it possible for embryos created in vitro to be tested for genetic diseases before they are transferred back into the woman, thereby preventing the birth of children with certain disabilities. Most recently, research into the early stages of pregnancy is making possible the routine treatment of older women by using intensive drug-therapy to re-stimulate their ovaries. Finally there is the research into foetal ovarian tissue which has been the subject of the most recent controversy and which holds the potential for treating women whose ovaries no longer function. There are two main strands to this work: one is into the possibility of transplanting ovarian tissue itself into another woman in line with other organ transplants, the other is into taking the very immature eggs from ovarian tissue, ripening them in laboratory conditions and then using them for infertility treatment.

Although the embryos are created in laboratory conditions, there is no scientific intervention in their development and no indications of damage to IVF children resulting from the method of their conception. It is the more recent developments which have raised the dilemmas behind the moral panic. That little distinction was made during the public controversy between the two was perhaps the best indication of how far public knowledge was lagging behind the march of science. This posed real difficulties for the scientific community when, through the recent consultation document on foetal ovarian tissue, it set out to explain its work to the public and seek their support.

Rules

First with the medical technology, Britain was also first with the regulatory system for it. The Warnock Report, presented to Parliament in July 1984, was a classic of its time, providing a basic framework which has withstood the rigours of the last decade. It could well be argued that if Warnock had been followed in the area of provision as well as regulation, some of the problems that have arisen over the years could well have been avoided.

Among its main recommendations were the regulation of fertility treatments involving the creation of human embryos in laboratory conditions, or the storage or donation of eggs or sperm and the regulation of research into human embryos. It set a cut off point after 14 days for research into laboratory created human embryos, based on this being the date of the appearance of the primitive streak, identified as the appropriate reference point in the development of the human individual. Whilst recognising the need to set some barriers beyond which science could not go, the Warnock report recognised the difficulty in setting absolute standards in a pluralistic society.

Following on from the Warnock report was the Human Fertilisation and Embryology Act 1990, establishing the Human Fertilisation and Embryology Authority to regulate research and treatment involving the laboratory creation of human embryos, and setting out the legal rights of adults involved in the process and children born as a result of it. The HFEA does not have jurisdiction over research or infertility treatments that do not involve the creation of embryos in vitro, so the use of drugs for superovulation, although the target for public anger because of the resulting multiple births, is not regulated. Some of the new procedures also escape supervision, and the controversial research into foetal ovarian tissue could proceed without the authority's consent.

A second benchmark work was the Polkinghorne Report of July 1989. This did not deal with infertility treatment per se but with the use of foetal material in all areas of medical research and treatment. Its recommendations include the separation of decisions about abortion and subsequent use of foetal tissue, separation of personnel to be involved in each process, requirement of informed consent from the mother and monitoring of all research into foetal tissue by a local ethics committee. A central tenet of the report was the acceptance of "a special status for the living human foetus at every stage of its development which we wish to characterise as a profound respect, based upon its potential for development into a fully-formed human being. That respect carries over in a modified form to the dead foetus." The report said its recommendations should form guidelines rather than legislation.

Framework

These two reports provide an ethical framework on which to build, especially in resolving the status of the human embryo and the justification of its use in research. Further work is needed, however, in developing the arguments to deal with the social and scientific changes of the last decade. First, although Warnock set out a number of possible areas of future development, the report did not anticipate either the speed or complexity of the advances. Hence the difficulties now being encountered in decisions about, for example, the research into foetal ovarian tissue. Secondly, changing family structures require a re-examination of the argument that the welfare of the child necessitates a two parent family. Warnock gives only the briefest examination of women-centred arguments and scant reasons for rejecting them. Thirdly, developments in thinking about the welfare state put stress on the contribution of public services to quality of life rather than simply crisis management. This gives the opportunity for a reappraisal of the provision of the new technologies within the NHS, bringing them in from the cold and placing them in the mainstream.

In seeking to develop a policy for the new reproductive technologies, this pamphlet will look in greater detail at the public debate and controversy in these three areas – ethics, feminism and the NHS – before drawing together the arguments.

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The 'yuk factor'

So far, it is the ethical debate which has most captured the public imagination, with the media casting themselves in the role of champions of a popular morality.

But what is the theoretical basis? The utilitarian approach was rejected as holding the inherent threat of a slide over time into acceptance of medical technologies that were inherently unacceptable. Thus, there was also a rejection of the ability of either the Human Fertilisation and Embryology Authority or the medical profession to deal with the moral issues involved. The former was seen as likely to operate as little more than a rubber stamp to the partisan decisions of the latter. For once, what was wanted was an absolute moral position.

Thus was spawned the 'yuk factor', a sort of collective heaving of the gut over the new techniques and their implications, typified by William Oddie in *The Sunday Times*. "If a thing is wrong, it is wrong," he writes, "and all the compassion in the world will not make it right" – it is "grotesquely unnatural", it is "playing God" and it is unpredictable in its effects both on the women whose nature is being over-ridden and on the children produced by this "macabre medicine."

It is easy to caricature an argument that reduces ethics to gut instinct. To do so would be to underestimate the dilemmas. There is evidence from surveys that the media's 'yuk' threshold is considerably lower than that of the public who have generally been prepared to accept medical assistance in establishing new families. But the 'yuk' factor implies that there is a need to draw a line. The debate is where this line should be.

Equally, it is not acceptable simply to walk away from the ethical problems to argue, as some have tried to do, that these are private matters best decided by the individual doctor and patient – or, more often, just by the doctor – on a personal basis. Most of the ethical issues involved in the new reproductive technologies are not issues of medical ethics as such. Many more, including those which have caused the greatest public controversy, relate to the social consequences of the the new technologies and in particular the impact they have on women's role in society and on family and social relationships. This chapter will look in particular at the ethical issues involved in three areas: the use of foetal ovarian tissue, older motherhood and pre-implantation screening.

Consenting guinea pigs

There are two general points to be made concerning the use of relatively untried techniques on patients and the issue of consent.

It has been argued that the drugs and procedures used in IVF and similar techniques, in particular micro-manipulation of embryos, might cause long term damage to children born from them. On the scientific evidence the jury is still out. On the positive side, the drugs used to induce the superovulation involved in IVF and similar techniques are also widely used in other forms of fertility treatment and are not subject to any of the controls exercised by the HFEA. They are naturally occurring drugs used over short periods of time and documented evidence of damaging side effects is limited. In addition, current developments are improving the safety record. General anaesthetic with its attendant risks has been replaced with sedation for the egg collection procedure. Even the research into ovarian tissue transplants would offer distinct safety improvements over egg donation, with the risks of hyperstimulation and egg collection to which egg donors are exposed.

On the negative side, the long term effects on either women or gametes and embryos is not yet known. The record of side effects showing up much later in life, or even in subsequent generations, has continued to bedevil the drugs industry and women's fears remain. Despite the Warnock Committee's recommendations on continuing research into children born as a result of the new reproductive technologies, such work has been spasmodic and the children in any event are not yet old enough for the results to be conclusive.

Secondly, there are reservations about the conditions under which people give consent in the case of experimental treatment. Under the HFE Act information should be given to patients about each stage of the procedure and signed consent forms obtained for both treatment of the patient and also handling of gametes and embryos.

Linking these two issues is the responsibility of the medical profession in developing the new reproductive technologies. Much research evidence exists showing the vulnerability to medical experimentation of people entering these new treatments. In one study it was found that couples who had undergone unsuccessful IVF cycles and finally abandoned treatment would be prepared to try out new treatments if they had a success rate of 20%. It is hard to imagine other categories of patients undergoing – on a fully informed basis – elective treatment with such a low success rate. As long ago as 1987, a group of American doctors questioned, in an article in the prestigious American journal *Fertility and Sterility*, "Are we exploiting the infertile couple?". They pointed to three areas of exploitation: inappropriate use of medical credentials, misuse of the new reproductive technologies and the need for truth in advertising.

Still more taxing are the social implications of the newer developments, in particular their implications for family structures and the role of women. One

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of the surprising things about the current debate is the extent to which it has not been influenced by the massive changes that have taken place in family structures since the '60s. The most recent figures show that 30% of children are born to single women. Yet the debate about the new reproductive technologies – whether as a result of the Government's attack on single parents, echoed by the Left, whether in a fit of nostalgia or in a search for the absolutism posited by William Oddie – has been based on a model of the traditional family.

Telling the kids

One of the key moral objections raised is, 'what do we tell the children?'. It is assumed it is more distressing to tell a child that its mother needed treatment with ovarian tissue which came from a dead foetus, than to tell it that its genetic father did not know of its existence and that if he had he would not in any event have wanted anything to do with it. Family is a social construct and, as research being conducted under Professor Susan Golombok at City University shows, it is the quality of parenting that makes the difference to the well-being of the child, rather than the exact nature of the relationship – genetic, birth or social – between parent and child.

The fact that the genetic link is not always the determinant of parentage is also recognised in the law which in Britain has determined that the legal mother of the child is the woman who gives birth to it. This applies not just in the hypothetical case of foetal ovarian tissue but also to children born from egg donation and host surrogacy. In the former, the woman who provides the egg retains no rights in relation to any child born from it; in the latter, the surrogate mother is the legal mother and the woman who provided the egg has formally to adopt the baby.

Whose consent?

A second issue is who should give consent to the use of foetal ovarian tissue. Already the Polkinghorne report has recommended that consent should be provided by the mother, although in the interests of good practice the father should be consulted. The report raises some questions about the special status of certain types of foetal tissue in relation to the use of brain tissue and the possibility of there being any "personality transfer" between donor and recipient. It finds the arguments unconvincing but urges further caution.

Dr Charles Erin, of the Centre for Social Ethics and Policy at the University of Manchester, has raised two points which would militate against further restrictions. First, the special interest that people have in their genetic material is because it has been handed down through generations – but this inheritance does not of itself carry significance. Secondly, people cannot determine what their children will do with their genetic material, as they cannot control who their children will chose as sexual partners.

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A woman-centred approach to the issue of consent would in fact seek to weaken the recommendations in the Polkinghorne report. First, it would exclude the recommendation of consulting the father, on the basis that, as with abortion legislation, the disposal of the foetus is the prerogative of the mother, not the father. Secondly, it would give women the ability to give some direction in how the foetal ovarian tissue should be used, an ability which is excluded under the Polkinghorne guidelines.

Post-menopause

The second medical development to raise ethical dilemmas is that of treating post-menopausal women. The cries of alarm that greet the 'over-riding of nature' have not been levelled at the treatment of younger women who have been through an early menopause or who have, for some reason, suffered premature ovarian failure. Like the use of foetal ovarian tissue, the potential for treating older women is enormous. Robert Edwards is undertaking research which holds the potential for restimulating ovarian function in post-menopausal women and sees this as a major development area for the future.

What remains to be seen is whether society generally feels that there is an upper age limit for motherhood and where this should be. The previous limit, as set by the menopause, coincided with most women's life expectancy. This seems now to be taken as a 'natural' limit, for reasons that are not completely clear. Objections raised to older mothers include the possibility of the mother being mistaken for the child's grandmother, of the mother dying before the child reaches adulthood or of an older woman's difficulty in coping with the physical stresses of caring for a young child. However, women can now expect to live longer and to remain fit and active, untrammelled by the rigours of repeated pregnancy and childbirth. So there is no more reason why a woman should not become mother at 60 than there is why a man should not become a father at the same age.

Pre-implantation diagnosis

The third area where new medical developments have raised intense ethical debate is that of pre-implantation diagnosis and related research. In this embryos created in vitro can be tested for particular conditions so that only unaffected embryos are transferred back into the woman: affected embryos can be discarded at laboratory stage. The tests are done by taking a single cell from the embryo at an early stage before the cells have differentiated: at this stage each one has the potential to develop into a complete human being and contain all the individual's genetic information. The technology already exists to identify a small range of conditions but has so far rarely been used. Ideally this can be a means of helping parents at risk of having a child with a life-threatening disability, either because of their genetic

make-up or due to the age of the mother. The older alternative of ante-natal testing carries both the risk of miscarriage or of a late termination with all the hardship that involves for the mother. In pre-implantation diagnosis the issue of termination never arises because the affected embryos are not transferred back into the woman.

However, it is this treatment above all which has given rise to the 'designer babies' qualms. First, while screening out embryos and hence children with life-threatening conditions might look beneficial, at least from the parents' point of view, the question then arises of what would happen if scientists identified the genes responsible for intelligence, criminality or good looks. Secondly if pre-implantation diagnosis was linked to gene therapy, the genetic make-up of the embryo could be altered to similar effect.

Thirdly, and perhaps most seriously, the whole issue raises questions about our society's attitude towards people with disabilities. This problem is, of course, inherent in the existence and long standing use of ante-natal screening, often used to identify and then terminate fetuses with conditions that are not necessarily life threatening or to reduce a triplet to a twin or single pregnancy, in which case normal fetuses are destroyed. The practice begs two questions, which are not confined to medical ethics but affect areas of social policy and social provision which go far beyond the confines of the health service. One is the segregation of people with disabilities, leading to a lack of awareness or appreciation of them by the rest of society, which perhaps makes it harder for prospective parents to assess their response to a disabled child. The other is the lack of provision for people with disabilities, leaving prospective parents feeling that if they did have a child with a serious disability, they simply could not cope – rightly assuming they would most probably have to cope on their own.

Commerce

The wild card in all of this is the commercialisation of the new reproductive technologies. Not only are people undergoing relatively new medical procedures – they are paying to do so. For providers of the service and the drug companies there are large amounts of money involved. The American women's magazine *Lear's* in December 1993 carried a critical analysis of the finances of what it called "The Stork Market". It has given rise to a consumer approach from patients towards medical treatment. What this implies about equity of access to the new reproductive technologies, about being able to buy fertility and about the role of the clinician, goes against the grain even of existing national, let alone Labour health policy. The solution to the commercial dilemmas is to have a coherent and comprehensive public sector provision, which is the subject of the next chapter.

Infertility and the NHS

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It was perhaps inevitable that a Conservative government would put regulation before provision and restriction before enablement. The Warnock Committee made recommendations on the ethical approach and regulation. What is less generally recognised is that it also made recommendations for the provision of these services:

- "We recommend that each health authority should review its facilities for the investigation and treatment of infertility and consider the establishment, separate from routine gynaecology, of a specialist infertility clinic with close working relationships with specialist units, including genetic counselling services, at regional and supraregional level. Where it is not possible to have a separate clinic, we recommend that infertility patients should be seen separately from other types of gynaecological patient wherever possible..."
- "We recommend the establishment of a working group at national level made up of central health departments, health authorities and those working in infertility, to draw up detailed guidance on the organisation of services...We recommend that one of the first tasks of the working group...should be to consider how best an IVF service can be organised within the NHS..."
- "We...recommend that consideration be given to the inclusion of plans for infertility services as part of health authority strategic plans."
- "We recommend that funding should be made available for the collection of adequate statistics on infertility and infertility services."

The committee recognised that infertility was "a condition meriting treatment". Since then there has been ample research evidence of the acute suffering experienced by both men and women who have difficulty in becoming parents. The intensity of this suffering has been used by some clinicians to rank it as a "lack of ease" or "dis" ease, alongside other major diseases and thereby justify treatment under the NHS. This, however, is a limited ap-

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proach. If applied across the board it could be used to exclude from the NHS other treatments which are elective, which are about quality of life or which are for conditions which are either non-life threatening or which the patient could, with counselling, accept such as blindness, deafness, or some condition requiring plastic surgery.

People should not have to prove they are in acute distress before they earn the right to NHS treatment but rather that they suffer from a medical condition which constitutes a disability for them and which can be overcome with medical assistance. Warnock also talks about an entitlement to advice and investigation of infertility but to have a right to have a medical problem discovered without then having a right to treatment is illogical and cruel.

Who's the purchaser?

If the purchaser is the individual consumer then the development of services will follow that demand. If the biggest purchaser had been, as it should have been, the NHS, developments might have been very different.

In the event, provision has been so badly neglected by the NHS that Britain, which pioneered the medical technology, now has amongst the worst provision of the treatment in the western world. In Australia in 1988 1 in 200 of all births was the result of treatment using these new technologies. In Israel the state pays for such treatment and in France women can reclaim the costs from the state. Even in the USA women can often claim payment under their private medical insurance scheme. Meanwhile in Britain 90% of treatment takes place in the private sector. Medical insurance schemes will generally not pay for treatment of pre-existing conditions so companies are likely to bail out once tests establish that the patient is indeed suffering from infertility.

Even worse, while failing to ensure a national policy for service provision the Department of Health also fails to take any responsibility for monitoring public provision or ensuring any equity or consistency in public policy in this controversial area of medicine. At a time when the Conservative government was setting performance indicators across the board in public services and the new reproductive technology debate was at its height, Tessa Jowell, MP for Dulwich, put down a parliamentary question to find out how much of various forms of treatment were being bought by the NHS purchasing authorities. On February 3rd 1994, she tabled the following question: "To ask the Secretary of State for Health, if she will list the NHS purchasing authorities who purchase infertility services according to their purchasing strategies submitted to her department; how much each authority spends on infertility services; which NHS purchasing authorities provide each of (a) advanced reproductive technologies generally (b) in vitro fertilisation (c) gamete intra-fallopian transfer and (d) infertility counselling within their infertility service purchasing plans; and how much they spend on each service."

Tom Sackville, junior health minister, replied: "Individual health authority

purchasing plans are monitored by regional health authorities. The hon. Member may wish to contact the chairmen of the regional health authorities for details."

No-one knows

However, it seems that most of the Regional Health Authorities did not know either. A survey in England found that only one (Anglia and Oxford NHS Executive) was able to provide detailed information about the activities of purchasing authorities under its remit. The former Mersey Regional Health Authority, now subsumed under the North West NHS Executive could give proportionate spending on different treatments. The former South-Western Regional Health Authority, now subsumed under South and Western NHS Executive, could identify which of their purchasers bought the new reproductive technologies but no further details and the former North East Thames Regional Health Authority provided a copy of its guidance for purchasers.

The rest of the Regions referred the writer on to the District Health Authorities. West Midlands NHS Executive thoughtfully provided a set of sticky address labels with the addresses of the districts' chief executives.

A survey of District Health Authorities undertaken by the College of Health for *Issue*, the national fertility association, in May 1993, found a wide disparity between approaches. 65% did not have a formal policy for the purchase of infertility treatments and 22% were unable to give any details of the specific infertility treatments purchased. Only 25% bought IVF treatment under contract and 21% bought IVF under extra contractual referrals.

With limited funds spent on the new reproductive technologies, health rationing is severe and most of the Health Authorities that do purchase treatment apply stringent criteria to patient selection. Some of these are medical, related to the prospects of success for different categories of patients. In most cases there is an upper and sometimes a lower age limit, restrictions on the type and duration of the medical condition to be treated and a range of preliminary tests to be undertaken. Usually there is a limit – often 3 – to the number of treatment cycles offered.

There are also criteria for the 'type' of patient who will be treated. Usually the specification is a heterosexual couple, either married or in a stable relationship of a specified number of years standing, with no surviving children or, if there are children, from an earlier relationship and not living with the couple. Some practitioners will justify the 'couples qualification' on the grounds that infertility is a couple's disease because it takes two to make a baby. Some patients will argue that with so many couples waiting so desperately for NHS treatment, they do not see why single women should get a look in. Purchasing authorities can point to the HFE Act's stipulation that in providing treatment, the paramount concern must be the welfare of any child born as a result of such treatment, including consideration of the child's

need for a father. This in turn can be traced back to the Warnock Report which adjudicated that "as a general rule it is better for children to be born into a two-parent family, with both father and mother".

Social rationing

The new reproductive technologies are perhaps the only area of treatment where the NHS openly applies health rationing on the basis of social criteria. The philosophy underlying these criteria is that the western norm of the heterosexual two parent family is the one most conducive to the welfare of the child. That these criteria are stricter than those applied to any other form of parenting is an added irony; it is even possible for single people or gay or lesbian couples to foster or adopt children. What could end up being unusual about test tube babies is not the circumstances of their conception but the fact that they were born into proven stable, heterosexual two parent families.

It is also probably the only area of NHS provision where patients are regularly asked to pay fees. In effect there is a three tier system operating: private, NHS and fee-paying NHS. In some areas the fees are set on a means tested basis, in others as a flat rate 'contribution' towards costs. Either way, the NHS 'fees' can run to several hundred pounds.

In the absence of national guidelines or funding for provision of new reproductive technologies, District Health Authorities have been forced to improvise and also to find all of their own funding. They have been able to draw on both the publication by Leeds University of an *Effective Health Care Bulletin* of August 1992, setting out some factors in provision of infertility services and on guidelines drawn up by the Royal College of Obstetricians and Gynaecologists. Some have produced their own comprehensive policy documents and developed treatment protocols for GP, district hospital and tertiary centre co-operation. But the resulting patchwork of provision across the country is a far cry from the equity of treatment expected from the NHS.

The failure of provision has driven many into the embrace of private medicine. Fortunately in Britain the regulatory powers of the HFE Authority to license treatment centres and monitor their performance has provided some assurances about standards of care and access to information. It has avoided the position in the USA where some treatment centres are so inexperienced that they have yet to produce any 'take-home babies'. However, the cost of private treatment (£2,000 a cycle, excluding drugs which may be prescribed on the NHS by a sympathetic GP) excludes the vast majority of prospective patients.

The national consensus that underpins the NHS is that access to medical treatment should be determined neither by income nor by which side of the street you live on. If medical treatment is required and if the treatment is valid it should be available on an equitable basis to all. Sadly, the NHS nationally has neither rejected the new reproductive technologies as being invalid nor made any attempt to ensure its equitable provision.

The feminist mistake

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One of the most curious aspects of the debate over the new reproductive technologies has been the apparent alliance between the feminists and arch-conservatives.

Feminist opposition has been vociferous and long-standing. In the early '80s a prestigious group set up the Feminists International Network of Resistance to Reproductive and Genetic Engineering. Their antipathy was not just directed at IVF and other forms of assisted conception but towards intervention in women's fertility generally by a patriarchal medical profession. Thus were linked issues such as the Dalkon Shield with its damaging effects on women's fertility, the equally damaging prescription in the USA of Diethylstilbestrol which produced infertility in the daughters of the women who took it and the manipulative use in the Third World of the contraceptive drug Depo Provera.

One of the arguments against the new reproductive technologies has been the damaging and by and large unpublicised side effects, such as ovarian hyperstimulation syndrome and ovarian cancer, the former responsible for the death of one woman in Britain in early 1994. Provision of the new reproductive technologies is seen as being irrelevant to the wider needs of women and no substitute for the need to deal with the factors in modern society that damage women's fertility. Subservience to the medical profession in undergoing assisted conception is cast as a manifestation of false consciousness on the part of some of the sisters, especially when it is to overcome male infertility.

Irony

Yet the feminist position is full of ironies. The prevalence of infertility is thought to be on the increase, although accurate measures of it are notoriously difficult. One of the reasons for this increase is thought to be the trend towards women delaying their child-bearing until they are established in their careers. Age, sexual experimentation and intra-uterine devices in the interim are all variously blamed for contributing to the decline in fertility. In some senses time and nature caught up with the pill generation. The British post-menopausal mothers who hit the headlines were by and large models of political correctness, successful, independent and strong-minded, only wanting to complete already full lives by having a child.

Whose right?

Before looking at some of the feminist arguments in more detail, it is important to deal with the issue of the rights of women as opposed to the rights of children. The Warnock Report rejects the idea that it is women's 'right' to have children and that the individual whose welfare must get top priority must be that of any child born as a result of the new reproductive technologies, with the need for two parents being the one welfare consideration specified. There is a recognition that the relationship between the two parents might break down but no suggestion as to how to deal with this, or whether this is damaging to the welfare of the child.

To turn first to the issue of whether women have a right to a child. It is futile to talk about a 'right' to have a child in relation to a treatment which has only an 18% success rate. However, women do have the right to control their own fertility and this right, in terms of contraception, has not been linked to either marital status or sexual orientation. Efforts by society forcibly to control women's fertility (for example through enforced sterilisation or contraception programmes) have been rightly condemned. In addition, women have a right to medical treatment on the NHS and, as discussed in the previous chapter, this should include the right to treatment to overcome infertility.

Secondly, in dealing with the welfare of the child the only consideration explicitly mentioned has been the need of the child to have two parents of opposite sexes. It is difficult to see the logic of placing on women who conceive their children through the new reproductive technologies stricter requirements than are placed on any other type of childbearing or childrearing. This is particularly true in the absence of any evidence that either single or gay or lesbian parents are damaging to the welfare of their children. If the welfare of the child was the real consideration then it would be more logical to exclude from treatment people who have a previous conviction for an offence involving child abuse. Alternatively, if there is to be discrimination between different forms of parenting, there has to be the construction of some criteria which assess quality of parenting, rather than just quantity and gender of parents.

Underlying some of the feminists' concerns is perhaps the basic issue of the role of motherhood and the destabilising effect the new reproductive technologies have had on this female preserve, shattering for the first time the certainty of motherhood. Fatherhood was always a fairly dodgy notion, known (usually) to the mother, until recently impossible to prove and until the advent of the Child Support Agency possible to eliminate completely from a child's life. Although banned by the Catholic Church, Donor Insemination, which separated the genetic from the social father, has never aroused moral outrage on the level seen at the start of 1994 over the advances in assisted motherhood. The establishment in law that if a couple were married and unless he specifically objected to his wife's treatment with donor insemination the

husband was legally the father of his wife's child has not led to public angst over the nature of fatherhood. Perhaps it's because men talk less about fertility problems or because they are not prone to stating publicly that they are not the 'real' or 'genetic' fathers of their children – unless there's an inheritance at stake. Or perhaps it's just because a man's relationship with his children starts after their birth and is more social than physical.

The new reproductive technologies opened up the possibility that the woman who gives birth to the child might not be its 'real' mother and this opens up the whole issue of what is a 'real' mother. What was once a single, discrete role, has been subdivided into three parts: genetic, birth and social. The genetic mother provides the genetic material, the egg; the birth mother carries and gives birth to the child; and the social mother raises the child. With the new reproductive technologies, the three can be separate women. The HFE Act adjudicated between the three mothers; the first time the law had entered into what had previously been the self-evident nature of motherhood.

The possibility that seems to be rejected in the feminist approach is that women could gain control of the medical technologies or that the health services could make them available in a woman-centred way. This was, by and large, the approach that was taken to both contraception and abortion. Contraception was equated with women's liberation and abortion on demand was an integral part of women's right to choose. The latter battle has not yet been won and, indeed, both in America and Britain, the revival of the anti-abortion lobby, perhaps as a result of the backlash against the '60s, has threatened to turn the clock back rather than forward.

Provision of abortion services on the NHS is still extremely patchy. According to a survey of Health Authorities by the Pro-Choice Alliance/Pregnancy Advisory Service, the percentage of all abortions carried out under the NHS ranges from 12% to 95% with an average of 57% across England and Wales. Whilst reliant on only a very small sample size, the survey authors concluded that "the responses and comments are sufficient to provide clear evidence of considerable problems faced by women trying to obtain an NHS abortion". Yet the championing of these two areas of medical service by the feminist movement with the influence it can bring to bear on the political processes was undoubtedly instrumental in securing even the progress made so far. Similar support could transform the position of the new reproductive technologies.

An implied question behind the feminists' position is about the importance of motherhood to women – whether the false consciousness lies in undergoing sometimes painful, usually harrowing, medical treatment or in being so desperate to have a baby in the first place. There are two points to consider here. One is that, however much traditional family structures may be thought to have disintegrated, alternative forms of parenting in our society are very limited. The changes taking place in fostering and adoption are well known. Further, given the West's nuclear one or two parent family structure, there is

little opportunity for the shared care of children found in the extended families or in communal living in other societies. Secondly, despite cheerful talk in infertility books of childfree living, there are few practical explanations of this. More importantly, there are few services available to women to help them to come to terms with the fact that one of their life options might be closed off to them and that they might, in the long run, be forced to accept this. The counselling required by the HFE Act falls short of what is required. Ironically the women's movement would be best qualified to provide women with the support they needed to make the mental and emotional transition.

Freedom for women has to be the ability to say yes, as well as no, to having children and also to have medical assistance, if needed, to overcome obstacles to what is for most women a natural process. Ready access to a full range of infertility services, designed and delivered in a woman-centred way and including, where necessary, assisted conception would provide women with the choice and control that they need in this important area of their lives.

Indeed, one of the problems with the new reproductive technologies currently is that access to them is so restricted, whether by private sector pricing or public sector rationing, that choice disappears. Patients who manage to get onto an NHS treatment programme, often a feat in itself and then endure two years or more on a waiting list, are more likely to feel grateful to get the chance to have treatment than to feel free to choose dispassionately to turn down the offer. Women forced into specialist private clinics, may neither have access to the range of services nor the finances to pay for a gradual work-up. They are more likely to decide what treatment they want and then simply go and buy it – sometimes irrespective of whether they have been through complete infertility testing, whether there is a reasonable chance of success and sometimes regardless of their past record of treatment. In America, gynaecologists have recognised that patients whom they turn down will simply shop around until they get what they want.

Placing these services in the mainstream of public sector provision would both alter the thrust of their development and take away their scarcity value and mystique. This would in turn enable women to make a more dispassionate assessment of their worth and to make more valid choices about their options.

Labour's approach

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Despite the solid foundations laid in the Warnock and Polkinghorne reports, the rapid progress of science, social changes, the need for a distinctly political voice and, not least, the need to deal with the 'yuk factor', all make it necessary to revisit some of the basics.

Two principles that can help inform a Labour approach, which are also two of the party's core values, are equity and equality. Equity would best be defined as the principle that the services and benefits provided by society should be equally distributed and available on the basis of universally applied criteria. Equality is the equal status of all people, regardless of age, gender, race, class and the other qualities which are used to discriminate. To this could be added a third principle, from medical ethics, which is beneficence, the principle that action should be oriented towards making things better for people, helping them achieve their life goals.

These principles can help to guide Labour's approach to ethical issues such as the use of foetal ovarian tissue in research or treatment, the subject of so much recent angst. Its use in research holds out the potential of providing benefit to women suffering from a range of conditions and diseases which currently prevent them from having children. Its use in treatment holds out the potential of enabling such women to have children but only if potential problems were also resolved, such as elimination of the risk of damaging side effects either to the women or their children and prevention of abuses either to the mother of the foetus or the foetus itself. To ensure that these qualifications were met, approval would have to be in two stages; first for the research and only later for the treatment. Continuing the public involvement and debate over the scientific process might also prevent a repeat of the dislocation of science and society.

To ensure that the new reproductive technologies develop in a way that is generally beneficial to society requires greater direction to research. Currently the HFE Authority approves research involving human embryos. In doing so it takes into account the purpose of the research; proposals to use embryos for trivial reasons would not be approved. However, the HFE Authority does not direct or co-ordinate research – currently the subject areas are left to the

requirements or interests of individual centres or researchers. To provide the direction needed would require both central funds and central commissioning, probably by the Department of Health. An alternative approach, simply to ban research because it might come up with something unacceptable, is not society controlling science but society running away from science in total panic.

Equity

But that deals only with beneficence: what then of the other two, equity and equality? Equity would demand that the benefits resulting from developments in research and treatment should be accessible to all women. What this argues for is a national policy on the provision of treatment to be implemented through the Local Health Authorities. This could include the three level structure envisaged by the Warnock Committee where treatment was provided at either primary, secondary or tertiary level depending on the technology and expertise required with protocols agreed between the health professionals for progression through the different tiers of treatment. Because of the lack of NHS centres for treatment, the Department of Health would need to fund some or all of the start up costs.

With the rapid development of medical science, it might be that the Warnock model for provision is out of date. Most of the new techniques can now be carried out entirely on an out-patient basis. In addition, the innovative scheme pioneered in Liverpool of linking in specialist university services with district general hospitals has made IVF more widely available throughout North-West England and North Wales. These developments might open out more models for provision that would provide greater flexibility and spread in services or open up possibilities for grouping women's services together.

Equality

Turning to the third principle, equality, a Labour approach to the new reproductive technologies would have to ensure that their deployment recognises and enhances the equal status of women. Allowing these technologies to make women subservient either to their male partners or doctors would justify the critical attitude of the feminists. The need for equality has several implications. First, it raises questions about the rights of women to treatment or to a child. The Warnock Report considers that it is the welfare of the child which is paramount: if it is thought that the child would be at risk the woman should be refused treatment. However, whilst women might not have the right to a child, they do, as discussed above, have a right to expect appropriate treatment for their medical condition. If the appropriate treatment is one of the new reproductive technologies then they certainly have a right to it as much as they would to any other medical treatment that they needed to overcome physical or health problems.

Secondly, it raises questions about the application of criteria for treatment, in particular the social criteria which have little to do with the woman's medical condition. If it is accepted that women have the right to control their own fertility then this right applies to all women regardless of marital status, sexual orientation or age.

A third point that needs to be considered in relation to equality is the need to end the wider discrimination against women either by relegating motherhood to a secondary status or by making women choose between motherhood and career. What perhaps is the saddest thing about post-menopausal mothers is that they were forced to defer motherhood for so long. One of the saddest things about women who experience difficulty in having children is that some say they find themselves, childless, without any social role purpose or value.

Finally, there is the question of dealing with the 'yuk factor'. If Labour sets out its own principles and policies, this great expression of public squeamishness does not just disappear. Insofar as it captures a real, if somewhat inarticulate, public objection to some aspects of medical treatment, the 'yuk factor' has to be allayed. To do this requires consistent explanation and maintenance of the dynamic articulation between science, society and the political process.

Failure of the political process to enter into the debate about the future of the new reproductive technologies has restricted their potential and with it the options open to very many women. Active political support is required if these technologies are to take their place in the mainstream of women-centred health services, and if women are to enjoy real freedom of choice.

Infertility, feminism and the new technology

Do women have a 'right' to have children? What limits should be placed on scientific research into infertility treatments? Should provision be available on the NHS?

This pamphlet argues that the traditional feminist alliance with arch-conservative opponents of the new reproductive technologies is misguided, denying women a basic choice about their lives. Contrasting the history of feminist attitudes to contraception and abortion, Sally Keeble writes that: "Freedom for women has to be the ability to say yes, as well as no, to having children".

Further, it argues that the ethical dilemmas posed by the possibilities of scientific developments raise issues of fundamental importance to society such as the role of the family, parenting duties and the purpose of the welfare state.

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