Compassionate transfer: patient requests for embryo transfer for nonreproductive purposes

Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

A patient request to transfer embryos into her body in a location or at a time when pregnancy is highly unlikely to occur is deemed a request for "compassionate transfer" and often reflects the patient's deeply personal, strongly held preferences and values. It is ethically permissive for physicians to honor or decline such requests if they do so in a nondiscriminatory manner. (Fertil Steril® 2020;113:62–5. ©2019 by American Society for Reproductive Medicine.)

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KEY POINTS:

- A patient request to transfer potentially viable embryos into her body in a location or at a time when pregnancy is highly unlikely to occur, and when pregnancy is not the intended outcome, is deemed a request for "compassionate transfer."
- Valid and reasoned arguments exist to support provider decisions to perform the compassionate transfer of embryos for nonreproductive purposes and to decline to assist in such transfers. Principles of reproductive liberty, physician autonomy, medical futility, nonmaleficence, and distributive justice are potentially invoked in decision-making in this area.
- Programs should develop explicit written policies and procedures for handling requests for compassionate transfer of embryos, including requirements for written informed consent, and make these written policies available to all patients.

INTRODUCTION

Patient requests to transfer embryos when pregnancy is not desired may raise clinical and ethical dilemmas for providers and their patients. During in vitro fertilization (IVF), embryo transfer ordinarily is performed to produce pregnancy and childbirth. In rare but clinically and ethically significant instances, a patient requests transfer of existing cryopreserved embryos into her body with intent not to reproduce but rather to dispose of the embryo(s). These patients, for one or more deeply personal reasons, desire a method of disposition other than laboratory discard, donation for research or third-party reproduction, or continued cryopreservation. Instead, they seek thaw and transfer into their bodies in a location, manner, or time in which implantation and pregnancy are calculated not to occur. An embryo transfer for nonreproductive purposes is often called a "compassionate transfer" to reflect a provider's benevolent empathy in facilitating a patient's desired method of embryo disposition. The Committee adopts the term "compassionate transfer" herein to describe embryo transfer when pregnancy is not intended but also acknowledges it is not a term of exclusion; provider compassion toward patient choices is certainly not limited to requests for nonreproductive embryo transfer. This Opinion discusses the practice of compassionate transfer from the perspective of patients and providers. It further examines the clinical and ethical considerations for fertility clinics in providing or declining to provide these services upon patient request.

TRANSFER OF EMBRYOS WHEN PREGNANCY IS UNDESIRED

Current IVF technologies allow patients to cryopreserve embryos developed from a treatment cycle, thus deferring disposition of these frozen embryos until a later date. To facilitate this decision-making process, clinics and providers solicit written instructions from patients and, where applicable, their partners as to their preferences for disposition of frozen embryos under a range of potential circumstances in the future. While many patients initially elect embryo cryopreservation in hope of increasing their chance of

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Correspondence: Ethics Committee, American Society for Reproductive Medicine, 1209 Montgomery Highway, Birmingham, Alabama 35216 (E-mail: asrm@asrm.org).

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pregnancy and live birth in the future, up to 40% of these cryopreserved embryos ultimately will not be used for reproduction and remain unused (1). A 2002 study of 340 clinics specializing in assisted reproductive technology (ART) found that a significant number of embryos remain in long-term storage, raising questions about how patients make decisions about embryo disposition and why they leave their embryos in storage. Clinics that offer cryopreservation typically request that patients express their desires regarding ultimate disposition of embryos not used for reproductive purposes. Patients are asked to indicate their preferences in a written form, generally setting out three (or possibly four) available options: 1) donate the unused embryos to research, 2) donate the embryos to another infertile patient, 3) allow the embryos to be discarded after thaw in the laboratory, or in some cases, 4) store the embryos indefinitely (2). In some instances, clinics may provide thawed embryos to patients for disposal so long as such practice is permitted by law.

Survey data and published legal disputes indicate that even when patients select an option for disposition at the time of treatment, they may change their mind at a later time (3). Given the potential of cryopreserved embryos to be successfully thawed and used for reproductive purposes well into the future, the opportunity for changes in the patient's life course and reproductive desires abound. In some instances, disputes arise between the patient and her partner over the disposition of unused embryos. It is currently unknown, but possible, that an option for nonreproductive transfer could alleviate disputes concerning embryo disposition.

Patients' disposition decisions in general can be emotionally complex or distressing, ethically challenging, and lead some patients to postpone a decision for as long as possible. Some research indicates that indecision about embryo disposition can result in an estimated 20% of patients leaving their embryos in storage indefinitely (1; 4). Patients who do not discard or donate their embryos reveal that embryos continue to have significance to them, representing the potential to become a child, or their ”virtual child,” even when they have no desire to use the embryos for reproduction (5). For some, it may seem impossible to reconcile their view about the moral status of the embryos with any of the disposition options available to them. Research on patients' decisions about disposition has found that many patients would prefer disposition options not made available to them, such as being present for or involved in the disposal or holding a ceremony at the time of disposal or burial at a place and in a manner that state regulations governing the disposal of biological material may prohibit (2, 6). Despite some evidence that patients would select the option of compassionate transfer if made available for embryo discard, at least some research indicates that fewer than 5% of US clinics offer this option to patients (7).

Patient requests for compassionate embryo transfer in a manner that is highly unlikely to lead to pregnancy, and when pregnancy is not the intended outcome, may be attractive to some because the process is closely analogous to the natural *in vivo* failure of embryos to implant, an outcome potentially associated with every embryo-transfer procedure (7). Some variation on the practice of compassionate transfer may permit transfer to a place in the woman's body where pregnancy will not likely occur, such as the vagina, or placement in the uterus at a time in the woman's cycle when pregnancy is highly unlikely to result. Patient-advocacy organizations have supported compassionate transfer, as evidenced by the inclusion of this option for embryo disposition alongside those typically offered by ART clinics (8). One of the few studies to examine patient views about compassionate transfers found that about 20% would be interested in this alternative (9). Those patients who prefer this disposition, letting the embryos be absorbed in the body, see it as more respectful, personal, or natural than disposal in the laboratory. Moreover, compassionate transfer may be virtually the only acceptable option for patients in an estimated 16% of US IVF programs that for religious, ethical, or other reasons do not permit discard in the laboratory (2).

Until recently, data on the availability of compassionate transfer were scant, though one 2009 article indicated that fewer than 5% of all US fertility clinics offered this option to patients (7). In a 2018 survey of members of the Society for Reproductive Endocrinology and Infertility (SREI), more information became known about provider practices and attitudes toward compassionate transfer. The SREI survey revealed that nearly 45% of all responders who were aware of this option had offered the service to a patient (10). A greater percentage of those surveyed (78%) reported that they would offer compassionate transfer if there was patient demand, while 45% said they would offer the option if there was guidance from ASRM in place addressing the practice. The survey also revealed variation in practice as to the location of embryo transfer (endometrium, vagina, cervix), the timing of embryo transfer, the number of embryos transferred, and the fee structures in place when a transfer was performed. Three providers reported pregnancies from compassionate transfer, though none were ectopic (10).

ETHICAL CONSIDERATIONS

The arguments for honoring patient requests to transfer embryos when pregnancy is not desired dwell in the realm of reproductive liberty, patient autonomy, and provider beneficence. Reproductive liberty is a broad-based principle that protects against outside interference with patient control over reproductive decision-making, including decisions about the disposition of embryos (11). A liberty-based argument in favor of compassionate transfer focuses on the harms that result from infringement on this patient choice, whether those barriers are imposed by providers, the state, or other third parties. The principle of patient autonomy, a respected value in reproductive medicine, also arguably includes the right to control one's embryos as a feature of patient self-determination. This Committee has previously acknowledged that some requests in assisted reproduction may be generated by a patient's deeply held private beliefs and values that are deserving of respect (12, 13). These beliefs and rationales are compatible with the exercise of reproductive liberty and patient autonomy.

The ethical principle of beneficence may also support a provider's decision to honor patient requests for compassionate transfer. According to this principle as applied in the medical setting, providers have a duty to act for the patient's welfare. The Committee has previously discussed that patients' treatment goals can include purely psychological, rather than physiological, benefits from the requested medical intervention (14). Allowing patients to undergo embryo transfer not intended to result in pregnancy can enhance patients' emotional, psychological, and social welfare; it thus may fulfill a physician's duty of beneficence as it is understood in its psychosocial dimension.

The arguments for declining patient requests rely on principles of physician autonomy, nonmaleficence, medical futility, and distributive justice. Physicians are not obligated to meet every patient request, particularly when treatment is futile or highly unlikely to engender any medical benefit (14). Compassionate transfer provides no medical benefit to the patient, and in fact is specifically calculated to avert the benefit for which the embryos were originally created. Providers may also argue against honoring patient requests out of concern for potential harms or unnecessary risks to patient well-being, including the remote possibilities of pelvic infection, ectopic pregnancy, and uterine implantation, leading to miscarriage or an unintended pregnancy (7). Additional factors that have an effect on providers and argue against compassionate transfer include the view that these transfers are an inappropriate use of resources, including provider and staff time, and can cause facility inaccessibility for others. An additional argument that compassionate transfer need not be made available to patients is based on notions of efficiency. Since patients intend the ultimate outcome of compassionate transfer to be embryo discard, the additional resources required to achieve this result compared to the traditional means of discard in the laboratory cannot be ethically justified (15). This argument, however technically accurate, fails to account for any emotional or psychological benefit a patient might gain as a result of directing disposition in a manner of her choice.

Other arguments for declining to provide compassionate transfer highlight ethical misgivings about performing a procedure that has no medical benefit, while at the same time requiring additional patient financial outlay because the procedure is not eligible for insurance coverage. As the Committee has previously discussed (14), clinicians may ethically refuse to provide treatment when, in their professional judgment, they regard such treatments as futile with minimal or no chance of success. Additionally, ethical considerations involve the concept of distributive justice, provoked by the clinical reality that compassionate transfer is only available to female patients. Single males or same-sex male couples who secure embryos for reproduction have no opportunity to seek embryo demise in the same manner as female patients, that is within their body. The Committee believes that enlisting a woman for this purpose exceeds the ethical parameters governing collaborative reproduction, as no reproduction is intended and no benefit to her can result. While single males or same-sex male couples may seek compassionate transfer for reasons aligned with those expressed by female patients, the risk/benefit ratio in third-party embryo transfer for nonreproductive purposes positions it outside the scope of ethical justification.

Finally, the Committee acknowledges that it can be psychologically, emotionally, and morally difficult for a patient to be in a position to activate a disposition decision for excess embryos. A compassionate transfer decision can lessen the sense of moral distress for some patients by allowing them to conclude that the ultimate outcome for their embryo—whether it implants or not—was made by nature, divine intervention, or a higher power, rather than the patient herself. While the belief that the ultimate outcome of the embryo was directed or decreed by some outside force may be a comfort to patients, it can be argued that this rationale is a form of self-deception or intentionally misconstruing the outcome of the transfer. Providers may object to colluding in patients' self-deception, preferring to encourage patients to address and resolve psychological, emotional, and/or moral dilemmas regarding excess embryos.

CONSENT AND DISCLOSURE CONSIDERATIONS

Patient requests for compassionate transfer should be regarded the same as patient requests for embryo transfer for reproductive purposes as far as matters of consent are concerned. Generally speaking, informed consent for embryo transfer, including compassionate transfer, must be obtained from both the patient and her partner, and must address all reasonably foreseeable risks including the possibility of pregnancy. In addition, patients must be notified of the cost of such procedures. In the event a patient and her partner disagree over the disposition of embryos, a provider can look to any preconception or other agreements the parties entered into for guidance. In the absence of specific language governing compassionate transfer, or in the event of ambiguity or uncertainty, providers are strongly encouraged to seek counsel from a qualified legal expert. Under no circumstances should compassionate transfer be performed without the express written informed consent of the patient into whom the embryos are being transferred.

Providers may accommodate patient requests for compassionate transfer either by performing the embryo transfer or transferring the embryos to another provider or facility willing to perform the requested compassionate embryo transfer. Patients are always free to transfer their embryos to another center that is willing to accommodate their disposition preferences. In the case of either direct service or transfer to another facility, providers are obligated to fully inform the patient of the potential risks involved. Moreover, providers are obliged to comply with preexisting reporting requirements governing embryo transfer, including any specific requirements surrounding compassionate transfer of embryos. In addition, any embryo thaw or transfer should be well documented in the patient's medical record. Clinics are strongly encouraged to develop and make available written policies to inform patients of their practices with regard to the disposition of embryos when pregnancy is not desired.

CONCLUSIONS

Patient decisions about embryo transfer and disposition in general are complex and, as is shown in the instances above, impact both providers and patients. Patient requests for embryo transfer in a place or at a time when pregnancy is highly unlikely to occur often reflect deeply held individual preferences and values and are entitled to respect. Principles of reproductive liberty and patient autonomy support these patient requests as a method of exercising control over a broad range of reproductive choices. It is ethically permissible for providers to honor such requests, so long as they engage in an adequate informed-consent process with the patient. However, providers are not obligated to provide such services. Physician autonomy, concerns about the provision of nonbeneficial treatment, and the maldistribution of scarce medical resources support physician refusals to honor patient requests for compassionate transfer of embryos, except in the case of impermissible discrimination. Clinics are strongly encouraged to develop and make available written policies regarding patient requests for compassionate transfer of cryopreserved embryos.

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The following members of the ASRM Ethics Committee participated in the development of this document. All Committee members disclosed commercial and financial relationships with manufacturers or distributors of goods or services used to treat patients. Members of the Committee who were found to have conflicts of interest based on the relationships disclosed did not participate in the discussion or development of this document.

Judith Daar, J.D.; Jean Benward, M.S.W.; Lee Collins, J.D.; Christos Coutifaris, M.D., Ph.D.; Joseph Davis, D.O.; Owen Davis, M.D.; Leslie Francis, Ph.D., JD; Ruth Farrell, M.D.; Elena Gates, M.D.; Elizabeth Ginsburg, M.D.; Susan Gitlin, Ph.D.; William Hurd, M.D., M.P.H.; Mandy Katz-Jaffe, Ph.D.; Sigal Klipstein, M.D.; Barbara Koenig, Ph.D.; Andrew La Barbera, Ph.D., H.C.L.D.; Laurence McCullough, Ph.D.; Richard Paulson, M.D.; Richard Reindollar, M.D.; Ginny Ryan, M.D.; Mary Samplaski, M.D.; Mark Sauer, M.D., MS; Rebecca Sokol, M.D., M.P.H.; Sean Tipton, M.A.; Lynn Westphal, M.D.; Julianne Zweifel, Ph.D.

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