Special Section: Bioethics Beyond Borders

Damaging the Future

The Health Rights of Children and the Issue of Short-Termism; Issues Facing Australian Bioethicists

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Abstract: This article considers recent ethical topics in Australia relating to the health rights of children in the contexts of (1) detention centers, (2) vaccination, and (3) procreative liberty, within a wider framework of discussion of the competing rights of society, parents, the child, and future generations.

Keywords: Australia; detention centers; children's health rights; vaccinations; procreative liberty

The most common—in the sense of widely discussed in mainstream media—health policy issue in Australia in 2017 continues to be that of assisted dying, with bills going forward in three of Australia's eight regions in May and in August.[1] A second topic, albeit one that has received less attention as a result of information restrictions, has been that of the role of health practitioners in treating asylum seekers. The human rights context to keeping asylum seekers in detention for lengthy periods with limited resources to monitor their health raises not only the issue of whether practitioners are contributing to harm by operating within such centers, but also a broader topic. This is: how, or indeed whether, bioethics should be reconceptualized so that "engaging with the political" is seen as a task for health practitioners and bioethicists.[2] The wider (and not new) argument is of whether "public health is inherently political" because "like any other resource or commodity…some social groups have more of it than others…(and) its social determinants are amenable to political interventions and thereby dependent on political action (or more usually, inaction)."[3]

The issue of the Australian government's alleged violation of the rights of asylum seekers is a broader one than this article can admit, but the 2015 report by the United Nations' special *rapporteur* on torture, Juan Mendez,[4] and *The Guardian Australia's* exposé in January 2016 of healthcare issues in detention centers, for example, depicted places designed to "damage," given high levels of mental health illness and delays in treatment for both physical and mental health issues.[5] (In the latter context, such delays have led to death). Australia's treatment of asylum seekers violates their health rights.[6] Should health practitioners—particularly given that they cannot report on what they have witnessed—operate in such centers, or by so doing, are they in fact complicit in a form of torture?[7] A 2016 article argued that health practitioners breach the principle of "do no harm" through inaction and silence, and that it is their duty to bring "the evidence base of right to health (and other inter-related rights) violations to the attention of the Australian public."[8]

The firm International Health and Medical Services (IHMS), contracted by Australia to provide healthcare services in detention centers, has been criticized

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for shortfalls in provision,[9] as well as for allegedly relying on strong sedative and antipsychotic medication—for children as well as adults—to address mental health issues.[10] Gillian Triggs, the former Australian Human rights Commissioner whose 2014 report *The Forgotten Children: National Inquiry into Children in Immigration Detention* received harsh governmental criticism, has noted that: "Australia is unique in its treatment of asylum seeker children. No other country mandates the closed and indefinite detention of children when they arrive on our shores. Unlike all other common law countries, Australia has no constitutional or legislative Bill of Rights to enable our courts to protect children."[11]

The Australian Medical Association (AMA) held a forum, *The Health Care of Asylum Seekers and the Harms caused by Immigration Detention, Especially for Children* in 2016 to discuss precisely the issue of health policy for refugees in detention.[12]

A 9-year-old asylum seeker who was held in immigration detention was awarded a settlement by the immigration department in May 2017 over claims that her physical and mental health deteriorated in her 12 months at the Christmas Island Centre.[13]

The rights of incarcerated children have also been under the spotlight in the context of ongoing public outrage following a 2016 television exposé on the treatment of indigenous juveniles at Don Dale Detention Centre in the Northern Territory (NT). Indigenous children are 26 times more likely to be in detention than non-indigenous children,[14] some areas of Australia showing even higher percentages: 97 percent of children in juvenile detention centers in the NT are indigenous, for example.[15] The use of restraints, tear gas, and spit hoods on juveniles has been reported, and the ongoing Royal Commission into the Protection and Detention of Children in the NT, which will table its findings on September 30, 2107,[16] has noted more than 50 percent of indigenous children under the age of 10 coming under protection notices.[17] Such a burden on health services requires a major reevaluation of the state's health policy.

A further issue relating to children concerns the Australian government's approach to immunization. In 2015, Australia removed welfare and tax benefits from parents refusing to vaccinate, and in 2017 has pushed for a consistent national policy to ensure that all states adhere to laws on unvaccinated children being banned from childcare centers. The ongoing debate has been between those who argue that this is an excessive governmental intrusion into family autonomy, and those who note the potentially fatal consequences for children, suggesting that those who opt out might bear some moral responsibility for the deaths of children infected by their own unvaccinated offspring.[18] The debate continues to flare up occasionally with controversy around the screening in Australia of the 2016 film *Vaxxed: From Cover-Up to Catastrophe*, for example, and the August 2017 enquiry into physicians allegedly assisting parents to gain vaccination exemption.

Finally, and to be explored at greater length in this article, one further ethical debate relating to children has derived from the decision by Australia's National Health and Medical Research Council (NHMRC) on April 20, 2017, not to allow parents to choose the gender of their baby.[19] The NHMRC's working committee, the Australian Health Ethics Committee (AHEC), had recommended condoning sex selection in certain circumstances. The NHMR's response however was that this sociopolitical issue requires more investigation, and, therefore, current regulations will continue to apply until such time as wider public

debate occurs and/or state and territory legislation addresses the practice.[20] Australian society needs to be ready both socially and politically for such a change.[21]

NHMRC guidelines already permit sex selection using preimplantation genetic diagnosis (PGD) to avoid the risk of transmitting serious genetic conditions, hemophilia and muscular dystrophy, for example.[22] Section 8.13 of the current Assisted Reproductive Technology (ART) Australian guidelines offer succinct regulations for such decisions.

Where the report becomes more ambivalent is on non-health-motivated sex selection (nonmedical selection). [23]

The AHEC report argued for widening options for nonmedical sex selection on the basis of:

- The potential for smaller families (in this following the United Nations Population Fund's view that "local fertility restrictions and spontaneous rapid fertility decline below replacement levels tend to compel parents who want both a son and a small family size to resort to sex selection")[24]
- Avoiding patients seeking sex selection overseas (the NHMRC guidelines acknowledge potential risks to the child through parents utilizing lower standards of care abroad as "reproductive tourists")
- Respect for patient autonomy and reproductive choice
- Increased procreative rights may diminish selective abortion

The NHMRC report, in conclusion, noted the following issues:

1) Increased health risks to women and to the child through ART
2) Resourcing
3) The social issue of whether sex selection might validate or reinforce gender stereotyping and discriminatory attitudes, following the World Health Organization (WHO)'s ruling that the practice of sex selection will distort the natural sex ratio leading to a gender imbalance, and reinforce discriminatory and sexist stereotypes toward women by devaluing females[25]
4) And finally, the "slippery slope" argument: that sex selection for nonmedical reasons might lead to enhanced, or "designer," babies, adjusted for characteristics such as eye or hair color

The report acknowledged that ethically, the distinction between "a desire to introduce variety to the existing sex ratio of offspring within a family and the desire to design the sex of the offspring based on the preferential selection of a particular sex due to an individual's or couple's cultural or personal bias, influences or desires" is not always clear.[26] The report therefore includes AHEC's suggestion of case-by-case regulation, whereby nonmedical sex selection, if based on "introducing variety to the sibship" as opposed to being based on "family design" is allowed only when the couple already have more than one child (including adopted children) of the same sex.[27]

Of the four points noted by the report, one can take issue with each. Julian Savulescu has argued for example on point 1 that abortion or female infanticide and its accompanying health risks, in the attempt to have the "right" sex,

might be seen as a greater evil than allowing parents to select for male offspring.[28]

Funding issues and the "slippery slope argument" are less significant than the idea of gender bias validation. On the first, given that nonmedical sex selection can be privately funded, if parents were to claim inequity in access to medical resources for the procedure, it would have to, presumably, be on the basis of deprivation of a service provided for those parents' better mental health or that of their already existing children, an argument that hardly seems likely. On the second, the "slippery slope" argument, the argument is not particularly useful, as it is feasible to legislate for one aspect of selection and ban others.

The most interesting is perhaps the social issue of whether sex selection is unethical by virtue of being discriminatory. This is where the issue of whether the child's right to flourish is best served by what the parents want becomes a rather complex matter. The parents' desire for a particular sex theoretically implies a child more likely to be validated by its parents and, therefore, more likely to flourish; here we might come to Julian Savulescu's argument of "procreative beneficence," in terms of which one selects the best traits for the child to have the "best" life.[29] However that relates to the best life within the family, within which the argument for sex selection to improve diversity might apply. What about the "best" life in terms of social norms?

Should parents forgo their own right to optimize their child's chances in a society that currently preferences the male gender in order to promote a future benefit? Are individual rights more important than species rights? Refusing nonmedical sex selection on the basis that the more important principle is that of promoting an ungendered society, rather than the principle of the rights of the parent, would be seen as an infringement of parental autonomy.

Should we, however, form an ethical regulation in the current day based on a praiseworthy future aim? This is the opposite end of the spectrum to Savulescu's pragmatic approach of allowing nonmedical sex selection as the lesser evil to aborting female embryos. Savulescu's argument has been countermanded by Rebecca Bennet, who does not see that the argument for procreative beneficence expresses a genuine moral obligation.[30] More usefully, Peter Herrisone-Kelly has argued that sex selection for nonmedical reasons is "incompatible with a proper parental love: that is, with the sort of love that a parent ought to have for her child or, equivalently, with the sort of love that someone accurately describable as a good parent will have for her child."[31] Parental love is an aspect of valuing human dignity, just as not selecting sex is; both make no assumptions about the "better life" based on whether one gender flourishes more than another, but suggest that the child will autonomously find whatever form of the "good life" that child defines as such. In short, a good life for a lower-earning woman who faces discrimination may in fact lie in her sense of the righteous battle that gives her meaning. It all depends on how one defines the "better life." Savulescu has conceded that in many cases there will simply be no answer to the question as to which of two children has better life prospects at birth.[32]

As Sparrow argues, there are three interests in conflict here; those of the child, the parents, and the "world."[33] Herrisone-Kelly, examining the "external and internal ideologies whereby a parent might decide what is the 'better life'

for a child," also reminds us of Derek Parfit's discussion of the depletion model relating to the ethics of exhausting resources in the present day to the detriment of future generations.[34] How much, ethically speaking, does one owe the future?

Seen in a different context, does incarcerating children not indicate the severe consequences of preferring a short-term solution to a problem perceived by the Australian government over future social benefit? Short-term solutions to health policy issues relating to detention will have an enormous impact on resourcing, given the numbers of those damaged by childhood detention who will need considerable support in the future.

David DeGrazia argues that our obligations to future generations are a matter of justice, and that future persons' interests should not be discounted (as some economists suggest) on account of their temporal distance from us.[35] Yet as Jonas has noted, traditional ethics delimits moral concerns to the community of *contemporary human beings*. Nature and future humanity are not included within its horizon.[36] Perhaps one of the greatest harms children face today is that of policymakers' inability to think beyond the current crisis.

Notes

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8. See note 6, *Durham et al. 2016*.
9. Two agencies, International Health and Medical Services (IHMS) and the Offshore Service for Survivors of Torture (OSSTT), provide mental health services for refugees and asylum seekers under contracts with the Australian government.
10. *Submission by Human Rights Watch On the Situation in Australia To the Committee on Economic, Social and Cultural Rights,* 61st Plenary Session May 2017; available at https://www.hrw.org/sites/default/files/supporting_resources/human_rights_watch_submission_on_australia_to_cescr_may_2017.pdf (last accessed 22 Aug 2017).
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21. Currie J. Australia ART guidelines oppose baby sex selection. April 24, 2017; available at http://www.bionews.org.uk/page_823669.asp (last accessed 22 Aug 2017).
22. Preimplantation genetic diagnosis (PGD) for nonmedical sex selection is prohibited in the United Kingdom, Australia, Canada, China, and India. The United States allows the practice, as do Italy, Mexico, and Thailand. In Australia in 2017, only four of the eight Australian states and territories had legislation regulating the clinical practice of ART, with sex selection for nonmedical purposes prohibited in two Australian states.
23. Although there are methods other than ART—such as the Shetlles or Whelan methods of timed intercourse—for sex selection, there is no consistent scientific evidence to indicate that such methods are effective. The two major approaches are in vitro fertilization with preimplantation genetic diagnosis (IVF with PGD), in which embryos created in the laboratory are analyzed for male or female chromosomes and implanted accordingly, and sperm sorting, in which separation of the X and Y sperm concentrates the sample to the desired gender.
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