

THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinions Related to Global Reproductive Health

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Abstract

The American Medical Association (AMA) *Code of Medical Ethics* offers guidance on reproductive health. Assisted reproductive technology raises ethical issues of respect for patient autonomy, privacy, informed consent, and discrimination, and it has societal consequences with ethical implications. The *Code* also addresses economic inequalities, access to health care, and disparities in health care broadly enough to be relevant to global reproductive health.

Introduction

Global reproductive health is a broad issue that raises ethical concerns related to reproductive technology (all reproductive treatments or procedures that handle human oocytes or embryos), economic inequalities, health care access, and gender and racial disparities. The *Code of Medical Ethics* offers guidance on many of these issues.

Reproductive Technology

The *Code* addresses issues of reproductive medicine most directly in Chapter 4.2, which gives guidance on several key issues related to reproductive medicine that have arisen because of modern technology. Some of the important ethical issues raised are respect for patient autonomy, privacy, informed consent, discrimination, and broader societal consequences.

Respect for patient autonomy. Opinion 4.2.1, "Assisted Reproductive Technology" [1], explains that "candor and respect are ... essential for ethical practice," as patients who have difficulty in having children are often "psychologically very vulnerable." With the aim of fostering increased respect for patient autonomy, Opinion 4.2.1 also states that "physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should ... value the well-being of the patient and potential offspring as paramount" [1]. Similarly, with regard to sperm or egg donors, Opinion 4.2.2, "Gamete Donation" [2], states that physicians should "discuss, document and respect the prospective donor's preferences for how gametes may be used, including whether they may be donated for research purposes."

Privacy. Opinion 4.2.2 recognizes the “concerns about the privacy of donors and the nature of relationships among donors and children born ... through use of their gametes by means of assisted reproductive technologies.” Physicians should therefore “inform prospective donors ... under what circumstances and with whom personal information, including identifying information, will be shared for clinical purposes” [2]. Physicians should also “discuss, document, and respect the prospective donor’s preferences regarding [release of identifying information](#) to any child (or children) resulting from use of the donated gametes” [2].

Informed consent. Opinion 4.2.3, “Therapeutic Donor Insemination,” states that “physicians who choose to provide artificial insemination should ... obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if appropriate)” [3]. Opinion 4.2.2 explains that physicians should “inform prospective donors ... about the clinical risks of gamete donation ... including the near and long-term risks and the discomforts of ovarian hyperstimulation and egg retrieval as appropriate” and “about the need for full medical disclosure and that prospective donors will be tested for infectious disease agents and genetic disorders” [2]. Opinion 4.2.2 additionally states that physicians should inform donors “whether and how the donor will be informed if testing indicates the presence of infectious disease or genetic disorder,” “under what circumstances ... personal information ... will be shared,” “how donated gametes will be stored,” and “whether and how the donor will be compensated” [2]. Similarly, Opinion 4.2.4, “Third-Party Reproduction,” states that physicians should “inform the patient about the risks of third-party reproduction for that individual,” including “possible psychological harms to the individual(s), the resulting child, and other relationships” and that physicians should “satisfy themselves that the patient’s decision to participate in third-party reproduction is free of coercion” [4].

In addition to informing donors and patients about medical risks, the *Code* provides guidance on storage of embryos created for IVF treatment that are not intended for immediate transfer. Opinion 4.2.5, “Storage and Use of Human Embryos,” explains that physicians have

an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be ... used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor ... made available to other patients for purposes of reproduction ... made available to investigators for research purposes ... [and] allowed to thaw and deteriorate ... [or] otherwise disposed of [5].

Discrimination. Opinion 4.2.1 states that physicians who offer assisted reproductive services should not “discriminate against patients who have difficult-to-treat conditions,

whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity” [1]. For example, regarding artificial insemination (using sperm from a third-party donor to help a woman achieve pregnancy), Opinion 4.2.3 states that “physicians who choose to provide artificial insemination should ... provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient’s marital status” [3].

Societal consequences. Opinion 4.2.4 states that “collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children” [4]. The *Code* also addresses the potential harms of reproductive cloning (use of somatic cell nuclear transfer to create a human embryo that shares all genes with the donor cell). Opinion 4.2.6, “Cloning for Reproduction” [6], explains that “reproductive cloning might be ethically acceptable to assist individuals or couples to reproduce and to create a compatible tissue donor” but that “reproductive cloning also carries the risk of psychosocial harm” to the cloned child. Opinion 4.2.6 further explains that cloning “may have adverse effects on familial and societal relations and on the gene pool.... Moreover, reproductive cloning has the potential to be used in a eugenic or discriminatory fashion—practices that are incompatible with the ethical norms of medicine” [6]. As such, “reproductive cloning is not endorsed by the medical profession or by society” [6].

Economic Inequalities and Access to Health Care

Many women around the world face access problems when seeking quality care related to reproductive health [7, 8]. The *Code* discusses access to health care broadly enough to be relevant to reproductive health, which includes issues of scarcity, cost, and necessity [9–11]. Chapter 11.1 recognizes that disparate access to health care is a primary ethical concern to which physicians have an ethical obligation to respond. Opinion 11.1.1, “Defining Basic Health Care” [12], states that “society has an obligation to make access to an adequate level of care available to all its members.” Opinion 11.1.3, “Allocating Limited Health Care Resources” [13], states that physicians “should advocate for policies and procedures that allocate scarce health care resources fairly among patients.” Similarly, Opinion 11.1.4, “Financial Barriers to Health Care Access” [14], explains that “physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means” and that physicians should “take steps to [promote access to care](#) for individual patients, such as providing pro bono care.”

Disparities in Health Care

Health care disparities are a common theme of concern in public health. Indeed, as Julie Hwang notes:

Racial disparity in the healthcare system has been criticized as one of the major social and economic problems in the United States. Racial and ethnic minorities consistently face challenges in the healthcare system and subsequently face higher mortality, lower health status, and higher propensity for certain illnesses and diseases [15].

Opinion 8.5, “Disparities in Health Care” [16], explains that disparity “represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients.” Opinion 8.5 describes health care disparities as “differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences” and states that such differences “constitute inappropriate variations in health care” that “may contribute to health outcomes that are considerably worse” for members of certain [minority groups](#). To ensure quality of care, physicians should “avoid stereotyping patients” and “work to eliminate biased behavior toward patients” [16]. Opinion 8.5 further states that the medical profession has an ethical responsibility to “increase awareness of health care disparities” and “support research that examines health care disparities” [16].

Conclusion

The Code offers guidance on issues related to global reproductive health, including ethical issues of patient autonomy, privacy, informed consent, discrimination, and societal consequences related to the use of reproductive technologies. The *Code* also offers guidance on issues of economic inequality, access, and disparities in health care, which are key factors related to global reproductive health.

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