Cross-border reproductive care: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

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Cross-border reproductive care (CBRC) is a growing worldwide phenomenon, raising questions about why assisted reproductive technology (ART) patients travel abroad, what harms and benefits may result, and what duties health-care providers may have in advising and treating patients who travel for reproductive services. Cross-border care offers benefits and poses harms to ART stakeholders, including patients, offspring, providers, gamete donors, gestational carriers, and local populations in destination countries. This document replaces the previous document of the same name, last published in 2013 (Fertil Steril 2013;100:645–50). (Fertil Steril® 2016;106:1627–33. ©2016 by American Society for Reproductive Medicine.)

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KEY POINTS

- Cross-border reproductive care (CBRC) refers to the activity surrounding patients who travel outside their country of domicile to seek assisted reproductive services and treatment. CBRC affects both the departure and destination countries from and to which patients travel.
- CBRC is a growing worldwide phenomenon, raising questions about why assisted reproductive technology (ART) patients travel to another country, what benefits and harms may result, and what duties physicians may have in advising and treating these patients.
- The main reasons cited by patients for CBRC are a desire to access broader and higher quality care, a need to reduce the cost of care, an effort to circumvent legal restrictions in a departure country, and a desire for privacy or cultural comfort in a destination country.
- Cross-border care offers benefits and poses potential harms to ART stakeholders, including patients, offspring, providers, gamete donors, gestational carriers, and local populations in destination countries.
- Physicians in departure countries have no independent duty to inform patients about opportunities for CBRC but must not misinform patients when responding to questions about ART options abroad.
- Physicians in destination countries have a duty to uphold local standards of care, legal requirements, and informed consent but have no duty to learn about or disclose the legal, practical, and other nonmedical barriers a patient might face in accessing CBRC.
- Patients considering CBRC should seek out advice from qualified legal experts who can provide guidance on legal aspects of such activity, both in the destination country and upon their return to the departure country.
- Referral to other qualified experts, including mental health professionals, should be considered and is encouraged when appropriate.

Infertility knows no political boundaries, but prevailing policies, costs, and laws within an individual's country of domicile can hamper access to treatment. These formal and informal country-based restrictions on access to ART do little to temper their citizens' desire for biologic parenthood. Increasingly, prospective parents from around the globe who face reduced access to fertility care at home are traveling across national borders to seek ART treatment. This practice, commonly referred to as CBRC, has significant implications for stakeholders in both departure and destination countries. What follows is a discussion of the incidence and reasons for CBRC, its potential benefits and harms, and the ethical considerations that arise in treating or advising patients who leave home to access assisted reproductive care.

THE INCIDENCE OF CBRC

Comprehensive data on the worldwide incidence of CBRC are emerging as researchers, professional organizations, and patient groups delve into the question of who travels to access reproductive care and why. In a 2010 survey of CBRC in Europe, researchers counted

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24,000–30,000 cycles of cross-border treatment annually, involving 11,000–14,000 patients (1, 2). Based on a total of 525,640 treatment cycles during the same period, this means that approximately 5% of all European fertility care involves cross-border travel (3).

Survey data from the United States indicate that 4% of all fertility treatment provided in the country, or approximately 6,000 cycles, is delivered to non-US domiciliaries (2, 4). The largest groups of incoming patients are from Latin America (39%) and Europe (25%). The incidence of US patients traveling abroad for care is estimated to be far lower than the rate of patients coming into the United States (2, 5).

Researchers caution that the volume of CBRC activity is difficult to estimate accurately given the lack of a robust international reporting system (6). Logically, it is easier to collect data in destination countries and regions that maintain ART databases in which a patient's country of origin is included as a variable. Identifying those who leave home to access care requires either high patient response rates to posted surveys or elaborate tracing through multiple foreign ART databases. To date, a precise accounting of global ART travel remains a goal rather than a reality.

THE REASONS FOR CBRC

The factors that motivate patients to travel abroad for fertility care are varied, complex, and often interrelated. The reasons for CBRC fall into four basic categories: 1) access; 2) cost; 3) regulation; and 4) privacy. Each is described briefly below.

Travel to Access Broader and Higher Quality Care

A patient's ability to access fertility care in his or her country of domicile depends upon the supply of ART services, the quality of care offered, the array of treatment options available, and the wait time associated with obtaining care. Survey data suggest that each of these factors plays a role in motivating cross-border fertility travel, particularly in the Middle East, Southeast Asia, and Latin America where ART clinics are sparse (6).

Travel is also more prevalent from departure countries where the supply of donor gametes and gestational services is low (compared with demand), owing primarily to regulatory, compensatory, and/or anonymity policies. Countries that restrict payments to gamete donors and gestational carriers see the majority of their fertility travelers leaving to access these services across borders (5, 7). National policies that require disclosure of donor identity also impact the availability of donor gametes, and hence factor into fertility travel. Patients in Sweden, the United Kingdom, and Norway, for example, report the desire for access to anonymous gamete donors as a factor in their decision to seek care abroad (1, 8). In Canada, 80% of women who travel for ART do so in search of anonymous donor eggs (5).

Patients' desire to access higher quality care also figures prominently in CBRC. A majority of patients who travel abroad for care have received treatment in their home country, often for several years. Treatment failures, along with a perception that clinics abroad employ more highly trained personnel, utilize more up-to-date equipment, and offer more specialized services, incentivize experienced ART patients to seek treatment abroad (7–9). Finally, patients travel to avoid long wait times—a reality in countries that include infertility care as part of their national health service (9, 10).

Travel to Reduce the Cost of Fertility Care

The high cost of ART is a well-described barrier to its use. Because fertility treatment can be prohibitively expensive, it is utilized by only a fraction of those in need of care (11). Even patients who can afford care often incur financial hardship in their quest for parenthood (12). Global price variations are published, with the average price of an in vitro fertilization (IVF) cycle highest in the United States (13) and significantly lower in countries such as India (14, 15). The fiscal impact of ART on patients varies across the globe; patients in countries that fund care as part of a national health service are impacted the least while those in non-reimbursement countries are impacted the most, sometimes incurring lasting financial harm (11, 16).

Disparities in the fees paid to gamete donors and gestational carriers also incentivize travel. Media reports indicate that India has been a popular destination country for accessing gestational surrogacy services due to significantly lower compensation amounts (17). Fees to oocyte donors also vary considerably from country to country (1). Surveys of patients who travel to access third-party reproductive services indicate that cost is a significant factor in their decision to leave home (1, 2).

Travel to Circumvent ART Law

Legal regulation of ART worldwide occurs on a country-by-country basis, with no overarching international treaties or formal laws in place. Logically and empirically, jurisdictions with restrictive laws are more likely to serve as departure countries, while nations with few or no legal restrictions are patronized as destination countries. The act of seeking fertility care outside of one's country of residence to avoid application of prevailing law is sometimes referred to as "circumvention tourism" (18, 19).

ART regulation that motivates CBRC falls into two broad categories: 1) restrictions on who can access fertility care and 2) restrictions on what fertility care can be accessed. Laws addressing "who" typically restrict access based on patient demographics. Restrictions on patient age, marital status, and sexual orientation are embedded in law in some countries, sending older, single, and gay and lesbian patients across national borders. By contrast, in some US states, strict nondiscrimination laws prohibit ART clinics from denying care on the basis of a host of demographic factors, including race, ethnicity, disability, and marital status, sexual orientation, and gender identity (20, 21).

Legal restrictions on "what" services can be offered do little to quash patient desire for these services. Prohibitions on ART services, including preimplantation genetic diagnosis (PGD), sex selection, compensated gamete donation, and

compensated gestational surrogacy exist in some jurisdictions and prompt fertility travel. It is argued that bans on certain treatments express a country's core values, but skepticism arises when patients who return after receiving "prohibited" treatments face no legal, medical, or social consequences, likely contributing to continued travel to avoid restrictive laws in a patient's home jurisdiction (22, 23). At the same time, there is little or no support for punishing patients who engage in law evasion in pursuit of biologic parenthood; nor is there widespread advocacy for penalizing physicians who assist patients in their quest to access CBRC, though laws in a handful of countries do deem such conduct unlawful (12, 24).

Travel for Privacy and Cultural Comfort

The physical, psychological, emotional, and financial burdens that infertility can engender lead some patients to seek treatment abroad. Often these patients will patronize a country in which they have extended family or possess a degree of cultural familiarity. A desire for privacy as well as increasingly easy access to international travel are cited by patients as factors in their decision to seek treatment abroad (2). Family connections, cultural comfort, and access to racial and ethnic-matched donor gametes also play a role in CBRC (7).

The growing data surrounding CBRC confirm that patient motivations for fertility travel are diverse. At the same time, retrospective literature reviews conclude that patient levels of satisfaction with CBRC and its outcomes are generally high (25).

POTENTIAL BENEFITS OF CBRC

Fertility travel can potentially benefit patients and their partners, offspring, ART providers, gamete donors and gestational carriers, and local populations in destination countries. Benefits to ART stakeholders flow from the five main factors that motivate cross-border care: improved access, reduced cost, circumvention of legal restrictions or avoidance of discrimination, enhanced revenue streams, and protection of privacy.

Improving Access to Care

Emerging data tracking CBRC suggest that tens of thousands of patients annually are accessing care abroad (1, 2). A reasonable, but unproven, assumption about these data is that but for CBRC these patients would forego care, or in some cases further care, in their home country. This presumed net increase in worldwide utilization of ART is a benefit to patients and their partners, especially those whose treatment yields a successful outcome.

On a more philosophical level, arguably access to cross-national care is a benefit to the offspring who would not have been born without the foreign treatment. Relatedly, both patients and offspring may be better off by the availability of higher quality care, offered earlier in the patient's life, increasing the chances of a healthier outcome for all.

Improved access to donor gametes and gestational services is also an overall benefit of CBRC. Third-party participants, particularly oocyte donors, play an increasingly important role in ART, boosting success rates to over 55% in US cycles (4). In countries with legislation limiting payment for oocyte donation, utilization of donor oocytes is very low (e.g., 3% of all United Kingdom cycles compared with 12% in the United States) (26). Improving access to donor oocytes improves success rates, thus benefiting those who travel to procure donor gametes.

Reducing the Costs of Care

Patients also benefit from the lower cost of care. Lower costs can improve outcomes by increasing the number of cycles a patient can afford to undergo. Also, research shows that patients whose treatment is covered by insurance experience lower rates of multiple pregnancy than patients who must endure financial hardship to access care (27). Affordability is related to better treatment decision making (e.g., fewer embryos transferred) because patients are not forced to voluntarily deplete their resources for a chance at biologic parenthood. That said, it must be noted that cross-border treatments have resulted in multiple pregnancies, a risk of assisted conception that should be disclosed to every patient no matter the location of their treatment (28).

Avoiding Discrimination

Traveling to avoid application of restrictive laws in place in a home jurisdiction allows patients to escape discrimination based on demographic characteristics that are unrelated to medical suitability for treatment. Enabling those who face discrimination at home to access care abroad enhances the diversity of patients who utilize fertility treatment worldwide. In a field sometimes criticized for catering to white, middle- and upper-income individuals, increasing diversity among the patient population by removing discriminatory barriers and lowering costs is a benefit to the individual patients as well to the medical practice (11).

Enhancing Revenue Streams

Cross-border care can benefit ART providers, ancillary health professionals, gamete donors, gestational carriers, and providers of general tourism services in destination countries. Revenues from traveling patients can contribute meaningfully to local economies (17). Increased demand for fertility services can enhance access to both ART and general medical care for local populations. ART clinics must be brick-and mortar-structures equipped with functioning embryology labs, surgical suites, and patient exam rooms. These improvements can benefit local populations in the form of increased ART services or convertible medical infrastructure.

Protecting Privacy

Some patients will benefit from the privacy that CBRC provides. Couples or individuals who struggle with infertility may wish to escape the scrutiny that even well-meaning family and friends can apply. Receiving treatment without having to report daily progress and eventual outcomes can be a relief for some patients. For others, accessing treatment in a country

of origin with a familiar language and cultural sensibility can also enhance the ART experience.

POTENTIAL HARMS OF CBRC

The potential harms of CBRC also can be measured according to impact on stakeholders, including patients and their partners, offspring, ART providers, third-party gamete donors and gestational carriers, and local populations in the destination country.

Health and Safety Concerns

The gravest concern for traveling patients is the protection of their health and safety. In the ART context, health and safety concerns can focus on the transmission of infectious diseases to patients or genetic disorders to offspring. In the absence of international policies and norms dictating quality control measures, patients are disadvantaged in their ability to discover and assess the standard of care in any given foreign jurisdiction. Essential measures of quality such as the expertise of physicians and embryology staff, the sophistication of the screening, surgical, and laboratory technology, and basic matters to prevent contamination, damage, and misdirection of gametes and embryos can be difficult for a visiting patient to assess. Indeed, patients take some risk when they access any fertility treatment, but the risk increases as patients leave their home country where information about quality is likely more accessible.

Language, Information, and Legal Barriers

Patients may be harmed by lack of access to understandable information about their treatment options. In many instances, patients do not speak the native language in the destination country. Giving informed consent in a foreign language is of questionable value and validity. Reduced quality of care and language barriers can combine to victimize patients once they arrive in the destination country and financially commit to treatment. At least one report warns that patients traveling to access donor eggs can experience "bait and switch"—the use of a different gamete donor than the one a patient selects—a scheme discovered when the growing child bears no resemblance to the selected donor (29). If a patient is harmed by treatment abroad, access to legal recourse may be exceedingly difficult. Medical malpractice laws in a destination country, combined with jurisdictional reach, can diminish the likelihood and extent of an injured patient's recovery from a negligent foreign provider (30).

Additional harms to patients and their partners include the possibility of changing or evolving legal schemes in destination jurisdictions. The timing and effective dates of such legal changes could jeopardize an individual or couple's anticipated or ongoing reproductive plan, possibly resulting in the inability to remove a newborn child from the subject country. Intended parents who commission a gestational carrier in a destination country for purposes of securing citizenship for their child in the place of birth can also experience legal difficulties upon return to their country of domicile. The increasing complexity surrounding the legal status of CBRC offspring cautions patients and their partners to give serious attention to matters such as legal parentage, immigration, and citizenship (31). As with any complex legal matter, consultation with a legal professional experienced in the laws of the destination country as well as the intended parents' home country is prudent, and is particularly important for surrogacy arrangements in which the child will be born in the destination country.

Harm to Offspring

The quality of ART care can impact offspring health, particularly in the context of multiple pregnancy. The morbidity and mortality associated with high-order multiple pregnancy are well described and have prompted some countries to limit the number of embryos transferred in any single IVF cycle (32). Patients who travel to circumvent embryo transfer limits are at increased risk for multiple pregnancy (28).

Additionally, offspring who are the result of gamete donation abroad may have less access to information about their genetic origins than donor-conceived children produced by domestic arrangements. While access to and information about gamete donors are highly variable, offspring attempting to locate their gamete donors abroad would likely face greater hurdles than their domestically conceived counterparts.

Harm to Donors and Gestational Carriers

Concern about exploitation of gamete donors and gestational carriers in destination countries occupies much of the critique of CBRC (22, 33, 34). This critique presumes that patients seeking third-party reproduction will be wealthier and more politically powerful than women who act as donors or gestational carriers. In countries where the status of women is already problematically low, building a market for reproductive services can fuel the view that a woman's value is limited to her physical characteristics and child-bearing capacity. While payments to donors and gestational carriers can temporarily raise their economic status, some argue that such practices permanently harm women by reducing them to commodities available for exploitation. Harms may also include malfeasance by an intermediary agency or breach of an agreement by an intended parent or couple, inflicting economic harm on third-party donors or gestational carriers. In rare but devastating cases, an intended parent may fail or refuse to claim parentage over a child born via CBRC surrogacy, leaving the gestational carrier with the child in her care and no legal recourse against the foreign commissioning parents (35).

Donors and gestational carriers in destination countries may suffer physical, social, economic, and psychological harm. It is unclear how much and what quality health care these woman receive and whether they are stigmatized in their native culture for taking on this role.

Harm to Local Populations

Tourism has the effect of raising the price of goods in the visited area, and travel for reproductive purposes can be expected to have that same effect. Increased demand for services

in destination countries could raise the price for domestic populations, making their access more difficult. Also, a nation's effort to attract foreign ART patients could negatively impact its ability to provide health care to its own population. To the extent that resources—human, financial, and technological—are diverted to fertility care, local populations may suffer from lower quality and less health care as a result of this siphoning effect (36).

ETHICAL CONSIDERATIONS FOR DEPARTURE-COUNTRY PHYSICIANS

Patients who travel for ART begin this journey in their home country, often by consulting several sources for information, including physicians. If a potential ART traveler has a preexisting relationship with a provider in a departure country, several legal and ethical dilemmas can be anticipated. Three specific questions arise:

1) What duty, if any, does the departure-country physician have to inform the patient about opportunities for care abroad?
2) What duty, if any, does a departure-country physician have to inform patients about the risks and benefits of CBRC, including specific risks in a particular destination country?
3) What duty, if any, does a provider have to resume care of a patient who obtains ART services abroad and returns for follow-up care?

Guidance for each of these dilemmas can be gleaned from the familiar doctrine of informed consent.

Duty to Inform Patients about CBRC Opportunities

A fundamental principle of medical ethics is to respect patients by treating them as autonomous individuals. This means dealing with patients honestly and openly. One prong of the principle of respect for patient autonomy is expressed by the doctrine of informed consent. Briefly, physicians have a duty to provide patients with information necessary to understand their diagnosis and treatment options, as well as the risks and benefits of accepting or foregoing treatment so they can make knowing and informed decisions (37).

If a patient asks a treating physician about options for care abroad, the provider has an ethical duty to not misrepresent his or her fund of knowledge about those options. A physician with experiential or secondary knowledge about CBRC, including specific information about clinical options abroad, may disclose such information to inquiring patients. A physician has a duty to disclose any conflicts of interest, such as financial interests in an overseas ART program.

Any discussion about CBRC as a treatment option should include information material to a patient's decision, including any knowledge gaps or concerns the provider has regarding a possible care plan. At the same time, physicians who possess no information about CBRC have no duty to research the option for inquiring patients, nor are they duty-bound to offer the possibility of fertility travel as a treatment option.

Duty to Disclose Risks and Benefits of CBRC Care

Informed consent requires physician disclosure of the risks and benefits of suggested treatment. When a patient asks a departure-country provider about the possibilities of out-of-country care, that patient is not inquiring about treatment options being presented by the physician. Thus, the physician does not act as a treating physician vis-a-vis that patient and has no duty to be informed about or disclose risks and benefits of such treatment. If a physician possesses special knowledge about a particular provider or service of which the patient inquires, a duty arises to not misinform the patient or present false information. A departure-country physician has no independent duty to investigate the risks or benefits of treatment abroad. The physician is free to share opinions about the merits of CBRC and should be clear about whether the information is given as a recommendation or merely as guidance.

Duty to Resume Care of a Patient Who Receives CBRC Treatment

A patient who returns from abroad may have little or no documentation explaining the care she received. Lack of medical records can pose significant challenges for treating physicians, raising concerns about whether to treat or resume treatment of returning patients. In some cases, physicians may have a contractual duty to treat returning patients based on preexisting health insurance or other binding arrangements. Where no such duty exists, physicians are free to accept or decline to accept patients into their practice, so long as any declination is accompanied by reasonable notice giving the patient an opportunity to seek another willing provider. The physician-patient relationship is largely a voluntary one, which both parties may choose to enter or not, so long as their conduct is nondiscriminatory (38). A rare but possible interpretation of the returning patient's request for treatment would be that the patient merely suspended, rather than terminated, the relationship when she sought care abroad. In this case, a physician who wishes to decline treatment should be guided by the duty to not abandon a patient, including the related duties to notify the patient and give her time to seek care elsewhere. A physician who wishes to terminate an existing relationship with a patient returning after receiving cross-border care may refer the patient to a willing provider.

ETHICAL CONSIDERATIONS FOR DESTINATION-COUNTRY PHYSICIANS

Providers who treat traveling patients are held to whatever standards of care govern medical care in their jurisdiction, including standards governing informed consent. That said, do physicians owe additional duties to patients they know reside in, and plan to return to, another country? These additional duties might include disclosure of legal or practical information relating to the patient's return home. For example, if a physician knows that patients from certain departure countries have difficulty procuring immigration or citizenship paperwork for donor-conceived offspring, does the

provider have a duty to warn patients about this possible challenge? If a physician knows that a requested service is illegal in a patient's home country, does the provider have a duty to discuss the patient's desire to avoid application of these or other restrictive laws? We think not. A physician's duty to provide high-quality medical care and accurate treatment information does not include a duty to investigate or disclose nonmedical information over which the physician has no control and from which the physician derives no personal benefit. Destination-country physicians have no duty to act as a patient's legal advisor, and in fact doing so carries a risk of engaging in the unlawful practice of law. Patients considering CBRC should seek out advice from qualified legal experts who can provide guidance on legal aspects of such activity, and providers should recommend this to their CBRC patients. Referral to other qualified experts, including mental health professionals, should be considered and is encouraged when appropriate.

CONCLUSION

CBRC is a growing reality in ART. The main factors that incentivize patients to travel abroad for fertility care—access, cost, regulation, and privacy—are poised to remain features of the global reproductive health market. The benefits and harms that accompany CBRC are far-reaching, impacting ART stakeholders as well as local populations and medical, economic, and political systems in both departure and destination countries. Physicians who treat ART patients from abroad have a duty to deliver the same quality of care required for all domestic patients. But the delivery of CBRC does not invoke a duty to inform or warn patients about the potential legal or practical hazards that may accompany such care. Physicians who are asked to assist patients considering ART travel may, but are not obliged to, offer guidance about the options for cross-border care. Referral to qualified experts, including legal and mental health professionals, should be considered and is encouraged when appropriate. As the practice and delivery of reproductive medicine becomes more internationalized, physicians are well served to understand the extent and limits of their medical, ethical, and legal duties to traveling ART patients.

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