**The pluralism problem in cross-border reproductive care**

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**ABSTRACT:** Outlawing well established forms of assisted reproduction places obstacles in the path of couples who wish to attain their reproductive goals with medical assistance. One effect of restrictive reproductive laws that has received widespread attention is cross-border reproductive travel. In Europe, such travel is permitted by the policy of free movement of persons that is a cornerstone of the democratic and economic stability of the European Union. Cross-border reproductive travel fails to promote moral and political pluralism in democratic states for three primary reasons. First, the opportunity for patients to go abroad for treatment tempers organized resistance to the law and allows government to pass stricter regulations than it otherwise might. Second, cross-border reproductive care has been shown to have deleterious extraterritorial effects that undermine the articulated rationales behind restrictive reproductive laws. Third, laws that generate demand for cross-border reproductive care often fail to satisfy the standard of proportionality that restrictions on human reproduction must meet.

**Key words:** cross-border reproductive care / democracy / pluralism / law / proportionality

**Introduction**

When countries enact restrictions on assisted reproduction as a sincere expression of their convictions about the proper scope of human reproduction, cross-border reproductive travel often ensues. Since countries in a democratic system committed to the free movement of persons can do little to restrict such movements, restrictive legislation can appear meaningless, except in a very powerful symbolic sense and except to the extent that individuals are prevented from crossing borders because of their own financial circumstances. Because of the easy access to cross-border reproductive travel, the commitments of stakeholders taking part in debates about restrictions on reproduction are affected. Since each side can be assured of attaining its goals, there is little to be gained from either caution on the one hand or resistance on the other. Those who desire a procedure are apt to be less concerned about whether it becomes outlawed, at least if they have the means to travel in order to acquire it. Those who wish to prohibit the procedure may feel justified in assuming a stricter position than they otherwise might, knowing that cross-border reproductive care will temper resistance to the law.

The fear that cross-border reproductive care might result in harm, either at home or abroad, is no longer a matter of mere speculation. Emerging evidence shows that those who have obtained risky reproductive services abroad and require extensive pre- and post-natal care upon their return can place a strain on national health services (McKelvey *et al*., 2009; Smith *et al*., 2010). The extent of the harm posed to citizens in destination countries by cross-border reproductive travel is also becoming increasingly understood (Merlet and Sénémaud, 2010). In view of these developments, restrictive reproductive laws that contribute to cross-border reproductive travel should be more carefully scrutinized. When scrutinized under the microscope of important democratic principles, the availability of cross-border reproductive care proves inadequate for promoting or sustaining moral pluralism. A better response to restrictive reproductive laws, impinging as they do on matters of great human importance, is to require them to exhibit a high degree of proportionality in the first instance.

**Moral and political pluralism in democratic states**

Moral or value pluralism refers to the view that values that may conflict with one another may nonetheless be equally correct (Galston, 2005). Political pluralism is the belief that diverse voices are what give a society a robust and salutary political life (Galston, 1999). The multiplicity of voices and perspectives on assisted reproduction poses a challenge to a democratic state in deciding whether and how assisted reproduction should be regulated. The state’s specific task is to find a way to allow moral pluralism to flourish within a political system where legislation tends to reflect the majority’s will. In doing so it must decide what sorts of restrictions on individuals’ freedom to act according to their value systems are permissible.

Although the legislative function in a democracy operates according to the principle of majority rule, an ideal democratic process will strive...
to acknowledge and accommodate differences of opinion through a
good faith negotiation between competing factions that leads to a col-
glective consensus about what best promotes the common good
(Cohen, 1999). The process works only if it is authentically participa-
tory, no one is forced to assimilate to anyone else’s position, and
the state is not itself biased in any one direction. These ideal conditions
admittedly are difficult to achieve. In plural societies, consensus on
all issues tends to prove elusive (Elshtub, 2006). To curb the harm
that can arise from majoritarianism, democracies require legislation
at the very least to satisfy the test of rationality. This limit, placed at
the extremes, allows legislatures a wide margin of appreciation to
take positions on policy as long as their actions are not arbitrary or
capricious (Ratner, 1978).

Most aspects of civic life fare quite well under this deferential legis-
lative standard. Others, such as human reproduction, are so funda-
mental to human experience and evoke such deeply held and
lative standard. Others, such as human reproduction, are so funda-
mental nature of the rights at issue in such cases, the margin of
appreciation accorded the state is narrowed to what has been
described as ‘the only or the least intrusive means of achieving the
aim pursued’ (S.H. and Others v. Austria, 2010). Such a standard is
meant to counteract the potential for majoritarian sentiment on vola-
tile issues to smother the interests of the minority. In this way, democ-
racy respects autonomy in matters of great human importance and
strives to avoid the oppression of minority points of view.

Infertility, law and cross-border reproductive care

Infertility is a disease posing physical and psychological hurdles that
stand in the way of a couple’s attaining their goal of building a
family. Assisted reproductive technology is a solution for some, but
it requires them to submit to what would otherwise be unwarranted
and undesired interventions in their reproductive choices. Assisted
reproduction goes smoothly for many patients, but it is sometimes
impeded by various sources of interference ranging from a lack of
insurance coverage to unsuccessful treatments to laws that inhibit
rather than facilitate particular reproductive goals. In the latter case,
couples may choose to leave their country of origin to obtain
medical treatment abroad.

In recent years, ethical debates about the scope of medical services
available to enhance a couple’s ability to procreate have resulted in
laws that curb access to certain procedures. These laws take different
forms ranging from (i) the prohibitive approach (Italy, Germany and
Austria), (ii) the cautious regulatory approach (Denmark, Sweden,
Norway and France), (iii) the liberal regulatory approach (the UK,
Spain and the Netherlands) and (iv) the laissez-faire approach (the
USA) (Nielsen, 1996). In Europe, the liberal regulatory approach is
characterized by regulatory oversight, whereas the prohibitive
approach is characterized by bans on particular procedures such as
gamete donation, preimplantation genetic diagnosis or the cryopreser-
vation of embryos. The prohibitive approach is in essence the rejec-
tion of moral pluralism. It takes the position that allowing moral
pluralism to flourish under a more permissive model would cause
harm of various sorts to befall patients, future children and the
larger society. For example, Italy, now exhibiting the most restrictive
reproductive regime in Europe (Crosignani, 2005), believed its for-
merly permissive stance caused harm to the reputation of the
country and its physicians, harm to future children who would not
be raised by their biological progenitors, and harm to donors from
unsafe procedures or conditions that exploit their poverty or
vulnerability.

Cross-border reproductive care has been sensationalized in the
media as alternatively subversive and exotic or dangerous and not
fully ethical. The unfortunate characterization of those who must
travel to realize their reproductive goals as ‘tourists’ has fueled a
debate over the most appropriate way of describing this phenomenon.
Referring to reproductive travel as ‘tourism’ is disfavored (Shenfield
et al., 2010), with the terms ‘cross-border reproductive care’ and
‘reproductive exile’ proposed as more appropriate substitutes (Mator-
ras, 2005; Pennings, 2005). Indeed, anthropologist Inhorn’s ethno-
graphic work has shown that “[l]egal barriers…bespeak the politics
of exile, and exile turns out to be an accurate descriptor of the
patients’ experience’ (Inhorn and Patrizio, 2009).

In addition to expressing concerns about terminology, commenta-
tors and ethics bodies have articulated several perspectives on cross-
border reproductive care. Bioethicist Pennings describes cross-border
reproductive care as a form of tolerance that promotes moral plural-
ism because it ‘prevents the frontal clash between the majority who
imposes its view and the minority who claim to have a moral right
to some medical service’ (Pennings, 2002). Pennings sees tolerance
of cross-border reproductive care as a solution to restrictive legislation
rather than a problem arising from it (Pennings, 2006) because it dis-
plays ‘a healthy degree of relativism…a spark of doubt about the
unique correctness of one’s own position’ (Pennings, 2004). Legal
scholar John Robertson sees cross-border reproductive care as a
poor solution not only because it permits only those with adequate
resources to escape the restraints of the law but also because it
forces patients to overcome additional psychological hurdles that com-
pound the burden of their infertility (Robertson, 2004). The European
Society of Human Reproduction and Embryology’s Task Force on
Ethics and Law believes that cross-border reproductive travel signals
the existence of a ‘structural deficit’ in the delivery of health care in
countries from which patients travel and calls on physicians and
patients groups to assume special obligations to address that deficit
(ESHRE Task Force on Ethics and Law, 2008). Finally, ESHRE’s Task
Force on Cross-Border Reproductive Travel considers cross-border
reproductive travel to be a public health problem deserving of close
study and expresses serious concern about the quality of care and
the safety of patients (Shenfield et al., 2010).

The common ground in scholarly commentary on cross-border
reproductive care is that crossing borders to obtain medical treatment
is not worrisome per se. Indeed, European law grants citizens of
member states the right to freedom of movement for the purpose
of purchasing goods and services abroad (Pennings, 2006). The crimi-
nal prohibitions on cross-border reproductive travel that exist in some
non-European countries, for example Turkey, would not be permitted
under the specific terms of the European Community treaty. This means that European nations may prohibit certain reproductive procedures at home but cannot prevent or penalize their citizens from seeking those prohibited procedures in other European countries. The freedom of movement also applies, of course, to those citizens not seeking to evade the law but simply preferring to obtain care elsewhere for reasons of cost, waiting times or other reasons.

**Cross-border reproductive care and moral pluralism**

Although not a perfect antidote, at first glance cross-border reproductive care might well appear to be an acceptable result when a member state’s majority has decided to limit the forms of assisted reproduction it will allow within its borders. Upon closer examination, however, cross-border reproductive care proves to be a poor substitute for moral pluralism for two primary reasons. First, the opportunity for patients to go abroad for treatment tempers organized resistance to the law and allows government to pass stricter regulations than it otherwise might. Second, cross-border reproductive care has been shown to have deleterious extraterritorial effects that violate the spirit behind restrictive reproductive laws.

The policy of free movement of persons thought to be essential to democracy and economic stability weakens the pressure on a state to moderate its stance on assisted reproduction in order to demonstrate even a modicum of deference to the minority point of view. When those whose options are curtailed by the law may simply travel abroad to achieve their reproductive goals, organized resistance to the law becomes less likely. We may for this reason characterize cross-border travel as a safety valve, but the valve does not promote or sustain moral pluralism—it merely removes pressure from lawmakers. Those who desire a procedure, if they possess the means to travel, may be less concerned about whether a prohibition of it is enshrined in legislation. Those who wish to prohibit the procedure may feel justified in assuming a stricter position than they otherwise might, knowing that cross-border reproductive travel will function to quell organized resistance. Under these conditions, government has an incentive, or at the very least an opportunity, to assume stricter and perhaps more symbolic positions on volatile issues than it might otherwise. Thus, cross-border reproductive care’s function as a safety valve against organized resistance at home is precisely what can trigger restrictive reproductive policies and permit them to flourish. Its availability eliminates the opportunity for dispassionate dialogue that is the hallmark of moral pluralism and in its place creates the illusion of benign acceptance.

Cross-border reproductive care proves to be an inadequate substitute for moral pluralism in another important respect. It allows the laws of one jurisdiction to have extraterritorial spillover effects that violate the spirit of those laws. When the citizenry of one country travel abroad to obtain the fertility services they are denied at home, they create demands and burdens in the host countries that would otherwise not exist. The ramifications of the influx of foreign demand are likely to be most worrisome when patients travel from wealthy home countries to relatively poor host countries. The demand for oocytes in particular is one that young, single women in resource-poor host countries have admitted they are only too willing to supply given their circumstances. Such conditions lead unerringly to financial exploitation, lack of informed consent and even criminal activity as the recent egg donation scandal in Romania attests (Merlet and Sénémaud, 2010). It is also of concern that resources expended by a destination country on the care of patients coming from abroad will reduce the capacity of that country to respond to the needs of its own citizens (Merlet and Sénémaud, 2010) and will result in a stratified delivery of care due to the migration of physicians into the private sector for the lucrative satisfaction of foreign demand (Smith, 2010). This fear has already been addressed in the cross-border transplant context by the Declaration of Istanbul on the Traffic in Organs and Transplant Tourism (Delmonico, 2008).

Although we currently lack hard data showing that local populations are ‘priced out’ of assisted reproduction by the artificial demand created by cross-border reproductive travellers, it has come to light that selling their eggs for use by others is often the only option local populations in destination countries are offered when they seek access to assisted reproduction (Merlet and Sénémaud, 2010). These concerns make the ongoing fact-gathering of ESHRE’s Taskforce on Cross Border Reproductive Care all the more urgent.

Given the problems that attend cross-border reproductive travel both inside and outside countries enacting restrictions on assisted reproduction, its existence cannot be described as sustaining or promoting moral pluralism in any satisfactory way.

**Assisted reproduction and the proportionality principle**

The primary problem with restrictive reproductive laws that contribute to cross-border reproductive travel is that they do not satisfy important democratic standards defining the limits of legislative competence. As a general matter, a legislature is free to enact laws that regulate everyday life as long as those laws are rationally related to achieving the legislature’s legitimate aims. Restrictions on procreative choice, though, must satisfy the higher standard of proportionality. Proportionality requires that the restriction align closely, albeit not necessarily seamlessly, with the ends the restriction is intended to achieve (Arai-Takahashi, 2002). This standard does not prevent a state from codifying normative or ethical perspectives in its laws regulating reproductive technology. But it does prevent a legislature from imposing restrictions that have little or nothing to do with the achievement of those normative goals.

The recent case of S.H. and Others v. Austria illustrates this point. The European Court of Human Rights was asked to evaluate provisions of Austria’s Artificial Procreation Act that banned egg donation altogether and sperm donation for IVF. The court held that the decision to use medically assisted reproduction to have a child fell within the scope of the right to be free from state interference in matters of private and family life. Even though Austria raised weighty justifications for its restrictions, among them the exploitation of egg providers and the risk that using third-party gamete donation for IVF would lead to the discriminatory selection of traits, the court nonetheless found the prohibitions disproportionate ‘unless . . . [they were] the only means of effectively preventing serious repercussions’ (S.H. and Others v. Austria, 2010). Since the government could count on medical professionals, guided by their code of ethics, to safeguard...
against and minimize the risks of harm from assisted reproduction, the court admonished Austria to choose ‘the only or the least intrusive means of achieving’ its aims. Although the court suggested throughout its opinion that Austria was entitled to a wide margin of appreciation in regulating assisted reproduction, its decision to permit Austria to elect only the least intrusive means and justify them with ‘particularly persuasive’ arguments signals its establishment of proportionality as the most appropriate standard for legislating in this context. Indeed, toward the end of its opinion, the court stated plainly that ‘where a particularly important facet of an individual’s existence or identity is at stake, the margin allowed to the State will be restricted’.

Italy’s well-known restrictions on assisted reproduction, enacted in 2004, have also come under increased scrutiny by its own constitutional court. Earlier this year, the Constitutional Court of Italy struck down provisions in the Italian law mandating the production of at most three embryos in any one IVF cycle and the requirements that the immediate return of all embryos produced to the woman’s uterus. The primary objection of the court was that, in purporting to protect embryonic life, the law took no account of the medical fact that ‘it is impossible to procreate without a certain degree of early embryo loss’ (Benagiano and Gianaroli, 2010). A second objection was that the law rendered clinical judgment practically irrelevant in the treatment of patients despite the individualized circumstances different patients invariably present. Like the European Court of Human Rights in S.H., the Constitutional Court of Italy was unwilling to defer to the legislature under a standard of rationality where a less intrusive approach—the resort to medical judgment—was available.

Other aspects of the Italian law may also fail the test of proportionality. In outlawing all forms of heterologous reproduction, the legislature’s stated goal was to reaffirm the heterosexual couple as the only appropriate locus for family formation and to avoid the harms that attend the introduction of third-party gametes into the reproductive process, namely (i) the threat to a couple’s relationship of having children not biologically related to both of them; (ii) the psychological danger to a child who does not know the identity of and is not raised by both of his biological parents; and (iii) injury to Italian society at large due to increases in marital breakdown and psychologically damaged children.

Ironically, it is cross-border reproductive care itself that calls into question whether Italy’s ban on heterologous reproduction is adequately proportional to the aims of the law. Via cross-border reproductive travel, which admittedly cannot be outlawed if it takes place within the European Union, all of the feared dangers to patients, children and society become subject to importation into Italy when patients return from abroad and give birth. Nonetheless, Italian legislators have not moved to enact provisions to combat these dangers or temper their ill effects. Despite the supposed importance of biological ties, the law itself makes clear that a gamete provider has no parental rights or obligations and that the commissioning couples are indisputably the child’s parents. Despite the fragility of family bonds that are thought to attend reproduction with third-party gametes, the law contains no provision requiring the couple to adopt the child so as to solidify those bonds. It fails even to make a symbolic gesture in favor of the child’s right to know his biological parents. Absolutely no consequences whatsoever attend the use of third-party gametes abroad; indeed, life proceeds as normal upon the delivery of the child in Italy.

This slippage between the claimed harms and the law enacted to address those harms is uncharacteristic of legislation that adheres to the proportionality principle. Now that the European Court of Human Rights has signaled its willingness to narrow the traditionally wide margin of appreciation member states have enjoyed in regulating assisted reproduction, Italy may be in a position to rethink provisions of its law beyond those that its own constitutional court has declared infirm.

Conclusions

ESHRE has noted that cross-border reproductive care signals a breakdown in the system of health care delivery. But cross-border reproductive care may also expose a breakdown in the legislative process itself. Instead of promoting or sustaining moral pluralism by tempering resistance to restrictions on reproduction, the availability of cross-border reproductive travel emboldens legislatures to enact stricter and more symbolic prohibitions than they might otherwise have the political wherewithal to do. The result is the export of claimed harms into other jurisdictions that are inadequately equipped to address the complications and burdens that arise when foreigners enter their borders in search of solutions to reproductive problems. The exploitation of young gamete providers and the distortion in the delivery of medical care to the local population are the likely results of the cross-border reproductive phenomenon.

Demand for cross-border reproductive care may also signal the failure of restrictive reproductive laws to satisfy the requisite standard of proportionality. In matters of great human importance, such as founding a family, democracies place limits on the power of the majority perspective on the common good to prevail over all others. Instead, respect and tolerance for divergent beliefs on private matters are customary and are often enshrined in the textual frameworks that outline the limits of government. In an area as important and as sensitive as human reproduction, it is not enough for restrictive legislation to pass a test of minimum rationality. More is required lest pure majoritarian will succeed in suffocating other, though perhaps less popular, sentiments on family life.

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