WMA STATEMENT ON ASSISTED REPRODUCTIVE TECHNOLOGIES

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006
and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

Assisted Reproductive Technology [ART] encompasses a wide range of techniques designed primarily to aid individuals unable to conceive without medical assistance.

ART is defined as any fertility treatments in which either gametes or embryos are handled.

Assisted reproductive technologies may raise profound ethical and legal issues. Views and beliefs on assisted reproductive technologies vary both within and among countries and are subject to different regulations in different countries.

Central to much of the debate in this area are issues around the moral status of the embryo, the way in which ART is viewed morally, societally and religiously, the child/ren born from ART, and the rights of all participants involved, i.e. donors, surrogates, the child/ren and the intended parents are just some of the issues central to the debate in ART. Whilst consensus can be reached on some issues, there remain fundamental differences of opinion that are more difficult to resolve.

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. Notwithstanding, the inability to conceive may also be as a result of prior illness.

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.

Faced with the progress of new technologies of assisted reproduction, physicians should keep in mind that not everything that is technically feasible is ethically acceptable. Genetic manipulation that does not have a therapeutic purpose is not ethical, nor is the manipulation on the embryo or foetus without a clear and beneficial diagnostic or therapeutic purpose.

RECOMMENDATIONS

1. Physicians involved in providing assisted reproductive technologies should always consider their ethical responsibilities towards all parties involved in a reproductive plan, which may include the future child/ren, donor, surrogate or parents. If there is compelling evidence that a future child, donor, surrogate or parent would be exposed to serious harm, treatment should not be provided.

2. As with all other medical procedures, physicians have an ethical obligation to limit their practice to areas in which they have relevant expertise, skill, and experience and to respect the autonomy and rights of patients.

3. In practice this means that informed 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 or influences to decide in a particular way.

4. The consent process should include providing the participant/s with understandable, accurate and adequate information about the following:

    - The purpose, nature, procedure, and benefits of the assisted reproductive technology that will be used.
    - The risks, burdens and limitations of the assisted reproductive technology that will be used.
    - The success rates of the treatment and possible alternatives, such as adoption.
    - The availability of psychological support for the duration of the treatment and, in particular, if a treatment is unsuccessful.
    - The measures protecting confidentiality, privacy and autonomy, including data security measures.

5. The following should be discussed during the informed consent process:
    - Detailed medical risks;
    - whether or not all biological samples involved in ART, including but not limited to donor eggs, sperm, gametes and genetic information, may be used for research purposes;
    - The risks of multiple donations and donating at multiple clinics;
    - Confidentiality and privacy issues;
    - Compensation issues.

6. Donors, surrogates and any resulting child/ren seeking assisted reproductive technologies are entitled to the same level of confidentiality and privacy as for any other medical treatment.
7. Assisted reproductive technology involves handling and manipulation of human gametes and embryos. There are different levels of concern with the handling of such material, yet there is general agreement that such material should be subject to specific safeguards to protect from inappropriate, unethical, or illegal use.
8. Physicians should uphold the principles in the WMA Statement on Stem Cell Research, WMA Statement on Human Genome Editing, the WMA Declaration of Helsinki, and the WMA Declaration of Reykjavik – Ethical Considerations Regarding the Use of Genetics in Health Care.
9. Physicians should, where appropriate, provide ART in a non-discriminatory manner. Physicians should not withhold services based on nonclinical considerations such as marital status.

Multiple pregnancies

10. Replacement of more than one embryo will raise the likelihood of more than one embryo implanting. This is offset by the increased risk of premature labour and other complications in multiple pregnancies, which can endanger the health of both the mother and child/ren. Practitioners should follow professional guidance on the maximum number of embryos to be transferred per treatment cycle.

11. If multiple pregnancies occur, selective termination or fetus reduction will only be considered on medical grounds and with the consent of all participants involved to increase the chances of the pregnancy proceeding to term, provided this is compatible with applicable laws and codes of ethics.

Donation

12. Donation should follow counselling and be carefully controlled to avoid abuses, including coercion or undue influence of potential donors. Explicit instructions should be provided about what will be done with any donated samples if the donor is known to have died prior to implantation.

13. The WMA holds the view that gamete donation should at best not be commodified, thus serving a humanitarian benefit.

14. To ensure appropriate controls and limits on methods used to encourage donations, this must be done in a manner that complies with national law and ethical guidance. Physicians should advocate for and contribute to such ethical guidance if it does not exist.

15. Due to the widespread use of genetic technology and registries, it has become possible to identify donors, despite clinics and donors' attempts to maintain strict confidentiality. A

child/ren born as a result of donation may in future contact donors. Potential donors must be made aware of this possibility as part of the consent process.

16. Where a child is born following donation, families should be encouraged and supported to be open with the child about this, irrespective of whether or not domestic law entitles the child to information about the donor. This may require the development of supportive materials, which should be produced to a national normative standard.

Surrogacy

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

18. Prospective parents and surrogates should receive independent and appropriate legal counsel.

19. Medical tourism for surrogacy purposes should be discouraged.

20. Commercial surrogacy should be condemned. However, this must not preclude compensating the surrogate mother for necessary expenses.

21. The rights of surrogate mothers must be upheld, and great care must be taken to ensure that they are not exploited. The rights of surrogate mothers include, but are not limited to:

    - Having her autonomy respected;
    - Where appropriate, having health insurance;
    - Being informed about any medical procedure and the potential side effects;
    - Where possible, choosing her medical team if side effects develop;
    - Having psychological help at any point during the pregnancy;
    - Having medical expenses such as doctor visits, the actual birthing process, fertilization and any examinations related to the surrogacy covered by the intended parent/s;
    - Loss if income covered if unable to work during the pregnancy;
    - Receiving the compensation and/or reimbursements agreed to in any legal agreement

Pre-implantation Genetic Diagnosis (PGD)

22. Pre-implantation genetic diagnosis (PGD) and pre-implantation genetic screening (PGS) 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 ethically acceptable reasons, including identifying those embryos most likely to implant successfully in women who have had multiple spontaneous abortions.

23. It is recommended to encourage screening for infectious diseases in sperm donors and to determine whether to inform donors of positive tests.

24. Physicians must never be involved with sex selection unless it is used to avoid a serious sex-chromosome related condition, such as Duchenne's Muscular Dystrophy.

Research

25. Physicians have an ethical duty to comply with such regulation and to help inform public debate and understanding of these issues.

26. Research on human gametes and embryos should be carefully controlled and monitored and in accordance with all applicable national laws and ethical guidelines.

27. Views and legislation differ on whether embryos may be created specifically for, or in the course of, research. Physicians should act in accordance with the declarations of Taipei and Helsinki, as well as all applicable local laws and ethical and professional standards advice.

28. The principles of the Convention on Human Rights and Biomedicine should be followed.