

M4

**Import and export of gametes and embryos**  
**Consultation meeting at Bioethics Centre, Otago University**  
**22 May 2013**

**Present**

Professor John McMillan, Director, Bioethics Centre  
Dr Lynley Anderson, Senior Lecturer, Bioethics Centre  
Dr Neil Pickering, Senior Lecturer, Bioethics Centre  
Dr Mike King, Lecturer, Bioethics Centre  
Professor Mark Henaghan, Faculty of Law  
Vicki Duell, Registrar at the Dunedin Family Court  
Dr John Angus, Chair of ACART  
Alison Douglass, member of ACART

**In attendance**

Betty-Ann Kelly, ACART Secretariat

*Note: The points listed below reflect comments by individuals and should not be taken as a consensus by meeting attendees.*

- The question of access to identifying information about donors needs to be considered in regard to any harm that arises from offspring not having such access.
- What arrangements, if any, are in place between New Zealand and Australian jurisdictions to enable the exchange of information about donors, where embryos or gametes are transported from one country to another?
- New Zealand has more control in regard to importing gametes and embryos than when gametes and embryos are exported.
- If ECART was to have the role of deciding import and export cases, clear rules rather than discretion would be the most useful approach.
- Why is money a problem in regard in this area? There doesn't appear to be a knockdown argument against commercial supply. [Neil Pickering provided a copy of a paper he has written for the Human Research Council on inducements in health research – paper is attached].
- However, not undermining broader public policy is also salient. The ethics associated with particular public policy positions are a secondary issue.
- A high level issue is whether imported material should be treated any differently to internally sourced material: are there relevant differences that justify different treatment? What we do here with locally sourced gametes and embryos should apply to imported gametes and embryos.
- If consistency is the issue, then other requirements in the statutory framework need to be taken into account.



# Ethics Notes

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Health Research Council of New Zealand

Te Kaunihera Rangahau Hauora o Aotearoa

## Inducements, autonomy and justice

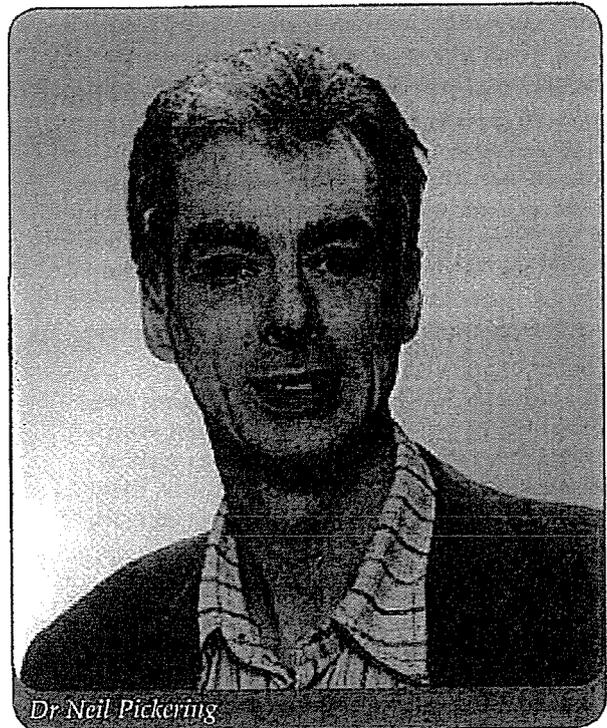
By Dr Neil Pickering, HRC Ethics Committee member

This short article, considers the various New Zealand guidelines relating to inducement in health research. In particular, I am concerned to unearth the ethical problem which the relevant parts of the guidelines seem designed to address. At the end I offer an analysis which raises questions about the ethical problem which has been brought to light. I do not endorse this analysis, but offer it for discussion.

In various health research guidelines in New Zealand there is an apparent disagreement about the definition of inducement. In the Operational Standard<sup>1</sup> (OS) the definition of inducement is "a payment ... large enough or service provided extensive enough to persuade prospective participants to consent to participate in research against their better judgement". Inducement finds its place between 'coercion ... and intimidation' – not a good crew to be a member of. But other guidelines, including the HRC's *Guidelines on Ethics in Health Research*<sup>2</sup>, and the NEAC *Ethical Guidelines for Intervention Studies*<sup>3</sup> (and appendices 5 and 7 of the OS) speak of 'undue' and 'inappropriate' inducement. This seems to imply that there are levels of inducement which are 'due' or 'appropriate'. The difference between the OS main text and the other guidelines, then, is that in the former 'inducement' is necessarily a bad thing, but in the latter, it may or may not be.

Inducement, whether it is 'undue' by definition or not, is an offer made to make someone better off (relative to some baseline) if they'll do what the person offering the inducement wants.<sup>4</sup> (This is in contrast to 'coercion', which is the threat to make someone worse off if they don't do what the coercer wants.) We can infer two things about inducements from this, relevant to participation in health research. First, that inducements are intended to influence minds – that indeed is their point (Wertheimer and other commentators<sup>5</sup> see inducements as a form of the exercise of power, or of the application of pressure). Second, inducements are introduced into a situation by the inducer, who is thereby and therefore trying to exercise control.

In the various guidelines, at least two reasons are offered for judging that inducements are wrong.



Dr Neil Pickering

The HRC guidelines suggest that the problem with inducement lies in its undermining voluntariness. Voluntariness is a criterion for informed consent; and so inducements undermine informed consent. The Ethical Guidelines for Intervention Studies and the OS (in its appendices) suggest that the problem with inducement lies in its leading to people consenting to research 'against their better judgement'. These may well not be exclusive considerations, but it is worth considering each separately.

(Continued on page 3)

(Continued from page 1)

The issue with the impact of inducements on voluntariness is related, in the HRC guidelines, to influence (e.g. the influence of financial award) and to the dependency or vulnerability of the groups at whom the inducements are aimed. These two issues may be connected, for the influence that an inducement may have will presumably be related to the size of the inducement, but the size of an inducement is not merely its dollar or other 'objective' value, but the extent to which it is needed or desired by the person to whom the inducement is offered. Thus a group which is socio-economically deprived may be more influenced by a \$500 offer to take part in research than a group which is socio-economically better off. In terms of the underlying values identified in the NEAC documents, this is an issue of justice in the distribution of burdens – in this case, for example, the risks which participating in health research may occasion. The inducement may be thought to cause a mal-distribution of these burdens.

The issue with people consenting to research 'against their better judgement' seems to be exemplified by the fact that inducement is the sort of thing which gets people to take a risk they would not otherwise have taken. If a person would not have participated in the research without the influence of the inducement, it is inferred that this reflects the person's 'better judgement', presumably just because it represents their judgement in its uninfluenced state.

The upshot of all this is that undue inducements are regarded as untoward influences on choices which should be based on other sorts of considerations. What these considerations are is not specified, but they include such things as balance of risk against benefit, and so on.

Now I want briefly to offer a rather different analysis of this ethical appraisal of inducement, for the sake of argument. The analysis is that in the various guidelines a measure of paternalism has been introduced into the picture. In short, it may be suggested that implicit in the guidelines is that people should not *allow* inducements to influence them. The OS says that "where a research procedure involves serious discomfort and/or the real, though slight, possibility of serious harm ... one can easily imagine that the motivation of persons who volunteer to participate may be monetary". But the analysis I'm describing asks: what is wrong with monetary motivations? Why should people not be allowed to take them into account in their decision making? In this analysis of the guidelines, the concern to protect people from the influence of inducement is pictured as a meddling in the sorts of considerations they may take into account. This analysis does not

claim this is the intention of the guidelines, but that it may be their effect.

Interestingly both approaches to inducement can be seen as being concerned to promote autonomy and reduce injustice. The various New Zealand guidelines can reasonably be said to be concerned to protect people's autonomy from undue influences such as inducements which may also tend to play on the vulnerabilities of certain populations. On the alternative analysis, the current New Zealand Guidelines appear to reduce autonomy by restricting choice, and to use the perceived vulnerability of some populations to inducements as a rationale for doing so.

*Dr Neil Pickering is a senior lecturer in the Bioethics Centre at the University of Otago. He is a member of the HRC's Ethics Committee, and has also served on the University of Otago's Human Research Ethics Committee. He is the author of a number of articles on research ethics, and co-convenes a post-graduate paper in Health Research Ethics taught at the University of Otago.*

#### References

1. New Zealand Ministry of Health (2002) *Operational Standard for Ethics Committees* Wellington, Ministry of Health
2. Health Research Council of New Zealand (Revised 2005) *Guidelines on Ethics in Health Research* Auckland, Health Research Council
3. National Ethics Advisory Committee (2009) *Ethical Guidelines for Intervention Studies* Wellington, Ministry of Health
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5. Lidz, CW, Mulvey, EP, Hoge, SK, Kirsch, BL, Monahan, J, Eisenberg, M, et al. (1998) Factual sources of psychiatric patients' perceptions of coercion in the hospital admission process. *Am J Psychiatry* 155: 1254-60

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