

Chapter 9

Reproductive Medicine and Medical Tourism

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ABSTRACT

Reproductive medicine is practiced in a distinctive environment. This environment is shaped by the rapid pace of medical advancement, and the fact that reproductive medical tourism tends to involve third parties. There are many unresolved problems and a need for guidelines to advance proper medical practice. There are also differences in historical, political, religious, and social environments in the destinations involved in reproductive medical tourism. These generate problems relating to the rights and welfare of both patients and children. This chapter discusses these and other problems concerning differences in legal regimes, and discrepancies between the treatment received in the destination country and that provided after returning home. Most significantly, the problems are accompanied by a failure to acknowledge the paramount importance of the rights not only of patients, but also of unborn children. To engage in reproductive medical tourism without regard for these rights is not permissible.

INTRODUCTION

The foundations for medical tourism in the field of reproductive medicine in Japan were laid in 1949 by Keio University's success with *Artificial Insemination with Donor Sperm* (AID). It is said that Keio University used sperm donated by students to conduct artificial insemination in order to produce children for returned servicemen, who had become infertile after contracting malaria and other infectious diseases while serving in Japan's campaigns in Southeast Asia. This technology continues to yield around 200 births each year in Japan, and the cumulative total is estimated at between 15,000 and 20,000. In practice, however, the use of AID is a confidential arrangement between the patient couple and their doctor, one which in vast majority of cases is never revealed even to the child.

The most revolutionary advancement in reproductive medicine came in 1978, when the first successful in vitro fertilization and embryo transfer was performed. This new technique was swiftly adopted across the globe, and was first performed successfully in Japan in 1983. With the subsequent success

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in micro-insemination in 1992, it became possible to create a child with just one sperm, one egg, and a uterus. People who previously had no prospect of producing a child now had choices that gave them hope. These dramatic advancements opened up possibilities for reproductive treatments in combinations hitherto unimaginable, employing any number of different techniques. Reproductive and fertility treatments that were previously impossible now came within reach, if patients were prepared to travel to where they were offered.

Reproductive medicine, however, differs in many respects from other forms of medicine, and in the context of medical tourism poses many problems not encountered elsewhere. This chapter begins by outlining the distinctive features of reproductive medicine. This is followed by a discussion, based mainly on a review of the existing literature, of conditions in several different countries and the resultant characteristics and problems these countries face in the medical tourism field. Drawing on this review, the chapter identifies some essential problems and issues concerning reproductive medicine for those people prepared to travel in order to achieve their goal of having children.

REPRODUCTIVE MEDICINE: AN OVERVIEW

Japan is one of the world's most advanced countries in the field of reproductive medicine. Around 580 clinics offering *Assisted Reproductive Technology* (hereinafter ART - used here in its basic sense as referring to in-vitro fertilization and micro-insemination. Note however, that some other studies use this term also to encompass *Artificial Insemination with Husband Sperm* or AIH) are currently registered with the Japan Society of Obstetrics and Gynecology (JSOG). This is an exceptionally large number when compared, for example, with the 451 registered clinics in the United States as of 2011 (Centers for Disease Control and Prevention, 2011), and the combined total of 1,005 clinics across the 34 countries of Europe as of 2009 (Ferraretti, Goossens, Kupka, Bhattacharya, de Mouzon, Castilla, Erb, Korsak, & Nyboe-Andersen, 2013)

Japan also outstrips the U.S. and Europe in terms of the number of ART procedures performed: 269,659 in 2011, as against 151,923 in the U.S. and 537,463 (or 15,307 per country) in the 34 EU countries. The number of children born through ART in Japan in 2011 was 32,426, or 3.1% of the country's 1.05 million annual births (Japan Society of Obstetrics and Gynecology, 2012). It is inferred from these figures that births involving some kind of fertility treatment, whether ART or otherwise, account for at least 10% of all births in Japan. Furthermore, embryo freezing technology in Japan is several years more advanced than in the West. Today, more children are actually born through the thawing and transfer of frozen embryos than through the conventional techniques of in vitro fertilization and embryo transfer.

Although Japan is thought to be a world leader in reproductive medicine, there are inevitably some cases where success is not possible due to a complete absence of eggs, sperm, and uterus. In those cases, reproductive treatments involving third parties are required. Usually, the practice of such treatments is informed by legislation and administrative guidelines, religious beliefs, ethical considerations, and specific social and economic contexts. In Japan, however, there is no such legal framework, and medical practice in this area is steered only by guidelines issued by JSOG.

Table 1 shows the historical process by which third-party reproductive medicine developed in Japan. There is no legislative provision in Japan for ART: the JSOG guidelines are the only substantive form of regulation. Clinics offering ART register with JSOG and are obliged to lodge annual reports on the treatments they provide. In 2013-14 there were around 580 registered clinics nationwide, and almost all

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