

# ESHRE Task Force on Ethics and Law 15: Cross-border reproductive care

G. Pennings<sup>1</sup>, G. de Wert, F. Shenfield, J. Cohen, B. Tarlatzis and P. Devroey

*Bioethics Institute Ghent, Ghent University, Blandijnberg 2, B-9000 Ghent, Belgium*

<sup>1</sup>Correspondence address. E-mail: guido.pennings@ugent.be

**This paper analyses the ethical aspects of cross-border reproductive care. Ethical questions are raised by some of the main reasons of cross-border travelling, i.e. law evasion and unequal access to treatment. The phenomenon also generates possible conflicts linked to the responsibility of the professionals. Three points are discussed: the moral obligation of the physician to refer the patient, his/her duty to provide information and counselling and the acceptability of fee-splitting. The recommendations focus on measures to reduce or limit the number of patients that have to travel abroad and on steps to guarantee the safety and quality of the treatment wherever it is provided.**

*Keywords:* access; cross-border care; justice; law evasion; reproductive tourism

## Cross-border reproductive care

Cross-border medical care is a growing phenomenon. It indicates the movements by candidate health care recipients from one country or jurisdiction where treatment is unavailable for them to another country or jurisdiction where they can obtain the treatment they need. This also applies to persons looking for infertility treatment. The present document will focus on the ethical aspects of this phenomenon. We will avoid the terms 'reproductive' or 'procreative tourism' because of their negative connotations and will use instead the neutral term 'cross-border reproductive care'.

The main causes of cross-border reproductive care are as follows: a type of treatment is forbidden by law (i.e. sex selection), certain categories of patients are not eligible for assisted reproduction (i.e. lesbian couples), the waiting lists are too long in one's home country (i.e. oocyte donation), the out-of-pocket costs for the patients are too high (i.e. absence of insurance), a technique is not available because of lack of expertise or equipment (i.e. preimplantation genetic diagnosis), a treatment or technique is not considered safe enough (i.e. cytoplasm transfer) and personal wishes (i.e. privacy considerations). The different causes of cross-border care can be divided into two groups: legal restrictions and/or availability. We will analyse the ethical implications of this complex phenomenon.

## Part 1. General ethical principles

### *Law evasion*

Many people are excluded from medically assisted reproduction in European countries. Restrictions in the law are a major cause of movements of patients to other countries.

Restrictions may exist in the form of a legal prohibition of certain treatments. In Italy for instance, no gamete donation or embryo cryopreservation is allowed. In Germany and Norway, oocyte donation and surrogacy are forbidden. Other people are excluded on the basis of personal characteristics like age, sexual orientation, marital status etc. In France, for instance, lesbian couples and single women do not have access to medically assisted reproduction.

Is there a moral imperative to obey the law? In other words, do citizens in a democracy have the right to obtain treatment abroad when this treatment is legally forbidden in their own country? There is a prima facie obligation of citizens to obey national law. However, there may be very good reasons for people to bypass the law by travelling abroad. There is a wealth of precedence in reproductive health care, i.e. termination of pregnancy, sterilization and contraception. Recent developments have attributed more value to reproductive autonomy. This principle justifies transgression in a number of situations as long as safety, efficacy and welfare of the patient and the future child is taken into consideration.

### *Access and distributive justice*

Some movements are caused by the lack of provision (i.e. insufficient number of centres) or availability of the technology and suboptimal or inadequate reimbursement. These movements, if large scale and long term, indicate a structural deficit in the national health care system and demand policy measures. All citizens have a right of access to decent health care, including reproductive health care in affluent societies (ESHRE Task Force on Ethics and Law 14, 2008). Normally, this care should be available in one's home country.

Another related reason could be the inability of patients to pay the high cost of treatment in their own country. This could be remedied by public funding and/or affordable private insurance coverage. However, in some circumstances, cross-border reproductive care can be justified. Two situations come to mind, i.e. exceptional shortage of material or infrastructure and highly specialized applications like preimplantation genetic diagnosis. In those cases, collaboration with European centres of reference might be the most cost-effective and safe way to offer quality treatment.

## **Part II. Consequences of cross-border reproductive care**

### ***Effects on legislation***

An important question for the evaluation of cross-border reproductive care is what the effect will be on the legislation. At present, the movements by patients to other countries can be seen as a form of civil disobedience which intends to change the existing legislation. However, the phenomenon may have the opposite effect: politicians may accept the movements of some citizens to clinics abroad as a safety valve, which decreases the pressure for law reform internally. In the latter case, the restrictive legislation will be maintained and patients will continue to seek care abroad. One condition should be fulfilled before cross-border movements of patients embarrass the government and incite them to change, namely visibility. Especially for highly personal and private interventions like infertility treatment, this condition is difficult to fulfil as patients do not want to go public with their problems.

### ***Resource-poor countries***

The movement of people from rich countries to resource-poor countries for all types of medical care may have undesirable implications for the health care system in these countries and for the local patients. The investments of health care resources (including qualified personnel) in foreign patients come down to the export of health care capacity. Since these countries are already struggling to provide basic health care for their own citizens, the resources could be used more efficiently for their own people. The second danger is exploitation. Frequently, the welfare level correlates with the risk of exploitation of the most vulnerable groups in the population. Especially for oocyte donation and surrogacy, this risk of exploitation is real. A final consequence might be that the average price for oocytes increases, thus making them inaccessible for the local patients.

## **Part III. Professional responsibilities**

### ***Referral***

When the physician has a conscientious objection against a certain treatment, he/she is not obliged to refer the patient to another clinic but he/she should provide adequate information. When the physician has no conscientious objection, his or her rights and duties depend on whether the law is permissive or prohibitive. If the law is permissive, the doctor has the moral obligation to refer the patient to a clinic that accepts to perform the treatment or intervention. If the law is prohibitive,

the physician, taking into account the reproductive autonomy of the patients and within the boundaries of safety, efficiency and welfare of the future offspring, is morally allowed to refer to a centre abroad. When the national legislation also prohibits a referral, the same reasoning applies. Indeed, this might be considered as the first step in a process of civil disobedience. The logic of this position would lead to support the physicians who take the responsibility to give the appropriate treatment to their patients and thus break the law. It is essential that the treatment for which the patient is referred is supported by the guidelines from national and international professional societies.

### ***Provision of information and counselling***

Referral of a patient abroad may mean that the patient receives little or no information and/or counselling. This may be due to language problems or inadequate standards of the clinic abroad. When a physician refers patients to centres abroad, he or she should also provide counselling in order to make sure that they know what will happen, what kind of questions they should ask etc. Referral does not eliminate his or her responsibility completely. It is also the professional responsibility of the referring physician to gather data to make sure that patients are treated well by the clinic to which he or she refers. More specifically, the patients should be informed of unproven efficiency, premature use of techniques in the clinic, multiple pregnancy rate etc.

### ***Financial arrangements***

Fee-splitting is a practice in which a doctor pays another doctor a certain amount if the latter refers patients to him or her. The practice of fee-splitting is morally unacceptable because it leads to practices which do not have the best interests of the patient in mind. For instance, the patient may be directed to a doctor who performs below standard, charges higher prices or practices in more inconvenient places thus unnecessarily increasing the costs (time, money etc.) for the patient. Such practices may generate a conflict of interest. Whenever a conflict of interests cannot be avoided, the conflict should be disclosed to the patient.

## **Part IV. Patient responsibility**

Patient organizations have an important role in disseminating accurate information to patients. However, due to the vulnerability of the patients and the difficulty of obtaining correct information, the main responsibility lies with the physician. Furthermore, these organizations may lobby at national and international level in order to increase access to adequate health care.

## **Part V. Role of the professional societies**

It is by excellence the task of a professional society to gather information to present a state of affairs and to provide a general picture of the different movements. Second, ESHRE should present itself, together with the patient organizations and national professional societies, as the promotor of the

interests of patients. Different tasks can be distinguished: inform the law makers, the media and the public of the benefits of assisted reproduction for infertile people, explain the negative consequences of restrictive laws, explain the responsibility of referring professionals, defend ethical pluralism and respect for different opinions. Educational activities and guidelines are an essential part of promoting standards. The further development of a certification system for fertility clinics and laboratories is of paramount importance to achieve this goal.

### Recommendations

- Regarding legislation, there are three recommendations: provide at least partial reimbursement for treatment to ensure equitable access for all citizens; adopt a less restrictive legislation not to force large groups of patients to travel abroad; and extend the portability of health insurance (at least for treatment that is not prohibited in the home country) to reproductive health care.
- Systems of control and verification should be installed. A system of certification may be introduced in order to guarantee that all patients get safe and effective treatment wherever they go. This system should not only include the technical and medical side but also compliance with ethical standards, including the provision of psychological counselling.

- The government, patients and professional organizations should organize awareness and information campaigns to warn the citizens for possible dangers of cross-border reproductive care.
- All professional parties, referring physicians as well as doctors abroad, should be aware of their responsibilities and of the relevant ethical guidelines.
- Professional organizations and referring physicians should collect follow-up data about the results and complications of treatment abroad. It is the professional responsibility of the referring physician to make sure that his/her patients are treated well in the clinics to which they are directed. Patients should be specifically informed of success rates and the risks and rates of multiple pregnancies.

### Funding

This work has been funded by the European Society of Human Reproduction and Embryology (ESHRE).

### Reference

ESHRE Task Force on Ethics and Law 14. Equity of access to assisted reproductive technology. *Hum Reprod* 2008;**23**:772–774.

*Submitted on April 8, 2008; resubmitted on April 8, 2008; accepted on April 21, 2008*