

The green grass on the other side: crossing borders to obtain infertility treatment

Guido PENNINGS

Bioethics Institute Ghent, Ghent University, Blandijnberg 2, 9000 Gent, Belgium.

Correspondence at: Tel./fax 0032 16 620 767; e-mail: Guido.Pennings@Ugent.be

Abstract

Background: Cross-border reproductive care, also known as reproductive tourism, is a growing phenomenon. More and more treatments, or parts thereof, are taking place in countries other than the patient's home country.

Results: The phenomenon is presented as a safety valve that takes the pressure of the restrictive legislation and simultaneously allows people to obtain the treatment they desire. These movements also hold a number of risks, both for the travelling patients and for the gamete donors and infertile couples in the country of destination. Finally, the possible role of patient organisations and medical professional societies is discussed.

Key words: Cross-border reproductive care, ethics, law, patient organisations, reproductive tourism.

Introduction

Cross-border reproductive care is a multifaceted phenomenon. Different kinds of cross-border movements can be distinguished by the parts involved: the material (gametes or embryos), the treatment or procedure and the persons (patient, physician, gamete donor or surrogate). The 'traditional' meaning, most in accordance with normal tourism, is when patients move to other countries to obtain the treatment they cannot get in their home country. However, a reverse movement can also be imagined when providers of genetic material are brought into the country. In Spain, a number of cycles are performed with foreign women serving as oocyte donors (Rubio *et al.*, 2006). There is no need for persons to travel if the material can be transported more easily. Danish sperm is moving all over Europe. American couples have sent sperm to Romania where it was used to fertilise donor eggs. The embryos are then shipped back to the United States. Depending on the problem or treatment, a service can be performed abroad and the material can be returned after processing. In the context of preimplantation genetic diagnosis (PGD), it is relatively common to send embryos abroad for biopsy and

send them back with the results. Economic and practical considerations presumably play an important role in the decision on which type of movement is preferred. We will focus in this article on the movements of patients abroad, although some problems that are generated by these movements are common to other kinds of movements.

At the moment, exact numbers on the extent of the streams are lacking. Recently, research has been performed on behalf of the European Commission to find out what is going on in Europe specifically for preimplantation genetic diagnosis. The survey identified 53 centres offering PGD. Seventeen centres confirmed that they received tissue samples and 36 treated patients from abroad (Lawford Davies, 2007). Even though this is a highly specialised treatment, the number of movements is already considerable: 332 couples in Spain, 127 in Belgium, 110 in the Czech Republic and 150 in Cyprus. Most of these couples travel because the procedure they seek is banned in their country. A recent survey in Italy showed that before the recent law on reproductive medicine (2004) 1066 Italian couples went abroad while this number had increased to 4173 in 2006 (Osservatorio Turismo Procreativo, 2006). This is most likely a serious

underestimation because it is based on a limited sample of foreign clinics.

Causes of cross-border reproductive care

Cross-border reproductive care has a bad reputation. This reputation is demonstrated in the use of the term 'reproductive tourism' (Pennings, 2004). Most people believe that the persons who travel abroad do this to obtain strange, extraordinary and unacceptable treatments. The cases most frequently cited are women giving birth over the age of 60, post-mortem parenthood as in the Blood case where a woman wanted to use her dead husband's sperm for reproduction etc. However, the overwhelming majority of the movements are made for treatments that are considered normal in the countries of destination. It is very instructive to compare the general attitude of politicians and public to medical tourism outside the field of reproduction with the attitude to reproductive tourism (Pennings, 2007). Cross-border movements for general medical interventions are positively evaluated as a means to use spare capacity and foreign expertise. The emphasis is on the right of the patient to high-quality health care. The Commission of the European Communities (2004) even proposes to simplify the existing rules on the co-ordination of social security systems and the procedures of health insurance to facilitate patient mobility. If we extrapolate this attitude to reproductive care, countries would inform patients about the opportunities in other countries, would reimburse couples going abroad for oocyte donation because the waiting lists are too long at home etc. The main explanation for the difference in attitude seems to be the idea that people moving abroad are looking for treatment that is legally prohibited in their home country. However, law evasion is only one reason for travelling. Anecdotal evidence provided by patients going abroad and clinics treating foreign patients allows us to deduce the following reasons for travelling: the treatment is forbidden by law because it is considered ethically unacceptable; the technology is not available because of lack of expertise or equipment; people are excluded from treatment because of specific characteristics; the waiting lists are too long; the out-of-pocket costs for patients are too high; the difference in price with the country of destination is large; the couples (who had a number of treatments in their own country) are convinced that foreign centres have something more to offer regarding diagnosis or treatment or both; and, patients are formally referred to a foreign centre of excellence by practitioners from their own country because of perceived differences in treatment possibilities or quality.

If one knows the reasons for travelling, one also knows which measures will reduce the number of movements; a flexible legislation combined with reimbursement of infertility treatment will stop a large part of the flow. At present, the political majority expresses its views on how society should be regulated in legislation. This inevitably implies that the values and principles of the minority are not or only partially expressed in the rules. Although the majority has the political right to do this, values like tolerance and respect for other people's opinion urge the majority to take the minority's position into account by adopting a flexible or less strict law. However, if they do not opt for compromise, allowing people with different views to go abroad is the minimal recognition of their moral and reproductive autonomy (Pennings, 2004).

Cross-border movements and their effect on law making

One of the important questions is how the possibility for citizens to go abroad affects the law making process. Two positions can be adopted: a) the possibility to go abroad incites law makers to soften their position because they will not be able to control people's behaviour and b) the possibility allows law makers to go for the strong position without taking into account the position of other groups in society. It is difficult to collect data that corroborate either position. I have defended the first position based on anecdotal information. For instance, the Swiss Federal Council argued against a referendum initiative that intended to prohibit most forms of IVF and the use of donor gametes because the only consequence of such law would be the flight of infertile couples to neighbouring countries (Conseil Fédérale Suisse, 2000). Underlying this position lies a number of convictions regarding the role of the law. The goal of the Swiss law makers is to decrease the number of what they considered as wrongful actions and applications. They realised that a strict law would not reach this goal since people would leave the country. This immediately shows the limits of legislation: one can determine which actions are performed on one's territory but one cannot determine which actions one's citizens will perform. This degree of control could only be obtained by taking drastic measures to restrict the freedom of movement of the citizens. This would inevitably imply massive violations of basic rights like the right to privacy, freedom and reproductive autonomy. Moreover, such measures would be diametrically opposed to articles 59 and 60 of the European Community treaty which guarantee free movement of services, including medical services.

Another argument in favour of this position is that governments tend to feel embarrassed when it becomes public knowledge that they oblige a considerable number of their citizens to look for treatment abroad. However, this does not work in this context because most people who obtain infertility treatment abroad do not broadcast this fact because of the highly personal nature of infertility. If all Italian couples who seek treatment abroad would tell their friends and family, this would most likely have an impact on the general perception of the law. Moreover, this would help to refute the general idea that people travelling to obtain infertility treatment are looking for strange applications.

The second position regarding the effect of the availability of reproductive care abroad on the law is defended by Richard Storrow. When analysing Great Britain's position on surrogacy, he concludes that they decided to curtail the practice because 'it was unnecessary to permit surrogacy in Britain given the availability of surrogates for hire in other parts of the world.' (Storrow, 2005). Storrow explains the fact that little outcry over these restrictions occurred precisely because it is relatively easy to travel to other countries. A similar conviction, according to Storrow, could have motivated France's ban on treatment for postmenopausal women and Britain's decision to outlaw anonymous gamete donation. A strong argument in favour of this position comes from Italy. The 2004 Italian law systematically excludes third-party involvement in reproduction. However, the Italian government recognises the parentage of Italian couples who employ gamete donation abroad and thus seems to accept the idea that the Italians will go abroad. Storrow concludes: 'In this context, then, policymaking that appears to signal a departure from globalist trends in favor of local values, actually depends upon tourism – a manifestation of globalization – for its viability against organized resistance.' (Storrow, 2005). However, at least as far as Italy is concerned, there was (and still is) a strong opposition against the law. Although the four referendums attempting to modify the restrictive law failed to reach the required quorum (not surprisingly, given the condition that 50% of the electorate should cast their vote for it to be valid), there was a referendum organised and more than 12 million Italians voted (Benagiano, 2005). Between 80 and 90% of those voters were in favour of PGD, embryo research and gamete donation.

Storrow's idea that the possibility to go abroad decreases the possible resistance to a restrictive law is highly plausible. Patients are primarily looking for a solution for their personal problem. When they find this solution, most are no longer motivated to fight the legislator. However, it seems unlikely that these

countries only adopted these laws because the escape route existed. On the contrary, almost all restrictive countries push very hard for 'harmonisation'. They want other countries to adopt similar laws, both to prevent their own citizens from going there and to increase the effectiveness of their legislation. In reaction to the birth of twins to a 59 year old British woman, the health secretary of the United Kingdom stated that 'we'll renew our efforts to have discussions with other countries as to the examples we set and they can establish ethical controls over some dramatic achievements of modern medicine' (Morgan, 1998). In a similar vein, Allan Rock, the Minister of Health of Canada, argued that 'a collective international effort is also necessary to prevent unethical practitioners from "country shopping" for opportunities to pursue unethical practices such as human cloning and "reproductive tourism".' (Rock, 2001). If the restrictive countries would need the escape route of a more lenient legislation before they could introduce their restrictive laws, they would try to maintain diversity.

Dangers for travelling patients

Cross-border reproductive care holds a number of dangers that are directly linked to the fact that patients have to leave the local health services. Depending on the country of destination, there may be a danger due to the violation of safety standards. Patients have the right to be protected from negligent or incompetent practitioners. Two points are worth mentioning here: the screening of gamete donors for transmittable diseases (both genetic and non-genetic) and the risk of multiple pregnancies. The second problem is deceit or at least misleading information, especially regarding success rate. Given the commercial context in which fertility clinics compete with each other, results inevitably function as publicity. When there is no independent supervision of the clinics, they may boost their results. In addition, counselling may be a real problem, mainly because of insufficient knowledge of a common language. Several solutions can be imagined. The clinic of origin could counsel the patients before they leave the country. This will help but may not be sufficient. At the receiving side, more and more large clinics that attract high numbers of foreign patients from specific countries, hire physicians from those countries to accompany and support the patients during their treatment. The sole (but important) disadvantage that remains at that moment is social isolation. Patients are cut off from their usual support channels like family and friends which may be important given the stress associated with infertility treatment. In view of these problems, patient organizations and physicians

should think about how they can contribute to an improvement of the situation for patients.

The main contribution that patients groups can make is to educate their members and alert them of the possible risks. At the ESHRE meeting in Barcelona 2008, the International Consumer Support for Infertility (iCSI) issued a fact sheet entitled 'Travelling abroad for assisted reproductive technology (ART) treatment'. iCSI, which is an international alliance of infertility patient organisations, provides a list of issues to consider including medical, financial, legal and emotional points. The Human Fertilisation and Embryology Authority (HFEA) also advises patients who are considering to travel abroad for fertility treatment to find out about the standards and regulations applicable in the different countries. They point out that the standards of care in overseas clinics may not be the same as in the United Kingdom. The key issues according to the HFEA are: What happens if treatment abroad goes wrong? Is patient information kept safe and confidential? What is the legal position of the donor in that country? Are they anonymous? Do donors have legal responsibility for the child? How are donors recruited, compensated and screened? However, collecting information on these issues is more easily said than done. How is a patient ever going to verify the information provided to him or her? Especially in countries with very little or no governmental or independent control in the field, one has little choice but to accept what the clinic is telling. Still, asking the right questions about multiple pregnancy rates, donor screening etc. is a first step. It is important that patient organisations are aware of the increasing importance of reproductive travelling among the infertile and about their possible role in helping the people who opt for this solution (Merricks, 2007).

The responsibility of physicians and professional societies

The role and responsibility of the physicians in the country where the patients come from is far from clear. Although it could be argued that these people are their patients, they are not treating them (unless they prepare the cycle at home). How far does the professional responsibility reach? Should they refer? Should they provide counselling and information? There is a general moral obligation to inform the patient. It can be argued that it is part of this obligation to provide people who tell the doctor that they intend to go abroad with information on the treatment for which they travel or to refer them to a patient organisation who will do so. However, there might be a legal problem. In countries, like Germany, formal referral is prohibited when the treat-

ment is not allowed in the country. In Switzerland, no addresses of service providers abroad may be given to patients and neither may collaboration with foreign centres be established (Emery, 2005). Irish doctors' fears about potential prosecution has led to "inverted referral" in the context of PGD (Lawford Davies, 2007). This means that patients must contact the clinics in other countries and these clinics afterwards approach the clinic of the patient for the relevant medical records. This leads to several problems. First, if patients have to look for a clinic without any guidance from the doctor, the result will largely depend on their educational level. Not everyone knows how to surf the internet and even less people know how to select the right clinic. Abandoning the patients at a time when they are particularly vulnerable seems a harsh and irresponsible decision. On the other hand, referral is not a neutral act and generates a certain degree of complicity, both legally and morally.

From a moral point of view, several problems arise simultaneously when looking at this topic. First, there is the question to what extent citizens of a country have a moral obligation to obey the laws of their country. This may apply even more to persons who are financed by society like physicians (at least in countries with a large public health system) and who represent one of the stable pillars of society like medicine (Heng, 2006). Secondly, the legal rules may conflict with the moral convictions of the physician or his or her professional obligations (ESHRE Task Force on Ethics and Law, 2008). When the moral convictions of the doctor fit the legal rules, there seems to be little problem except when the legal prescriptions are opposed to general professional duties. The physician has the general obligation to promote the welfare of his or her patient. In fact, the doctor may be convinced that a certain treatment is the best for the patient even if it is against the law. The attitude of some doctors during the time that termination of pregnancy was prohibited in most countries can serve as a historical precedent. This could also apply, for instance, to insemination of lesbian couples or single women or to embryo selection in couples with a high genetic risk.

Finally, there is the question of the responsibility of the doctors for monitoring and follow-up of families and their children. In the context of PGD, some clinics in the patients' home country were reluctant to get involved in following up children born as a result of prohibited treatment (Lawford Davies, 2007). Other clinics just did not see this as their responsibility. Two levels of involvement can be distinguished here: data collection and collaboration in research on the one hand, and medical care for patients on the other hand. Regarding the latter, the

answer is simple: physicians have a duty of care for their patients regardless of where the treatment was provided. As far as data collection is concerned, medical data necessary for follow-up could be transferred directly by the patient rather than by the doctor.

The professional societies could be involved at the national and international level. It seems evident that control of professional behaviour is first exercised by the national medical associations and that measures for professional non-compliance and/or misconduct are taken at that level. Simultaneously, international organisations (like ESHRE, ASRM, IFFS and FIGO) can contribute by developing guidelines for good clinical practice and continued education and information of both practitioners and patients. Moreover, the professional societies could, together with the patient organisations, lobby with the politicians to prevent the adoption of restrictive laws that would push even more patients into travelling as a method to avoid or circumvent illegal treatment or forced abstinence from treatment in their home countries.

Consequences for people in providing countries

The discussion on the risks and dangers is mainly focussed on the fertility patients from the Western countries. However, one should also pay attention to the effects on the infertile couples and gamete donors at the site of treatment delivery (Storrow, 2005). A first danger regards the risks for oocyte donors and surrogates. There are strong indications that a number of countries and clinics are violating patient rights. A few years ago, several cases of misconduct by physicians in a Romanian clinic were revealed (Magureanu, 2005). The oocyte donors, who were illiterate and minimally educated, had not given informed consent, they did not receive information on the procedure and the possible health risks and no follow-up care was provided when the donors developed complications. The contract signed by these women stipulated that they would never go to another doctor to be treated if they developed health problems, not to divulge to any Romanian authority what had happened in the clinic and to refrain from launching legal action against the clinic, regardless of the side-effects of the procedures. It is not clear how many similar cases occur but it is evident that measures should be taken to prevent this from happening. Given the considerable financial interests involved, clinics managed on a purely for-profit basis might be tempted to take short-cuts, especially if they know that there is no real control. It was probably no coincidence that a clinic which was run by Israeli doctors and catering to Israeli patients was

established in Romania. The loose regulation and oversight in Romania makes the country much more attractive and suitable for this kind of business (Anonymous, 2005). Still, it is important to realise that the infractions are violations of Romanian law and could happen because of a lack of supervision. Most services for which people travel are fully within the law of the servicing country.

The exploitation of women is the most urgent and most serious problem (ESHRE Task Force on Ethics and Law, 2007). According to some, the amount offered to poor people in poor countries functions as 'undue inducement'. In other words, the persons are no longer able to give voluntary informed consent. There are, however, a number of serious problems with this concept. According to Emanuel (2004), we can only speak of 'undue inducement' if people would be prepared to accept unacceptable risks. The risks involved in oocyte donation are not unacceptable. Obviously, there is a duty on the part of the physician to reduce the health risks for the candidate donor to a minimum, for instance by carefully screening candidate donors for factors predisposing for ovarian hyperstimulation syndrome, by reconsidering ovulation induction regimens and by closely monitoring donors (Mertes and Pennings, 2006). However, this presupposes that regulatory and health care standards in the servicing countries are up to par with European countries. It would be extremely difficult for patients and/or physicians to ascertain in another country that the clinic follows good clinical practice, that the donors are fully informed and that they understand what they are doing. It is hard to estimate to what extent the possibility of women being exploited for their oocytes is a concern for patients moving to some countries. The same question can be raised regarding the flourishing surrogate motherhood programs in India where low caste women are induced to perform surrogacy for rich foreigners. However, they ought to be concerned, just as people going to China for organ transplants should worry about where the organs come from. One should at least inform patients that there are legitimate concerns about exploitation in some countries. It is too easy to say that infertile people will do anything to have a child. Even if this were true, this would be no excuse or justification for their collaboration in exploitative or abusive practices.

A final consequence, in agreement with some of the effects in cross-border medical care, is that the travellers create a demand that in turn prices infertile citizens of the host countries out of the market for infertility treatment (Storrow, 2005). There is no proof of such mechanism at present but on specific points this is very likely. Women who need donor oocytes in a poor country will have to pay the fee

that is offered to foreign patients. On the other hand, cross-border care is a complex phenomenon and one should not blame it for every injustice in the health care system of the host country. It is unlikely that infertile patients in poor countries will have access to high technology medical treatment even if no patients come from abroad. There is at least a chance that people who need IVF benefit from the presence of a modern clinic that would not be there without the foreign patients. Empirical studies are needed to corroborate such statements.

Conclusion

Cross-border reproductive care is not ideal. It should be considered as the solution to allow patients a minimum of autonomy in a country with restrictive legislation or substandard care. However, there are dangers associated to these movements for the patients who go abroad and for the persons involved in the country of destination. These dangers can best be avoided by taking measures to minimise the number of movements. Given the political context, and the wish of political parties in a democracy to express their values in legislation, it is unlikely that this will happen soon. In the mean time, both the patient organisations and the professional societies can help to improve the situation by lobbying for more flexible laws, by informing patients about the dangers and by contributing to the collection of data.

References

Anonymous. Romanian 'mail order baby' fears. BBC News, 7 February 2005.

Benagiano G. The four referendums attempting to modify the restrictive Italian IVF legislation failed to reach the required quorum. *Reproductive BioMedicine Online* 2005;11: 279-81.

Commission of the European Communities. Follow-up to the high level reflection process on patient mobility and health-care developments in the European Union. Commission of the European Communities, Brussels 2004.

Conseil Fédéral Suisse. Avis du conseil fédéral. Initiative 'pour une procréation respectant la dignité humaine'. (2000) <http://www.admin.ch/f/pore/va/20000312/explic/index.html>

Emanuel EJ. Ending concerns about undue inducement. *J Law Medicine Ethics* 2004;32:100-5.

Emery M. What ethical issues on the welfare of the child need to be addressed during psychological counselling? Paper presented at the pre-congress course of the Joint Special Interest Group Psychology and Counselling and the SIG Ethics and Law, Annual meeting ESHRE, 19 June 2005, Copenhagen, Denmark.

ESHRE Task Force on Ethics and Law. Oocyte donation for non-reproductive purposes. *Hum Reprod* 2007;22:1210-3.

ESHRE Task Force on Ethics and Law. Cross-border reproductive care. *Hum Reprod* 2008;23(10):2182-4.

Heng BC. 'Reproductive tourism': should locally registered fertility doctors be held accountable for channeling patients to foreign medical establishments? *Hum Reprod* 2006;21(3): 840-2.

Lawford Davies J. Europe struggles to meet the legal, ethical and regulatory challenges posed by more patients travelling abroad for PGD. ESHRE press release, Monday 2 July 2007.

Magureau G. Egg donation and conflict within the Romanian legal framework. Paper presented at Core European Seminar: Human egg trading and the exploitation of women, Brussels, 30 June 2005. <http://www.handsoffourovaries.com/pdfs/appendixg.pdf>

Merricks W. Fertility tourism: too many choices, too little support? Donor Conception Network, 2007.

Mertes H, Pennings G. Oocyte donation for stem cell research. *Hum Reprod* 2007;22:629-34.

Morgan D. Licensing parenthood and regulating reproduction: towards consensus? In Mazzoni CM (ed) *A legal framework for bioethics*. Kluwer Law International, The Hague, 1998, 107-15.

Osservatorio Turismo Procreativo. Turismo procreativo: sempre piu coppie cercano la cicogna all'estero. Conference, 30 November 2006, Roma, CECOS Italy.

Pennings G. Legal harmonisation and reproductive tourism in Europe. *Hum Reprod* 2004;19:2689-94.

Pennings G. Ethics without boundaries: medical tourism. In Ashcroft R, Dawson A, Draper H, McMillan J (eds) *Principles of health care ethics*, second edition. John Wiley & Sons, London, 2007, 505-10.

Rock A. Speaking notes for Allen Rock, Minister of Health. Presentation at the World Health Assembly, Geneva, Switzerland, 14 May, 2001. <http://www.hc-sc.gc.ca/english/media/speeches/14may2001/mine.htm>

Rubio M, Romo R, Jiménez M, Cana MA, Caligara C, Fernandez M. Oocyte donor's profile at IVI Seville. *Hum Reprod* 2006;21, suppl.1: i72.

Storrow RF. Quests for conception: fertility tourists, globalization and feminist legal theory. *Hastings Law Journal* 2005;57:295-330.