

NO-PATIENT SAFETY IN REPRODUCTIVE MEDICINE ⁽¹⁾

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I. Introduction

In Europe and The United States of America, restrictions are being formulated on couples' access to reproductive medicine services which go beyond those expressly imposed by law. It can be said that these restrictions of access are based in some cases on the futility of intervention, in others where there are clinical risks for the mother and for the future child, or even where the future child is at risk of psychological and social harm resulting from the incompetence of their progenitors. These restrictions are made by doctors within reproductive medicine services, some of whom are questioning law and jurists if their objections to granting access to certain couples are licit.

The fact that the question is being asked is in itself of some interest. In truth, until a few dozen years ago, perhaps doctors could not even remember ever asking such questions of law ⁽²⁾. The point is that over much of the previous three centuries, doctors and social workers developed what is known as 'medical policing', aiming to foster 'hygienism' as a

ruling practice in Europe, with the goal of 'purification' and 'health of the people' ⁽³⁾. It was certainly the case that they had power to decide everything necessary to control family relations, including the permanent removal of the children, based on their interpretation of what was in the children's best interests ⁽⁴⁾. This medicalisation of child protection, in specific terms, rested upon efforts to remove children from families of alcoholics in order to give them better alimentation and conditions of health. This was how, over the course of a century, around 100,000 children were sent out of the United Kingdom to the colonies, having no say in the matter and with many having been falsely informed that their parents had died. In the context in which this movement unfolded, it is probable that those who took these decisions were convinced that they were the right ones ⁽⁵⁾.

The practice of separating children from their parents out of sanitary concerns appears to have been common in Europe. It is only recently, in the

⁽¹⁾ This article is part of another text entitled *Restrições no acesso à parentalidade*

⁽²⁾ In view of other types of restrictions and of parental privations prior to the emergence of reproductive medicine.

⁽³⁾ BRUNO BARREIROS, *O discurso higienista no Portugal do século XVIII: tradição e modernidade*. In Adelino Cardoso, et. al. coord., *Arte Médica e Imagem do Cotpo: de Hipócrates ao final do século XVIII*, Lisboa, Biblioteca Nacional, 2010, p. 123-136.

⁽⁴⁾ EEKELAAR, *Family Law and Personal Life*, Oxford, Oxford University Press, 2007, p. 9ff

⁽⁵⁾ *Op.cit.*, p. 14.

final two decades of the twentieth century, that it became necessary and habitual to ask of the law and jurists how the best interests of the child might be defined...⁽⁶⁾ In the middle of the twentieth century a movement gained force which opposed the excessive regulatory power of the state in favour of individual autonomy. This movement found juridical expression in the rise in both the number and importance of fundamental rights enshrined in the constitutions of various countries. At the same time as this, sociologists were revealing how the greatest violence was taking place within the so-called 'family sanctuary', while radiologists were able to verify how babies suffered fractures which had been caused deliberately within the family⁽⁷⁾.

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The result of these tendencies was, naturally, the transference to laws and courts of the decision-making powers of doctors and social workers. That is to say, laws now came to define the types of cases in which it is legitimate to intervene within families in order to determine how citizens conduct their lives, and the courts had to interpret these laws and determine concrete cases; and while it is true that such deliberations had to be based upon the reports of health providers, the power of final decision was transferred to the realm of law.

In Portugal, the Constitution of the Republic states that "parents have the right and the duty to educate and support their children" (art. 36, No. 5) and, furthermore, that "children cannot be separated from their parents, except when parents have failed

to fulfil their fundamental duties towards them and always by means of judicial ruling" (No. 6).

In addition, within the sphere of ordinary law⁽⁸⁾, the ways in which the State can intervene are well defined and, amongst other limitations, can be found the obligation to ensure that intervention is minimal (art. 4. *d*), proportional (*e*) and gives prevalence to measures which maintain the integration of the child within the family (*g*).

Nowadays, therefore, prevalence is given to fundamental rights; and *the question is put between the State and the individual rights of citizens*: to what extent can laws and courts limit the fundamental rights of citizens? To what extent — and under what conditions — can public services restrict rights? Concretely: does the fundamental right to procreate and form a family have limits? Who has legitimacy to define and impose limits? Can health authorities and doctors restrict access to health services which have evident consequences in parentage?

II. Fundamental rights involved

a) The right to the free development of personality

The right to development of personality, while establishing a "general tutelage of personality", enshrines a "general freedom of action", a "freedom of behaviour" in the sense of individual autonomy and self-determination, "granting each person the

⁽⁶⁾ *Op. cit.*, p. 16.

⁽⁷⁾ *Op. cit.*, p. 15.

⁽⁸⁾ Particularly Law No. 147/1999, of September 1st, (child protection and children at risk regulation).

freedom to draw up their own plan of life”⁽⁹⁾. Every citizen is granted this right.

The right to free development of personality should be considered within the framework of discussion of this topic⁽¹⁰⁾. The truth is that the decision to procreate has great implications across a number of domains — psychological, physiological, sanitary, economic — and such a decision must be seen as a structural constituent of individual autonomy and personal freedom.

b) The right to form a family

The “right to form a family” granted to all persons, married or not, by art. 36, No. 1, 1st part, Constitution of the Portuguese Republic is, indisputably, a right to procreate⁽¹¹⁾. In this way,

⁽⁹⁾ Paulo Mota PINTO, *O direito ao livre desenvolvimento da personalidade*, in *Separata de “Portugal-Brasil, ano 2000”*, Boletim da Faculdade de Direito, Coimbra Editora, 2000, p. 149-246.

⁽¹⁰⁾ And of other topics related to reproductive medicine and with filiation in general. Thus, when it is argued whether adopted children have the right to legally know biological links still unknown (cf. art. 1987 CCiv) or the right to know the identity of their already recognised progenitors; or when it is discussed, in a parallel case, if children born by artificial insemination using donor gametes have the right to know who provided the eggs or the sperm which contributed to the conception; or even, in a case twice as difficult, we might say, if a child born from a donated embryo can know the identity of the couple who produced and donated this embryo. These rights can also be invoked in order to counteract the deadlines which limit judicial actions necessary to establish filial links which have not yet been recognised or to refute juridical arguments that might be contrary to biological truth.

⁽¹¹⁾ And, secondly, it is a right to establish corresponding relations of paternity and maternity. In violating this second dimension of the above mentioned right, norms, in particular, which prohibited the father from adopting or the mother from declaring maternity of an adulterous or incestuous child would also be considered unconstitutional. What would also be considered unconstitutional are norms which, conversely, prohibited a child born out of wedlock from establishing his filiation by bringing a paternity test action, or from regulating such actions, as in legislation prior to the Reform of 1977, demands which are not justified by the diversity of conditions surrounding the birth of the child; but the unconstitution-

ality of such norms would become clearer in art. 36, No. 4, of the Constitution of the Portuguese Republic.

norms which had the following characteristics would probably be considered unconstitutional: those which enforced sterilisation upon persons carrying certain diseases; which penalized unmarried persons with children; which established, under Malthusian demographic policy, a maximum number of children which couples could have and which sanctioned persons, married or unmarried, who had children exceeding this number. A norm which prohibited certain couples from conceiving children would also probably be considered unconstitutional.

c) The right to health protection (64.º CRep)

One of the dimensions of the right to health protection is the right to demand of the State services aimed at preventing and treating illness.

Ever since The World Health Organisation defined infertility as a global public health issue⁽¹²⁾, there is no doubt that health institutions should provide services aimed at curing the condition⁽¹³⁾. Having said this, all kinds of guarantees associated with the realization of these types of social rights are present particularly within the national system of health; this is true, above all, in the case which interests us, that of universality, which prevents discrimination in citizens’ access⁽¹⁴⁾.

ality of such norms would become clearer in art. 36, No. 4, of the Constitution of the Portuguese Republic.

⁽¹²⁾ <http://www.who.int/reproductivehealth/topics/infertility/perspective/en/index.html>

⁽¹³⁾ The very existence of Law No. 32 of 2006 suggests that such services should be rendered by the National Health System.

⁽¹⁴⁾ CANOTILHO, JJ; MOREIRA, V., *Constituição da República Portuguesa anotada*, vol. I, 4th ed., Coimbra, Coimbra Editora, 2007, p. 827.

III. Restrictions of access to parentage

The question which is asked is the following: for reasons of safety, to avoid risks for the mother and/or the child, should medical services add new restrictions to the right to accede to parentage — in addition to those already enshrined in law ⁽¹⁵⁾ — by means of reproductive medicine practice?

aa) Restrictions due to *futility*

The notion of “futile intervention” developed within the framework of the end of life; and the question has also been discussed in the case of severely handicapped new-born babies ⁽¹⁶⁾. It is understandable that doctors would wish to use all the technical means at their disposal, and it is also easy to imagine how families are unwilling to accept loss and prefer the continuation of treatment. In certain cases, however, doctors are faced with the possibility of intervention which is not going to produce any effects or which could be prejudicial to the interests of the patient ⁽¹⁷⁾. In spite of all the difficulties and the extent to which everything depends on the assessment of concrete cases, it is now accepted that doctors are not obliged to proceed with treatment, nor should they do so, when it is felt that their actions are likely to be therapeutically futile.

More recently, there has been discussion of the futility of treatment in relation to reproductive

medicine ⁽¹⁸⁾. Doctors have tried to define the cases in which the condition of the couple, and above all the woman, give rise to a very low probability of success in using techniques designed to assist reproduction. In some of these cases — and in spite of “not having clear quantitative indicators” — the probability of success can be lower or equal to 1%. In such cases, intervention can be considered futile, and health providers can refuse to proceed, as in all domains of medical practice. After all, here as in any other area of medicine, the rendering of futile care generates more risks for the patient than the advantages offered ⁽¹⁹⁾. The technical laws of the profession — the *leges artis* — justify the abstention of care, in other words, justify the restriction of access to attempts to achieve parentage.

It should be admitted, however, that here also it is possible to recognise the concepts of “physiological futility” and “normative futility” ⁽²⁰⁾; while the former concerns the consideration of the risks and physical advantages a patient might experience, the latter also takes into account the psychological advantages which improve the health of the patient. In certain cases it can be understood that the patient will come to gain considerable benefits, in spite of the very poor prognosis regarding the goal of possibly having a child ⁽²¹⁾. In such cases, a global view of the patient can recommend the practice of treatment physiologically futile but psychologically effective.

⁽¹⁸⁾ ASRM — *Fertility treatment when the prognosis is very poor or futile: a committee opinion*, 2012, in «Fertility and Sterility», vol. 98, No. 1, p. 6-9.

⁽¹⁹⁾ In addition to consuming resources which may be lacking in another sector of the health system.

⁽²⁰⁾ MASON; LAURIE — *Law and Medical Ethics*, cit., p. 476.

⁽²¹⁾ In this sense, the ethics committee of the American Society of Reproductive Medicine, cit., p. 7.

⁽¹⁵⁾ Law No. 32 of 2006, of 26 de Julho, arts. 4 and 6.

⁽¹⁶⁾ MASON; LAURIE — *Law and Medical Ethics*, 8th ed., Oxford, Oxford University Press, 2011, p. 475.

⁽¹⁷⁾ *Idem*.

bb) Restrictions due to low probability of success and/or due to risks to the mother and/or the future child. Imposition of life style ⁽²²⁾

Reproductive medicine doctors identify cases in which there is a relatively poor prognosis of a baby being born; these are cases in which the age of the mother and certain physiological conditions greatly diminish the chances of success; the American Society of Reproductive Medicine estimates that the percentage of success of interventions will be between one and five per cent ⁽²³⁾.

Once more, there should be a consideration of risks/benefits, according to the *leges artis*: the intervention is justified, in spite of a poor prognosis, if the risks for the woman are fewer than the advantages she is likely to gain; conversely, the refusal of treatment is justified when the probability of causing harm outweighs the expectation of success.

Again here there is the need to appreciate the emotional needs of a couple who are aware of the poor prognosis but who are particularly determined to try everything. These needs might lead the doctor to intervene with little hope of success, but with important advantages from the point of view of the couple's equilibrium. These interventions, however, should respect the limits imposed by the *leges artis*, even if understood in a way that understands the couple's mental health, which obliges the doctor not

to subject the patients to risks that outweigh the advantages of intervention.

Lastly, I believe that the consideration of all the risks and benefits is the only criterion which should guide doctors when deciding whether to intervene or not. By this I mean that the intense pressure exercised by the couple cannot justify the doctor passing beyond the limits of the *leges artis*; they can simply abstain whenever the intervention can be considered *bad medical practice*, after having considered both the risks and the physiological and emotional benefits. After all, in this area, there are no special rules which overrule the general deontological norms and medical law.

In many cases in which the consideration of risks/benefits does not favour intervention, doctors are aware of the causes of the initial poor prognosis. In fact, "life styles" which involve excess of weight, consumption of tobacco and alcohol, are factors which increase various risks for the mother and for new-born babies ⁽²⁴⁾. The document referred to above of the European Society of Human Reproduction and Embryology is highly elucidating regarding the technical advantages which can be obtained through alterations in "life style": the risks for the health of the mother and the newborn are lowered and the success rates of interventions rise. In the cases of excess weight and consumption of tobacco, a significant alteration in habits can even restore spontaneous fertility and dispense with the need for medical assistance ⁽²⁵⁾.

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⁽²²⁾ ASRM — *Fertility treatment when the prognosis is very poor or futile: a committee opinion, 2012*; ESHRE Task Force on Ethics and Law 17: *Lifestyle-related factors and access to medically assisted reproduction, 2010*.

⁽²³⁾ *Fertility treatment* ... p. 8.

⁽²⁴⁾ ESHRE Task Force on Ethics and Law 17: *Lifestyle-related factors and access to medically assisted reproduction*, In «Human Reproduction», Jan 2010, p. 1-6.

⁽²⁵⁾ *Op. cit.*, p. 5.

On the basis of this technical knowledge, doctors tend to demand the adoption of healthy habits by women and couples as a *prior condition* for initiating treatment. These demands, however, can be seen as an unacceptable intrusion into the individual freedom of women and couples. Could it be that there are sufficient reasons to restrict in some way the freedom to conduct life as you wish? And to what extent would it be reasonable to do so?

Firstly, it should be borne in mind that doctors are obliged to inform couples of the drastic consequences of unhealthy options. This information must form part of their normal competences and obligations, in order to obtain informed consent for interventions and for the agreement of couples to therapy.

124 Secondly, each citizen has the constitutional duty to *defend* their own health ⁽²⁶⁾. I am well aware that this norm cannot be understood in such a way as to eliminate the liberty and private autonomy which underpins the practice of informed consent and extends even to legitimize the refusal of treatment ⁽²⁷⁾. But I suppose that it is no longer considered eccentric to affirm that individual responsibility involves reasonable behaviours that limit costs to health systems and which permit relocating resources to sectors where there is risk of death due to the lack of rapid and thorough assistance ⁽²⁸⁾. It does

not appear to be sustainable to me that there should be a kind of bohemian citizenship which incessantly extends fundamental rights, and which complies with irresponsibility and accepts one-way solidarity ⁽²⁹⁾. If this constitutional norm has any significance, it can only reside in the obligation of each one of us to do all in our power ⁽³⁰⁾ to reduce factors of risk that affect one's general health condition. It does not seem to me at all exaggerated that doctors should establish the condition of altering couples' habits, since, in doing so, they do nothing more than stress that this is the opportune moment for the woman, or the couple, to fulfil their constitutional duty.

In addition, each citizen has the constitutional duty to *promote* their own health, which could also mean the duty to choose the options which improve their general health.

It could be said — conciliating these assertions with liberty and private autonomy — that a justified choice should be expected of citizens whenever the choice is for illness. In other words, each citizen has the right to choose illness, or to make choices which differ from the average person and which might delay a cure; but I believe that what should be demanded are choices which are truly justified and aware — a true exercising of liberty, of autonomy and responsible citizenship — instead of mere neglect and indifference, which only burden in

⁽²⁶⁾ Constitution of the Republic, art. 64, No. 1: "Everyone has the right to protection of health and the obligation to defend and promote it".

⁽²⁷⁾ João LOUREIRO, *Constituição e Biomedicina*, dact., vol II, Coimbra, 2003, p. 798-801.

⁽²⁸⁾ Cf. Jorge de Figueiredo DIAS, *Na era da tecnologia genética: que caminhos para o direito penal médico?* «Revista Portuguesa de Ciência Criminal», Year 14, No. 1 and 2, 2004, p. 247ff

⁽²⁹⁾ Solidarity — the sense of living *in solidum*, as part of a whole— implies that everyone is responsible for each person, but also that each person is responsible for everyone. In the end this is the sense of the famous speech by John Kennedy which everyone likes to cite ... and then forget.

⁽³⁰⁾ And not the abstract diligence that might be demanded of a "good family father".

some way all other citizens, if only through lack of consideration and disinterest.

Thirdly, within the specific sphere of reproductive medicine, the law ⁽³¹⁾ was particularly clear and incisive in imposing duties of collaboration upon the couple, with the aim of achieving the success of medical interventions; and to impose a singular consideration regarding the health of the child ⁽³²⁾. Indeed, article 13.º, n.º 1, b) obliges the beneficiaries to “rigorously observe all the orders of the medical team, both during the phase of diagnosis and during the different stages of the process of medically assisted procreation; and orders regarding “life style”, insofar as they have known influence ⁽³³⁾, either in reducing risk or increasing success, must be considered as “orders of the medical team” in terms of this norm. Article 12.º, a), in turn, reveals concerns regarding the health of the mother and the child. These rules appear to support a certain way of viewing all participants as responsible for the defence and promotion of health .

Fourthly, it seems more evident today than ever before — bearing in mind the high cost of services, and the scarcity of resources within the National Health System — that it is unreasonable for users to systematically consume resources, compromising the work of health providers merely due to a lack of consideration, without consequences. In truth, within a system whose resources are always finite,

excessive and unjustifiable consumption within one sector will always lead to lamentable shortages in other services, which aggravates the health of others or kills.

In spite of everything, establishing these conditions signifies great innovation and should be approached with caution.

Firstly, I consider it indispensable that public health services provide ways of helping couples who experience most difficulty in altering their “life style”. I am thinking, of course, in referral for psychological help and social services, as well as for consultations regarding nutrition, tobaccoism and alcoholism, integrated within a programme of accompanied rehabilitation ⁽³⁴⁾.

Secondly, knowing that progress can be slow and that women turn late to reproductive medicine services, the result of a delayed programme of change could mean women are beyond the age of fertility, and of the age in which they can have recourse to public services ⁽³⁵⁾. Such an outcome would clearly be unjust and inadequate.

Thirdly, it does not appear possible, at least within the sphere of the National Health System, to totally refuse access to women who have been unable to achieve reductions in their weight, or in their consumption of tobacco or alcohol; in fact, alteration of habits can be difficult and delayed. Nor should we overlook the difficulty resulting from

⁽³¹⁾ Law No. 32 of 2006, of 26th of July.

⁽³²⁾ See, however, the text below, in cc).

⁽³³⁾ This is one of those cases which confirms the nexus of causality between behaviour and lack of health cfr. João LOUREIRO, *Constituição e Biomedicina*, cit., p. 801.

⁽³⁴⁾ In private practices, such care can only take the form of simple recommendations, since isolated private doctors, or private clinics, lack the necessary facilities, integrated within a general health system.

⁽³⁵⁾ Cfr. the normative circular No. 18 of 2011, of 22 of July, from the central Administration of the health service (ACSS), which establishes upper age-limits consonant with recommended techniques.

consumption habits which are long held, and fed by an absent family and by socially irresponsible advertising, in other words, by other forms of lack of social solidarity of which they themselves have been victims ⁽³⁶⁾.

It is true that article 11, No. 2, of Law No. 32 of 2006, gives doctors the power not to collaborate with medically assisted procreation techniques, if they have medical reasons for refusal. I believe, however, that the refusal to intervene is only justified if it were against the *leges artis*, in such a way that it could be said to harm the woman; that is to say, the refusal only seems conceivable when the clinical profile suggests that the intervention would result, finally, in medical *malpractice*. In other words, there are no juridical instruments that would permit doctors to make decisions beyond their technical abilities, in the application of *leges artis*; in addition to these technical rules, doctors who refuse intervention would have to make a judgement about nonfulfilment of the legal obligation of collaboration and would have to qualify the nonfulfilment as guilty; all of this outside of any legal framework, legal professional intervention and without proper guarantees of a contentious solution.

I believe, therefore, that there are reasons which legitimize the insistence of doctors upon the effective collaboration of women and couples for the success of treatment and to guarantee the health of the child, in accordance with law No. 32 of 2006. And I understand that it is just and opportune to promote a balance between liberty and individual

autonomy and the solidarity which each one of us owes to everyone, in the sense of being responsible for increased costs and for delays in the rendering of care.

cc) Emergent risks of parental incompetence

When one thinks of the systems to protect childhood, the norm is to proceed in the best interests of the child, although the system still resists in issuing an operative definition, which might be understandable as not even worth trying, as each case is unique.

What is not the norm is to try to defend the best interests of a child which has not been born yet or which is not even conceived ⁽³⁷⁾; the chances of the law intervening to protect *concepturi* are few ⁽³⁸⁾. This consideration of offspring not yet conceived is also found within the sphere of reproductive medicine ⁽³⁹⁾, where doctors can predict the risks for the

⁽³⁷⁾ Legal protection of the conceived unborn is already relatively frequent. After all, the question over abortion arises from the search for a level of protection of the fetus which can be accepted by the community; the question of indemnification for harm suffered during pregnancy, normally due to unexpected effects of drugs, is another familiar issue; moreover it is common to add a small set of favourable inherited effects for the fetus, such as passive succession capacity, that is, the capacity to be called to succeed even prior to birth; lastly, it is known that the general rule is that parents represent the children, "even when unborn",... art. 1878.º, No. 1, CCiv.

Perhaps this is the moment to begin a discussion parallel to that which is taking place regarding the protection of future generations.

⁽³⁸⁾ I mention only passive succession capacity in testamentary and contractual succession, and the protection dispensed towards the goods, of children that a determinate person might have (art. 2033.º, n.º 2, and 2240.º, n.º 1, CCiv); and also the extension of the inhibition of parental responsibility towards children that the inhibited parents might have, when the inhibition falls upon all the children and the court does not give a contrary judgement (art. 1915.º, n.º 3 CCiv).

⁽³⁹⁾ The deontological code of doctors in Portugal recommends "... the consideration not just of the desire of the candidate parents, but above all of the interests of the future human being that may come to be conceived" (art. 62)

⁽³⁶⁾ João LOUREIRO, *Constituição e Biomedicina*, cit., p. 301.

children and refuse access to treatment to couples who reveal serious parental incompetence.

As far as I know, this topic has been largely ignored by jurists, although the first great affirmation of the defense of the welfare of the child not yet conceived can be found in the law about Human Fertilisation and Embriology in the United Kingdom, from 1990. Actually, the law determines that "no woman should receive treatment unless the welfare of the child to be born as a result of such treatment has been guaranteed (...) ⁽⁴⁰⁾. In addition, the law determines that the regulating authority issues a code of conduct which helps health units to assess the welfare of the unborn child ⁽⁴¹⁾.

After confirming appearances through inquiries and routine interviews, it was established as a practice to refuse access to treatment for couples who reveal absence of child-rearing ability and who put at risk the welfare of the new born child ⁽⁴²⁾. The typical situations which lead to the presumption of the inability to take care of the child are psychological instability of the couple, psychiatric disorders, drug abuse, a record of sexual abuse, domestic violence, and removal of parental responsibility regarding the other children. ⁽⁴³⁾. And one could add extreme

ignorance of all the acts of childrearing which would be indispensable in the event of having a child, or the couple's extreme poverty, which would not guarantee basic care to the future child.

The main reason which justifies this attitude of doctors is the feeling of being responsible for the birth ⁽⁴⁴⁾. Doctors do not want to bear responsibility for an expected and serious risk that the newborn baby is likely to run. And when they are made aware that many newborn babies conceived without medical assistance run the same risks, doctors state that they do not intervene in such births, they are not accountable or responsible for those children; in the present cases they intervene, and therefore feel responsible ⁽⁴⁵⁾.

However, despite such understanding of how doctors wish to prevent the newborn from suffering, this exclusion of couples based upon their parental incompetence is surprising from the legal point of view.

In fact, this exclusion of access leads to total restriction of a variety of fundamental rights — the right to personality development, to procreation, to forming a family. There is no doubt that fundamental rights allow restrictions, but they have to be enforced by a diploma that carries the force of law, which foresees the restrictions in a necessary, adequate and proportional way.

⁽⁴⁰⁾ "Par. 13. (5) A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth".

⁽⁴¹⁾ Par. 25, (1) and (2). The code of conduct was updated in 2013 — cfr. <http://www.hfea.gov.uk/402.htm>

⁽⁴²⁾ Apparently, the cases are widely known in Europe and The United States of America, where the scientific communities seek a common orientation — cfr. ASRM, *Child-rearing ability and the provision of fertility services: a committee opinion*, in «Fertility and Sterility» vol. 100, n° 1, July 2013, p. 50-53; ESHRE Task Force on Ethics and Law 13: *The welfare of the child in medically assisted reproduction, 2007*

⁽⁴³⁾ *Id.* cit., p. 50-51.

⁽⁴⁴⁾ ASRM, *Child-rearing ability...* cit., p. 52.

⁽⁴⁵⁾ There are also doctors who manage to reduce their responsibility to technical aspects of birth, leaving the consideration of emotional and social risks to others. The ethics committee of the ASRM, however, in spite of considering this position legitimate, does not fail to add the limits of tolerance, measured in terms of serious risk to the newly born — cfr. ASRM, *Child-rearing ability...* p. 52.

It must be recognised that cases susceptible to restriction by medical services have never been defined, nor are there criteria for their predicted identification, despite all the recent efforts of scientific bodies ⁽⁴⁶⁾.

It should be added that doctors, when proceeding in this way of protecting the future child due to parents' inability, put themselves outside the universal legitimacy which is recognised of them, outside their typical interventions which are confined to the practice of the technical rules of their profession, to the *leges artis* of medicine.

On the other hand, the protection of children and young people, despite being the object of updated regulation, has never taken this problem into consideration, let alone confer upon health services and their doctors the necessary legitimacy and competence to restrict the access of couples to parentage. There are organs which have the competence to intervene, their intervention being regulated and, if doctors are considered "an entity with competence in childhood and youth", (art. 7.º da Lei n.º 147/99), their practice should never contradict the will of the family in question.

Also the system of protection refers only to children who are in danger under the conditions foreseen in art. 3 of the respective law ⁽⁴⁷⁾. Based on these norms, the consequence is that specifically protective intervention cannot be aimed at a specific

concepturus, not even to an already *conceptus* unborn baby ⁽⁴⁸⁾.

On the other hand, it has to be said that denying access to parentage can be accused of violating the fundamental right to equality (art. 13.º CREP) and of being therefore discriminatory. In fact, no couple is prevented from procreation without medical assistance; neither does law try to do so — also because that would be unviable — nor does it penalize the one who procreates, despite the existence of the worst conditions of life, in all respects, that surround pregnancy and birth ⁽⁴⁹⁾. This being the case, the restriction of access to incapable couples who seek assistance for procreation places them in a situation of inequality relative to equally incapable couples who do not require medical services. Perhaps it could be argued that the response of law against those incompetent couples who procreate without assistance — the inhibition of parental responsibilities and the search for an alternative family — is a worse solution than that which would be convenient: being prohibited from procreating. If this were the case, then it could be said that within the sphere of assisted procreation it is possible to obtain a better solution — the absence of birth — and this new technical possibility creates not only an enormous difference relative to the earlier reality but also legitimizes a different legal treatment, which is therefore not discriminatory. However, even

⁽⁴⁶⁾ Cfr. the documents cited in the American Society of Reproductive Medicine (ASRM) and the European Society of Human Reproduction and Embryology (ESHRE).

⁽⁴⁷⁾ Law No. 147 of 1999 of 1st of September, in Portugal.

⁽⁴⁸⁾ In practice, the protection of a pregnancy and of the fetus can only arise reflexively from the protection developed relative to other children of the pregnant woman.

⁽⁴⁹⁾ A response which differs from prohibition or penalization is the immediate protection of the child, through inhibition of parental responsibilities and through seeking an alternative family.

though all this is open to discussion, the problem is precisely this: it is open to discussion within the sphere of law, and, in spite of this, restrictions of access are being practiced.

In other words, this practice of European and North American reproductive medicine services develops outside of the legal system⁽⁵⁰⁾ and of traditional doctrines regarding the respect for, and realisation of, fundamental rights.

Having said that, some observations can be added that can be relevant to this discussion.

Firstly, the difference between private medicine and the public health system carries some weight. In spite of the limits that are imposed by the principle of equality and the struggle against discrimination, it is acceptable for each private medicine unit to make some choice in terms of their clients; such an option appears less justifiable in the public services, paid for by all contributors, including couples who may be rejected.

Secondly, there is a known principle and process by which the newly born are removed from biological parents who place them at risk from birth, with the typical consequence that they are given up for adoption. It could be asked why a course analogous with the issue at stake is not followed, in other words, rendering medical assistance and promoting the birth of the child, with the high probability of this child being sent to an alternative family. This clearly presupposes that reproductive medicine doctors easily accept adoption as an alternative family.

Thirdly, given that doctors assume the responsibility of denying birth when the couple reveal parental incompetence, it can always be asked whether they would be equally responsible to have issued a bad judgement about the progenitors' competence, in the hypothetical event of having rendered assistance to a birth when they should not have done so. Would the children, or other carers of these children, be able to seek damages for harm caused by birth in a situation of danger that had not been properly assessed?

Fourthly, it should be noted that protecting the welfare of future children and excluding birth in cases of poor prognosis leads to the concrete idea that it is better not to be born than to be born to such poor parents. This consideration already has a difficult history, in the similar cases of *wrongful life*.

It remains to take into consideration the possibility of invoking 'conscientious objection'. This recourse in extreme situations is expressly foreseen, in general, in the Constitution of the Portuguese Republic (art. 41, No. 6) and is traditionally applied to medical activity. Since 2009, this has the power of Regulation which approved the Deontological Code of Doctors foreseen by the Statute of the Council of Doctors and issued by the competent bodies. In addition to this, Law No. 32 of 2006 guarantees that doctors "cannot be obliged to collaborate in the realization of any medically assisted procreation techniques if, for ethical reasons, they believe they should not do so"; and also states that "the refusal of the professional should specify the clinical or other reasons which motivated the refusal, namely conscientious objection".

⁽⁵⁰⁾ Unlike in the UK, where the law foresees a framework for such decisions, which is considered sufficient.

Thus, if in cases of futile intervention or based on consideration of risks/benefits respect for *leges artis* can be sufficient to evaluate the lawfulness of abstaining from treatment, in these other cases, of alleged grave parental incompetence, invoking conscientious objection can be justified. It should be added, however, that this recourse should not be trivialised, nor should it diminish the constitutional rights of others. It cannot become a common response when faced with couples whose predictable parental behaviour is below common levels. In truth, this evaluation is not supported by objective and known criteria, which raises the possibility that a refusal comes close to being merely subjective arbitrariness. On the other hand, exercising conscientious objection cannot impede the exercising of fundamental rights, for which there cannot be generalised objections, which makes the rendering of medical assistance impossible; and it is for this reason that the deontological code does not permit the exercising of conscientious objection in cases where the patient cannot benefit from "assistance by an equally qualified doctor" (art. 41). In other words, in order for a doctor to invoke conscientious objection, it is necessary to confirm that there is an extreme case of grave parental incompetence, likely to cause evident and inevitable risk for the future child; it will be necessary to report the circumstances foreseen in art. 37, No. 2 of the deontological code; and the assistance of an available doctor must be guaranteed (No. 3).

Supposing that the practice of restricting access due to parental inability is not legitimate (except for cases of conscientious objection) — and previous to a juridical discussion that radically broadens the legitimacy and instruments to protect *concepturi* — it is my belief that doctors should not exclude couples alleging parental incompetence ⁽⁵¹⁾.

In spite of these statements, the following cannot be denied: there is a problem of protecting the child to be born; reproductive medicine doctors might know better than other services the real dimension of the risks; and there are cases in which law already restricts parental responsibilities regarding unborn children with the clear intent of protecting them. All this leads to predicting that, sooner or later, law has to intervene to control restrictions of access to parentage in reproductive medicine.

In the meantime, it is worth noting that, from a juridical point of view, the practice is strange and it is a paradox to avoid birth in order to protect... a patient that as yet does not exist.

⁽⁵¹⁾ It seems opportune to suggest that "entities with competence in the area of infancy and youth" and committees for the protection of children and youths at risk are expressly given powers to intervene in the cases of pregnant women which have been noted by the reproductive medical services, with the aim of advising mothers-to-be, preventing harm, or promoting the search for an alternative family in the event of having found evidence of poor prognosis. This extension of the committees' competence to the time before birth should not alter the nature of the intervention, that is to say, it should always be based on the consent of the interested parties. In other words, the ability to accompany the pregnancy should never involve sending the case to court, in the event of disagreement.