

Cross-border reproductive care: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

Cross-border reproductive care is a growing worldwide phenomenon, raising questions about why assisted reproductive technology patients travel for care, what harms and benefits may result, and what duties health care providers may have in advising and treating the patients who travel for reproductive services. Cross-border care may benefit or harm assisted reproductive technology 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 2016. (Fertil Steril® 2022;117:954–62. ©2022 by American Society for Reproductive Medicine.)

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KEY POINTS

- Cross-border reproductive care (CBRC) refers to the activity surrounding the patients who travel outside their country of domicile to seek assisted reproductive services and treatment. Cross-border reproductive care affects both the departure and the destination countries from which and to which patients travel. Cross-border reproductive care 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 the departure country, and a desire for privacy or cultural comfort in the 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 they 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 they have no duty to learn about or disclose the legal, practical, or other nonmedical barriers a patient might face in accessing CBRC. Patients considering CBRC should seek 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.
- Patients seeking CBRC may have unique ancillary needs, and 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 assisted reproductive technology (ART) do little to temper their citizens' desire for parenthood. Increasingly, prospective parents from around the globe who face reduced access to advanced fertility care at home are traveling across

national borders to seek fertility and ART treatments. This practice, commonly referred to as cross-border reproductive care (CBRC), has significant implications for stakeholders in both the departure and destination countries. The following is a discussion of the incidence of 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.

INCIDENCE OF CBRC

Comprehensive data on the worldwide incidence of CBRC continue to evolve. In a 2010 survey of CBRC in Europe, researchers counted 24,000–30,000 cycles of cross-border treatment annually, involving 11,000–14,000 patients (1, 2) and representing approximately 5% of all European fertility care for that time period (3).

Early survey data from the United States found that 4% of all fertility treatments (approximately 6,000 cycles) were delivered to non-US domiciliaries (2, 4). More recent data from a 2017 study found that the percentage of ART cycles performed for non-US residents increased from 1.2% in 2006

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to 2.8% in 2013, with treatment delivered to residents of 147 countries. Compared with resident cycles, non-US resident cycles had a higher use of specialized treatment techniques, such as oocyte donation (10.6% vs. 42.6%), gestational surrogacy (1.6% vs. 12.4%), and preimplantation genetic testing (PGT) (5.3% vs. 19.1%) (5). The largest groups of incoming patients were from Latin America (39%) and Europe (25%). Conversely, the incidence of US patients traveling abroad for care is estimated to be far lower than the incidence of patients coming into the United States (2, 6).

The volume of CBRC activity is difficult to estimate accurately, given the lack of a robust international reporting system (7). 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. Some efforts have been made at gathering these data, with limited results. A 2016 study aimed at developing a prospective data collection system for CBRC in the United States and Canada found that only 1 of the 7 Canadian and none of the 46 US clinics that expressed interest in collecting data on patients' country of origin and reason for travel actually collected those data (8). To date, a precise accounting of global ART travel remains a goal rather than a reality.

REASONS FOR CBRC

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

Travel to Access Broader or Higher-Quality Care

A patient's ability to access fertility care in his or her country of domicile depends on the supply of ART services, the quality of care offered, the cost of fertility services offered, the array of treatment options available, and the waiting time for 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 scarce (7).

Travel is also more prevalent from the 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. The countries that restrict payments to gamete donors and gestational carriers see most of their fertility travelers leaving to access these services across borders (8, 9). National policies that require disclosure of donor identity also affect the availability of non-identified or nondirected donor gametes and hence factor into fertility travel. Patients in Sweden, the United Kingdom, and Norway, for example, report the desire for access to nonidentified gamete donors as a factor in their decision to seek care abroad (1, 10). In Canada, 80% of the women who travel for ART do so in search of nonidentified donor eggs (2). However, with the growing use of direct-to-consumer genetic testing,

anonymity cannot be guaranteed in any country. Even for gametes that were previously considered or intended to be anonymous, donor identity may at some point become known.

There are certain groups of patients who may be more likely to seek CBRC, such as individual(s) who may not be able to have a child without assistance. These may include people who are unmarried, single, gay, transgender, or of advanced age. For some people, there may be domestic restrictions placed on access to reproductive care related to local, cultural, and legal barriers, and these individuals may opt to seek reproductive care elsewhere (11–13). For example, a report on access to reproductive care in Middle Eastern countries found that only opposite-sex married individuals had access to reproductive care, with the exception of Israel (14).

Patients' desire to access higher-quality care also figures prominently in CBRC. Most of the 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, use more up-to-date equipment, and offer more specialized services, may prompt experienced ART patients to seek treatment abroad (9, 10, 15, 16). Finally, patients may travel to avoid long waiting times, such as in countries that include infertility care as part of their national health service (15, 17).

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 (18). Even patients who can afford care often incur financial hardship in their quest for parenthood (19). Global price variations have been published, with the average price of an in vitro fertilization (IVF) cycle being the highest in the United States (20) and significantly lower in countries such as India (21, 22). Data show that many individuals seek fertility treatment where ART is substantially less costly than in their home countries, despite concerns about lower reported success rates (13). 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, whereas those in non-reimbursement countries are impacted the most, sometimes incurring lasting financial harm (18, 23).

Disparities in the fees paid to gamete donors and gestational carriers also incentivize travel. 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). Media reports indicate that India has been a popular destination country for accessing gestational surrogacy services because of its significantly lower compensation amounts (24). However, a recent bill introduced into Parliament seeks to severely limit commercial surrogacy in India (25). Compensation to oocyte and sperm donors also varies considerably from country to country, and may or may not also include compensation for unpaid time from work relating to fertility treatments, travel time, and medical expenses (1, 26).

Travel to Circumvent ART Laws and Avoid Discrimination

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, the jurisdictions with restrictive laws are more likely to serve as departure countries, whereas countries with fewer 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" (27, 28).

Assisted reproductive technology regulations that motivate the use of CBRC fall into 2 broad categories: restrictions on who can access fertility care and restrictions on what fertility care can be accessed (13). Laws restricting who can access fertility care 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. An example of this was described earlier, in the report on access to reproductive care in Middle Eastern countries, which found that only opposite-sex married individuals have access to reproductive care, with the exception of Israel (14). Similarly, in Germany oocyte donation is legally prohibited, as is IVF for homosexual individuals (29), and in Italy same-sex individuals, single women, and people of advanced reproductive age are denied access to medically assisted reproduction (30). In 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, marital status, sexual orientation, and gender identity (31, 32).

Legal restrictions on what services can be offered do little to quash patients' desire for these services. Prohibitions on ART services, including PGT, selection of fetal sex, compensation for gamete donation, and compensation for gestational surrogacy, exist in some jurisdictions and prompt travel to seek ART services. As noted earlier, recent US data show that, compared with resident cycles, nonresident IVF cycles had a higher use of specialized treatment techniques, such as oocyte donation (10.6% vs. 42.6%), gestational carriers (1.6% vs. 12.4%), and PGT (5), suggesting that many of these nonresident cycles were possibly driven by a desire for these techniques. It is argued that CBRC is motivated in part by restrictive reproductive laws that exist in some countries (33). At the same time, there is little or no support for punishing patients who evade the law in pursuit of biologic parenthood; nor is there widespread advocacy for penalizing the physicians who assist patients in their quest to access CBRC, although laws in some countries do deem such conduct unlawful (12, 19). The patients considering CBRC should seek advice from qualified legal experts who can provide guidance on legal aspects of such activity, and providers should recommend this to their CBRC patients.

Travel for Privacy and Cultural Comfort

The desire for privacy or for care within a familiar environment may motivate some patients to seek treatment abroad.

Often these patients will select a country in which they have extended family or where they have a degree of cultural familiarity. A desire for privacy and increasingly easy access to international travel is cited by patients as factors in their decision to seek treatment abroad (2). Family connections, cultural comfort, and access to racially and ethnically matched donor gametes also play a role in seeking CBRC (9).

The growing data surrounding CBRC confirm that patients' motivations for fertility travel are diverse. At the same time, retrospective literature reviews conclude that patients' level of satisfaction with CBRC and its outcomes is generally high (34).

POTENTIAL BENEFITS OF CBRC

Cross-border reproductive care has potential benefits for ART stakeholders, including patients and their partners and offspring, ART providers, gamete donors, gestational carriers, and local populations in destination countries. These benefits flow from the 4 main factors that motivate the use of CBRC: improved access, reduced cost, circumvention of legal restrictions or avoidance of discrimination, and travel for privacy and cultural comfort.

Travel to Access Broader or Higher-Quality Care

Data suggest that tens of thousands of patients annually access CBRC (1, 2). A reasonable, but unproven, assumption regarding these data is that without CBRC, these patients would forgo or discontinue fertility care in their home countries. This presumed that net increase in worldwide utilization of ART is a benefit to patients and their partners, especially when treatment yields a successful outcome.

On a more philosophical level, access to cross-national care is a benefit to the offspring who would not have been born without the foreign treatment. Patients and their offspring may be benefited 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 another overall benefit of CBRC (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) (35). Improving access to donor oocytes improves IVF success rates for some patients, thus benefiting those who travel to procure donor gametes.

Travel to Reduce the Cost of Fertility Care

Patients also benefit from the lower cost of care in CBRC. Lower costs may improve outcomes by increasing the number of cycles a patient can afford to undergo. In addition, research shows that patients whose treatment is covered by insurance have lower rates of multiple pregnancies than the patients who must endure financial hardship to access care (36). Affordability is associated with better decision making concerning treatment (e.g., fewer embryos transferred), because patients may not be faced with the risk of depleting their resources for a chance at biologic

parenthood. That said, it must be noted that cross-border treatments have a higher rate of multiple pregnancies; this is a risk of assisted conception that should be disclosed to every patient, no matter the location of their treatment (37). Additionally, these multiple pregnancies are associated with poorer obstetric and neonatal outcomes; these additional (and likely unanticipated) costs may then be incurred by the patients in their home countries.

Travel to Circumvent ART Law and Avoid Discrimination

Traveling to avoid the application of restrictive laws in a home jurisdiction allows patients to escape from discrimination based on characteristics that are unrelated to their medical suitability for treatment. Independent of cost differences, patients may use CBRC to circumvent legal restrictions preventing fertility care in their home country. By traveling, patients who face discrimination at home have a chance to access the services they require to become parents, thereby realizing their right to build a family. 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 as to the medical practice (18).

Travel for Privacy and Cultural Comfort

Some patients will benefit from the privacy that CBRC provides. The individual(s) who struggle with infertility may wish to escape the scrutiny that even well-meaning family and friends may 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.

One additional benefit of CBRC may be the benefit to the local economies from inbound travel. Revenues from traveling patients can contribute substantially to local economies (24). Recent Turkish data found that the per capita expenditures of inbound medical tourists were more than double those of other tourists (38). Increased demand for fertility services can enhance access to both ART and general medical care for local populations. Assisted reproductive technology clinics must be brick-and-mortar structures equipped with functioning embryology laboratories, surgical suites, and patient examination rooms. These improvements can benefit local populations in the form of increased ART services or convertible medical infrastructure.

POTENTIAL HARMS OF CBRC

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

Health and Safety Concerns

The primary concern for traveling patients is the protection of their health and safety and that of their future children. In the ART context, health and safety concerns often 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; sophistication of the screening, surgical, and laboratory technology; and basic precautions 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 when patients leave their home countries where information about quality is likely more accessible.

In addition, if patients have medical or surgical complications from their fertility treatments that are identified after they return to their country of domicile, the lack of access to their medical records may present additional challenges to their care. Complicating this matter, patients may not be completely forthcoming about fertility care received internationally because of insurance coverage concerns. These unique situations may present unanticipated medical and ethical challenges for both the patient and provider.

Health and Safety of Offspring

The quality of ART care can impact the health of offspring, particularly in the context of multiple pregnancies. This is particularly true for CBRC, where limited patient information, out-of-pocket payments, time constraints, desire for success, and competition between fertility centers may push physicians to use more aggressive treatment protocols to increase success rates. This may lead to increased risks of maternal or fetal complications. 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 (39). The patients who travel to circumvent embryo transfer limits are at increased risk for multiple pregnancies (37). These situations may result in increased costs incurred later in their country of domicile (40–42). Illustrating this, French data (43) found that donor egg pregnancies conceived abroad had a higher number of embryos transferred (2.1 vs. 1.7, $P=.001$), a higher rate of multiple pregnancies (47.9% vs. 9.1%, $P=.001$), lower birth weight (2,678 vs. 3,045 g, $P=.001$), and higher prevalence of intrauterine growth retardation (11.1% vs. 4.2%, $P=.04$). Similar findings were seen in Australia, where at one center one third of all multiple pregnancy cases resulted from treatment overseas (44).

Additionally, offspring who are the result of gamete donation abroad may have less access to information about their genetic origins than identity-nondisclosed, donor-conceived children born following domestic arrangements. Although these donors were previously known as “anonymous,” anonymity for donors can no longer be guaranteed,

with the worldwide popularity of consumer genetic testing and online groups. Although 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, because access to these groups and services depends on a particular country's public access to online information.

Language, Information, and Legal Barriers

Patients may be harmed by lack of access to understandable information about their treatment options. Patients may not speak the native language of the destination country, which can make it difficult for them to make the best possible decisions regarding their treatment. 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. Misinformation may come directly from the fertility clinics or from CBRC brokers, who may provide limited transparency, with limited information about their services and remuneration (45). In addition, because of time pressures and different standards of medical ethics, physicians abroad may not follow the same standards of informed consent that patients experience in their home countries (46, 47). Ideally, CBRC fertility clinics should be transparent in disclosing the prices of all services to help avoid unanticipated debt after treatment (13). At least 1 report warns that patients traveling to access donor eggs can experience "bait and switch"—the use of a different gamete donor than the 1 the patient selects—a scheme discovered when the growing child bears no resemblance to the selected donor (48). In addition, the standard of reproductive care with respect to security of unused and frozen sperm samples, eggs, and embryos may not be assured, particularly in destinations with poor legal oversight (13, 46). 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 (49).

Additional harms to patients and their partners include the possibility of changing or evolving laws in destination jurisdictions. The timing and effective dates of such legal changes could jeopardize an anticipated or ongoing reproductive plan, possibly even resulting in the inability to remove a newborn child from the destination country. This may also affect cryopreserved embryos or gametes, which will be stored in the destination country but may need to be transferred internationally at some point in the future (50). Intended parents who engage a gestational carrier in a destination country for the purpose 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 (51). As with any complex legal matter, consultation with a legal professional experienced in the laws of the destination

country as well as the prospective 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 Donors and Gestational Carriers

Concern about exploitation of gamete donors and gestational carriers in destination countries occupies much of the critique of CBRC (33, 52, 53). This critique presumes that patients seeking third-party reproduction will be wealthier or more powerful in other ways 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 or childbearing capacity. Poverty, illiteracy, and absence of socioeconomic development in some societies may motivate some disadvantaged women to donate oocytes or serve as carriers for financial reward. Even worse, in some countries young women can be forced to participate in commercial donor or carrier programs shortly after reaching puberty (45). Although 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. However, it is important to note that for some women, being a gestational carrier offers a unique opportunity for financial gain and an improvement in personal circumstances.

Harms may also include malfeasance by an intermediary agency or breach of an agreement by a prospective parent(s), inflicting economic harm on third-party donors or gestational carriers. In rare but devastating cases, a prospective parent may fail or refuse to claim parentage of a child born by CBRC surrogacy, leaving the gestational carrier with the child in her care and no legal recourse against the foreign commissioning parents (54). In addition, in times when international travel is challenging or impossible (such as a global pandemic or natural disaster), it may be impossible for a gestational carrier to actually transfer the offspring that she has been carrying to the prospective parent(s).

Donors and gestational carriers in destination countries may suffer physical, social, economic, and psychological harm. It is unclear how much health care these women receive and of what quality and whether they are stigmatized in their native culture for taking on this role. For example, the economic pressure to have a donor produce as many eggs as possible may increase the risk of ovarian hyperstimulation syndrome in a geographic location with limited medical resources to treat this condition. Risks to gestational carriers include complications related to a multifetal pregnancy, postpartum hemorrhage, and shock. Additionally, destination countries may not have the same resources or access to care that would be available to pregnant women in their country of origin, thereby introducing increased risks over those that would be present if the same woman were to deliver in the prospective parents' country of origin.

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 the same effect. Increased demand for reproductive services in destination countries could raise the prices for domestic populations, making their access to services more difficult. In addition, 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 (55).

ETHICAL CONSIDERATIONS FOR DEPARTURE-COUNTRY PHYSICIANS

Patients who travel for ART begin their 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:

- What duty, if any, does the departure-country physician have to inform the patient about opportunities for care abroad?
- 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?
- 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 consulting 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 the information they need to understand their diagnosis and treatment options, as well as the risks and benefits of accepting or forgoing treatment so that they can make knowing and informed decisions (56).

If a patient asks a treating physician about options for care abroad, the provider has an ethical duty to accurately present his or her 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 relevant to the patient's decision, including any knowledge gaps or concerns the provider has

regarding a possible care plan. At the same time, physicians who have no information about CBRC have no duty to research the option for inquiring patients, nor are they duty-bound to offer the possibility of CBRC as a treatment option.

Duty to Disclose Risks and Benefits of CBRC Care

Informed consent requires physicians to disclose 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-à-vis that patient and has no duty to be informed about or disclose the risks and benefits of such treatment. If a physician possesses special knowledge about a particular provider or service about which the patient inquires, a duty arises not to 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. The lack or absence 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. When 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 (57). A 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 to provide 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 govern medical care in their own jurisdiction, including standards governing informed consent. That said, do physicians owe additional duties to patients who 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 the 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 illegal practice of law.

CONCLUSIONS

Cross-border reproductive care is a growing reality in ART. The main factors that incentivize patients to travel abroad for fertility care—access, cost, regulation, and privacy and cultural comfort—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 involve a duty to inform or warn patients about the potential legal or practical hazards that may accompany such care. The physicians who are asked to assist patients considering ART travel may, but are not obliged to, offer guidance about the options for CBRC. 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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Atención reproductiva transfronterera : Opinión del Comité de Ética de la Sociedad Americana de Medicina Reproductiva.

La atención reproductiva transfronterera es un fenómeno mundial en crecimiento, que plantea preguntas sobre por qué los pacientes que requieren Técnicas de Reproducción asistida viajan para recibir atención ,qué daños y beneficios pueden resultar y qué deberes deben tener los proveedores de atención médica para asesorar y tratar a los pacientes que viajan para recibir servicios reproductivos. La atención transfronterera puede beneficiar o perjudicar a las partes interesadas en las Técnicas de Reproducción Asistida, incluidos los pacientes, los descendientes, los proveedores, los donantes de gametos, los portadores gestacionales y las poblaciones locales en los países de destino.

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