British Journal of Medicine & Medical Research
4(13): 2517-2525, 2014

SCIENCEDOMAIN *international*
www.sciencedomain.org

Characteristics of a Transcultural Ethical Framework for Cross-border Reproductive Tourism: Insights from Existing Studies

Raywat Deonandan[1*] and Sarah Taber[1]

[1]Interdisciplinary School of Health Sciences, University of Ottawa, Canada.

Authors' contributions

This work was carried out in collaboration between both authors. Author RD conceptualized the study and wrote the manuscript, while author ST conducted the literature search and constructed the initial transcultural framework. Both authors read and approved the final manuscript.

Original Research Article

Received 8th October 2013
Accepted 1st February 2014
Published 18th February 2014

ABSTRACT

Reproductive tourism is the act of crossing an international border to seek assisted reproductive services, which can include maternal surrogacy. Ethical analyses of this phenomenon may be poorly served by considering the Western liberal framework alone. In previous studies, we identified 16 domains of ethical interest arising from this industry. In this paper, we sought perspectives in the scholarly literature that inform the development of an alternative to the Western liberal framework, incorporating more communalistic values that were then applied to the pre-identified domains. We concluded that a hybrid Western-communalistic framework, appropriate for helping to guide ethical analyses of reproductive tourism, incorporates an encouragement of third-party advocates to overcome power gaps between pertinent actors, and assumes the existence of a universal morality, such that a uniform standard of care can be expected regardless of cultural context.

Keywords: Assisted reproduction; IVF; ethics; ICSI; ART; ethical framework.

**Corresponding author: Email: rdeonand@uottawa.ca;*

1. INTRODUCTION

Reproductive medical tourism is one of the 21st century's more surprising products resulting from the collision of commerce with globalization and clinical care. Defined as "the travelling of [clients] from their country of residence to another country in order to receive a specific treatment or to exercise personal reproductive choice", [1] it involves the seeking of assisted reproductive technologies (ARTs), such as in vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI), pre-implantation genetic diagnosis (PGD), sperm and egg donation, and maternal surrogacy.

With respect to both maternal surrogacy and traditional reproductive technologies, India is thought to be the world's greatest provider of services. That country's ART industry is likely worth $500 million [2] to $2.3 billion; [3] and its provision of cross-border services plays a strong part in that revenue, judging from the extent to which Indian clinics overtly market to foreign clientele [4]. When the client is from a high income country (HIC), such as an OECD nation, and the jurisdiction providing the service is a low or middle income country (LMIC), such as India, the opportunity for exploitation and other types of ethical transgression is great. This is particularly true when maternal surrogacy is the service sought, as it uniquely involves issues relating to female autonomy, economic privation, changing definitions of family, and overall reproductive rights.

In our previous papers, [5,6] we enumerated a total of sixteen key domains of concern that define the ethical tensions concerning international maternal surrogacy and general assisted reproduction when the client is from an HIC and the service is offered in an LMIC. The conflict between medical and business ethics was ubiquitous across all analyses of this phenomenon. But also springing from those papers was the further realization that the Western liberal ethical framework, characterized in part by an emphasis on individual rights and autonomy, may be insufficient to the task of guiding an ethical appreciation of the nuances of the emerging global reproductive tourism industry, especially as it pertains to the limits of informed consent and definitions of pertinent actors in non-Western cultures. This position is reinforced by Widdows, [7] who also felt that the framework's over-individualistic nature renders it inadequate in this context. We thus proposed that a hybrid framework would be more appropriate. Such a framework would utilize the lexicon of the Western liberal approach, but would include the communal concerns and group responsibilities that characterize some non-Western perspectives.

With the current paper, then, we sought to identify existing published perspectives that might help to describe the dimensions of such a new hybrid framework, inasmuch as it is relevant to the international ART trade (particularly the maternal surrogacy industry) centred about India as the prime service provider. For the purposes of this study, the Indian ethical perspective is informed mostly by the philosophies of orthodox Hinduism and its related religions, Buddhism and Jainism. Comparisons with ethical frameworks derived from India's other communities, including Islam, Judaism, and overtly political and/or secularist philosophies are the domain of a parallel study not reported in this paper.

2. METHODOLOGY

We defined a new transcultural hybrid ethical framework –with its foundation the Western liberal framework--as one based on both a communal ethic and for the purposes of heightening utility for application to reproductive tourism specifically in India, the dictates of

orthodox Hinduism and related philosophies and religions. We performed a directed literature search to find descriptors of this set of philosophies using the following keywords: communal, Indian, Eastern, Hindu, Jain, Buddhism, group and community, along with ethics, framework and all grammatical variations of these words. Medline, Scopus, and Google Scholar databases were employed. All types of published materials were considered but only English publications were reviewed. The Hindu religion was selected as a search term due to it being overwhelming the dominant religion of India and one whose communalistic values, at least those effected at the village level, differ starkly from the individualistic ethic of the Western model.

Papers were each manually qualitatively reviewed for descriptors of communalistic values (specifically "communal", "group", "interactivity", "shared responsibility", and "group", as well as all grammatical derivations thereof) relevant to specific domains of interest to reproductive tourism, as defined in our earlier papers [5,6]. A description of those domains is given in Table 1. Note that exploitation of women, specifically, was not one of the domains for exploration, since it was not identified as such in our earlier work; however, exploitation is a crosscutting theme implied across several of the stated domains.

The initial review and coding was done by a single reviewer, with confirmation via re-review done by a second reviewer. We acknowledge that our use of the words "Western" and "communalistic" can be problematic, given the variety of applications those words enjoy in common parlance. However, in this study, Western pertains to a set of individualistic values typically associated with the application of modern liberal ethics. Communalistic, meanwhile, refers to any set of values that considers the role of an additional actor in having defensible interest in the deterministic actions of a primary actor, such as the consideration of the needs of a spouse or community member in establishing acceptable behaviour of an individual. While there is substantial overlap in these two concepts, for the purposes of this limited study, we have treated them as quite distinct.

Table 1. Description of essential ethical domains for reproductive tourism, as defined in an earlier paper [6]

Domain of interest to reproductive tourism	Description of domain
Misdirection of financial resources	Those who seek services abroad deny finances to their home community, and instead offer them to clinics in destination countries
Misdirection of medical resources	While a clinician in a destination country is providing services to tourists, they are not providing services to their home community
Implications of insufficiency	The act of tourists seeking services abroad implies that services are insufficient in quantity, type, timing or affordability in the home country
Quality control	Inconsistencies in the quality of medical services will occur between jurisdictions
Coercion	Given that seeking this care is an extreme response to medical duress, tourists might be vulnerable to coercion
Violation of destination country's moral paradigm	Reproductive technologies have the potential to introduce concepts and behaviours to societies unfamiliar or uncomfortable with them

Table 1 Continued ……

Applicability of the adoption standards	The state, as custodians of society's values, insists upon vetting adoptive parents for fitness; the same criteria could be applied to ART parents
Exploitation of the poor	Is it ethical to leverage poverty to receive a service that might not otherwise be offered or be affordable?
Robustness of informed consent	Legal requirements and definitions will vary between jurisdictions, affecting the extent and nature of risk communication
Criminality	If service seeking abroad is done to avoid prohibitions at home, then, in some circumstances, the provision of services to such a medical tourist might constitute the abetting of criminal behaviour
Custody rights of the surrogate	Laws and values vary between jurisdictions
Quality of surrogate care	It remains uncertain to what extent a surrogate's health is maintained beyond her gestational role
Limits of surrogate care	The moral argument for assuring that surrogate care extends beyond the delivery
Remuneration	Insufficient remuneration is a prime predictor of true exploitation
Possibility of abortion	The high possibility of selective reduction may conflict with surrogates' baseline value system
Medical Advocacy	To avoid conflicts of interest which arise when a clinician is paid by a client, the rights of a surrogate may need to be represented by a third party

Our initial search rendered 26 papers. Of those, ten papers were found to be useful in defining the points of tension between the Western liberal and a hypothetical transcultural-communalistic hybrid ethical framework for reproductive tourism [8-17].

3. RESULTS AND DISCUSSION

The following table (Table 2) summarizes the perspectives of these writers distributed across the pre-identified domains of relevance to reproductive tourism.

The following domains were not addressed in any of the found literature: Criminality, Custody rights, Quality of surrogate care, Limits of surrogate care, Remuneration, Possibility of abortion, and Medical advocacy.

Both the individualistic and communalistic frameworks agree on one key point, that the misdirection of resources is problematic. They differ on several important points: on which jurisdiction is responsible for that misdirection; on the relative importance of autonomy, especially as it related to coercion or exploitation; on the expected intensity of informed consent; and whether the moral paradigm of the destination country is an important consideration. The reviewed papers make no comment on the frameworks' distinctiveness with respect to quality control or the adoption standard, though some writers, such as Cohen, [18] have certainly explored the latter.

Table 2. Description of papers found to have utility in defining a transcultural hybrid ethical framework for reproductive tourism

Domain of interest to reproductive tourism	Paper with insights relevant to the (individualistic) Western liberal framework	Identified studies	Comments
Misdirection of financial resources	[8]	[9]	Both frameworks agree that this is an ethical transgression
Misdirection of medical resources	[8-10]	[10,11]	Discordance between frameworks; non-Libertarian frameworks frown on it except when service is medically necessary and not available at home
Implications of insufficiency	[9,12]	[9]	Western framework relieves home country of responsibility, since individual has autonomy to seek care abroad
Quality control	Not addressed in the identified papers	[8]	Notion of moral universalism supported by the Western liberalist view, suggests the need for global quality standards
Coercion	[7,14]	[7,13]	Western framework assumes that autonomy protected if choice is ensured; but it is false that consent is sufficient to render an act ethical
Violation of destination country's moral paradigm	[15]	[8,16]	Western framework's assumption of universal moralism does not recognize this as an ethical transgression.
Applicability of the adoption standards	Not addressed in the identified papers	[7,8,16]	Frameworks will disagree on which parties would be responsible for instituting such standards: polity, community, or clinic.
Exploitation of the poor	[7,8]	[8]	Discordance between frameworks most profound, as communal perspective argues that the more powerful players retain responsibility for the weak
Robustness of informed consent	[7]	[7,8,17]	Western liberal approach errs toward supremacy of autonomy, while communal approach allows for autonomy to be superseded in cases of likely exploitation

The role of stigma (of a surrogate mother or of a client seeking ART) in helping to define an ethical paradigm is not one considered in this study. In retrospect, that might be something of an oversight. However, elements of stigma are accounted for within both the domains of Coercion and Criminality, though not overtly so. Certainly, future workers on the evolution of a transcultural framework are well advised to give some thought to whether a paradigm should consider stigmatization as a defining trait and how competing frameworks deal differently with the different ways that dissimilar cultures value reduced stigmatization.

The absence of findings regarding the seven unaddressed domains is disappointing, especially in light of our earlier conclusion [6] that medical advocacy is a point of tension most in need of addressing from a framework perspective. Advocacy's importance stems from the tension between medical and business ethics, which often underlies critics' reaction to reproductive tourism. In the case of maternal surrogacy, the relationship between the surrogate and the client (purchaser of her services) is ostensibly a business relationship but the clinician, who is both the payment conduit and a paid service provider, is nevertheless bound by the rules of medical ethics, to act in the best health interests of all parties. This introduces the strong possibility of a conflict of interest, experienced by the clinician, which is not easily resolved through the Western liberal lens.

The role of an hypothetical advocate is to represent the interests of the surrogate both during contract negotiation and during the clinical procedures, both to help ameliorate the (often illiterate, impoverished and low caste) surrogate's lesser power, by virtue of her lower social status and to ensure that decisions made about her clinical care are seated in her medical best interests and not solely in the best interests of the paying client. While we had identified the potential role of an advocate in our previous work, [5] with the present analysis we have additionally shown that such a role can likely be justified in both a Western and communalistic ethic, and therefore has a strong role in any hybrid ethical approach.

Despite the dearth of literature commentary on this role, we feel that the existence of a third party advocate is seated within a communalistic perspective and might serve as the core around which a useful hybrid framework could be constructed. The acceptance of a need for advocacy satisfies the communalistic imperative for multiple party buy-in and the leveraging of community skills to augment individual shortfalls, while simultaneously not being a concept anathema or alien to the Western individualistic experience. This relates, as well, to one of the explored dimensions –the exploitation of the poor—in which the communalistic perspective allows for greater society, potentially represented by a dedicated advocate, to take responsibility for the wherewithal of an individual who is not socially empowered to negotiate an optimal surrogacy contract.

It must be noted that surrogacy contracts vary from nation to nation and often from clinic to clinic, as well. They attempt to embody both legal and ethical elements of the unique relationship between surrogate, clinic and client. What we propose is that the traditional contractual format be broadened to include a role for an advocate, who may act legally on the surrogate's behalf. The nature of that role, and its specific manifestation within a legalistic framework, is yet to be determined. But its effect, we hope, is to elevate the surrogate's negotiating power to be on par with that of the clinician and the client, who are both measurably more powerful, in terms of class, wealth and fluency with medico-legal systems.

A prominent theme that arises from our comparing of individualistic and communalistic frameworks is that the latter recognizes a responsibility to the client's home country,

whereas the former does not. This strikes us an important observation that is reflected in ongoing political debates in several Western nations. A common criticism of the medical tourism phenomenon in source countries (i.e., countries from which the medical tourists originate) is that the travel of medical tourists represents a divestment of resources meant for the source community in favour of the destination community. The placing of this controversy within the context of a discussion of competing frameworks allows for the introduction of cultural dimensions beyond the brazen financial concerns, including the potentially problematic role of medical tourists in effecting sociocultural tumult, as in the open seeking by same-sex couples of surrogates in conservative, somewhat homophobic Indian rural communities.

Indeed, cultural conflict is an expected byproduct of globalization, but has been largely ignored as most conversations about borderless trade have been situated within business norms, which today are arguably mostly Western libertarian constructs that focus on the impediments to individual free exchange. Any transcultural or hybridized approach must necessarily consider cultural concerns as more than just barrier to exchange, or as economic externalities.

A somewhat ironic conclusion is that the Western individualistic framework best argues for universal quality standards. This stems from the liberal belief in universal morality to the exclusion of cultural and moral relativism, though this is contradictory to the belief that communalism implies a conservative protection of local, cultural beliefs, as in the aforementioned same-sex example. The realities of globalization, wherein transnational commercial transactions rely upon standardization in law, finance, and terminology, strongly suggest a need for standardization in quality of care, as well. There is therefore a close association between the Western liberal framework and the tenets of globalisation.

Discussion of exporting the adoption standard to the assisted reproduction milieu is a rarity in the scholarly literature. Its rationale flows from the role of the state in vetting the fitness of prospective parents before the conferral of adopted children, and the natural subsequent question of whether the same rationale can be applied to prospective parents engaging a third party to help them acquire children in any untraditional fashion, i.e. through ART. The frameworks differ in which third party actor should be employed to effect a standard. The Western individualistic framework, in such cases where it accepts this standard, would likely bias this role toward a non-state actor, such as the clinic or clinician; whereas the communalistic framework would accept any actor in this role, but is biased toward either the state or the greater community.

There is an argument to be made that Western liberalism is more legalistic than any communalistic framework and therefore might be more resistant to exposing a clinician to the legal vulnerabilities inherent in being an arbiter of good parenting or of qualified parentage. In such a case, the state is the final backstop of legal responsibility, and therefore the arbiter of choice. It has been noted by legal scholars that the consideration of policy and regulation is essential for bioethical analysis of any kind of medical tourism, [19] lending some gravity to these considerations of legalism.

The question of the role of the adoption standard is an interesting one. Some jurisdictions have turned to family law, in particular the application of adoption standards, to help regulate definitions of parenthood in the case of surrogacy [18]. Whether adoption standards are the purview of individualistic or communalistic ethics remains uncertain. But, as Guido Pennings points out, [20] the concept of justice might be a relevant lens for viewing this issue. As

Justice is defined by both equality and access, it is arguable that it is unjust that two sets of parents, one seeking adoption and the other ART, would meet with different regulatory barriers. Yet this is the reality of colliding world views, which arguably necessitate the intervention of the punitive judiciary [21].

It seems to us that a truly hybrid framework relevant for application to reproductive tourism would, according to our results, be likely constructed around the acceptance of an independent medical advocate (especially for representing surrogate interests) as a key tenet, and an assumption of universal quality standards. The very existence of the industry gives weight to the individualistic framework, given its abrogation of any responsibilities to the source community (the country of origin of the service seeker) but allows for the strengthening of protections for the potentially exploited, as is recommended within the individualistic framework. A hybrid approach would then refrain from judging the existence of the industry, and would instead focus more on the leveraging of local human resources to empower and protect those least enabled in the surrogacy relationship.

The relevance of this work flows from the potential application of hybrid tenets to policy development. Strict legality aside, policies are only now solidifying with respect to the ART industry in India, and struggle for acceptance due to difficulties in aligning policy outcomes with assumed social values and state-defined morality. A hybrid framework offers some guidance in the navigation of these difficult ethical waters.

4. CONCLUSION

A creative consideration of a non-Western ethical approach might be a viable avenue to gleaning insights into this particularly complicated issue.

CONSENT

Not applicable.

ETHICAL APPROVAL

Not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Ferraretti AP, Pennings G, Gianaroli L, et al. Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies. Reprod Biomed Online. 2010;20(2):261-266.
2. Fontanella-Khan A. India, the Rent-a-Womb Capital of the World: the country's booming 1market for surrogacy. Slate Magazine; 2010.
3. Brenhouse H. India's Rent-a-Womb Industry Faces New Restrictions. Time Magazine; 2010.

4. Deonandan R, Loncar M, Rahman P, et al. Measuring reproductive tourism through an analysis of Indian ART clinic websites. International Journal of General Medicine. 2012;5:763-773.
5. Deonandan R, Green S, van Beinum A. Ethical concerns for maternal surrogacy and reproductive tourism. Journal of Medical Ethics. 2012;38:742-745.
6. Deonandan R. An Introduction to the ethics of reproductive tourism. In Labonte R, Runnels V, Packer C, Deonandan R, editors. Traveling Well: Essays in Medical Tourism. Ottawa: University of Ottawa. 2013;151-177.
7. Widdows H. Localized past, globalized future: towards an effective bioethical framework using examples from population genetics and medical tourism. Bioethics. 2011;25:83-91.
8. Donchin A. Reproductive tourism and the quest for global gender justice. Bioethics. 2010;24(7):323-332.
9. Whittaker A, Manderson L, Cartwright E. Patients without borders: understanding medical travel. Med Anthropol. 2010;29(4):336-343.
10. Connell J. Medical tourism: Sea, sun, sand and. surgery. Tourism Management. 2006;27:1093-1100.
11. Inhorn MC, Shrivastav P. Globalization and Reproductive Tourism in the United Arab Emirates. Asia Pas. J. Public Health. 2010;22:68S-74S.
12. Boggio A. Italy enacts new law on medically assisted reproduction. Human Reproduction. 2005;20(5):1153-1157.
13. Savulescu J. Is the sale of body parts wrong? Journal of Medical Ethics. 2003;29:138-139.
14. Bronsword R. Rights, Responsibility and Stewardship: beyond Consent. In Widdows H, Mullen C, editors. In The Governance of Genetic Information: Who decides? Cambridge: Cambridge University Press. 2009;990125.
15. Concejero AM, Chen CL. Ethical perspectives on living donor organ transplantation in Asia. Liver Transpl. 2009;15(12):1658-61.
16. Krishna L. Global ethics – A Malaysian-Singaporean perspective. Eubios Journal of Asian and International Bioethics. 2010;20:140-146.
17. Radcliffe-Richards J, Daar AS, Guttmann R, et al. The case for allowing kidney sales. The Lancet. 1998;351(9120):1950-1952.
18. Cohen IG. Circumvention Tourism. Harvard Public Law Working Paper No. 11-33. Cornell Law Review. 2011;97:1309.
19. Cohen IG. How to regulate medical tourism (and why it matters for bioethics). Dev World Bioeth. 2012;12(1):9-20.
20. Pennings G. Ethical issues of infertility treatment in developing countries. ESHRE Monographs. 2008;1:15-20.
21. Mainil T. Transnational Health Care and Medical Tourism: Understanding 21st- century of Patient Mobility. Towards A Rationale Transnational Health Region. Nieuwegein: NRIT Media; 2012.

Peer-review history:
The peer review history for this paper can be accessed here:
http://www.sciencedomain.org/review-history.php?iid=435&id=12&aid=3738