

Human germ-line gene editing

Recommendations

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Introduction

Recent research and expected further studies in gene editing raise high expectations, especially regarding possible therapeutic applications in humans. Most promising is the prospect of somatic gene editing, which may prove to be a game changer not only in the treatment of a whole range of serious genetic disorders, especially Mendelian ones, but also in the treatment of cancer and infectious diseases. At the same time, the possibility of a future application in the human germ-line raises serious concerns. In previous decades, legislation has been developed that does not allow changes to the human germline. What were the arguments behind this legislation, do they still apply and are they still convincing? If a technique can help to avoid serious genetic disorders, in a safe and effective way, would this be a reason to reconsider earlier standpoints? Discussion with relevant stakeholders is needed, including professional health care workers, patients and different lay publics, legal and ethical experts. Initiatives have been taken worldwide to exchange views about responsible governance and approaches to innovation using human gene editing. The European Society of Human Genetics (ESHG) and the European Society of Human Reproduction and Embryology (ESHRE) consider it to be their professional responsibility to contribute to further discussion by means of a set of Recommendations, based on a Background paper, focusing on human germ-line gene editing (GLGE).

The aim of this contribution is to inform and stimulate ongoing societal debates, as well as provide guidance, taking account of technical aspects of GLGE, its different possible applications, relevant clinical experience regarding the handling of reproductive risk, legal regulations and ethical and societal issues and concerns linked with GLGE. Because of the relevance of the latter, both the ESHG and ESHRE invited their relevant committees (respectively the Public and Professional Policy Committee of ESHG and the Ethics Committee of ESHRE) to take the lead in writing the Background paper and the Recommendations. These were discussed in both committees. A draft of the Recommendations has been online from October 17 until December 2, 2016 and has been presented at the ASHG meeting in Vancouver. The Background document and the Recommendations have been

posted online to solicit comments from the membership of both ESHG and ESHRE from April 3 until May 5 2017. After integrating the comments, the Recommendations have been endorsed by the Board of ESHG and the Executive Committee of ESHRE. This Document has a provisional nature, and is to be evaluated regularly, taking account of relevant scientific developments, possible future clinical experience, and further societal discussions and ethical reflection. The Recommendations should be understood against the argumentation provided in the Background document. We strongly recommend also reading this Background document and will refer to relevant sections below.

Opmerking [CM1]: Expected May 2017
This text will be the final version

Recommendations

In preparing this Document, it was considered crucial to make a distinction between non-reproductive GLGE in basic research, non-reproductive GLGE in preclinical research and possible future clinical (reproductive) GLGE.

I. Non-reproductive germ-line gene editing in basic research

Non-reproductive GLGE primarily concerns basic research. Although a sharp demarcation between basic research and preclinical research is difficult to make, basic research in this context is characterized by a focus on fundamental questions regarding human embryology and the methods applied in gene editing. Reproductive treatments in health care and adequate patient counseling may be served by a better knowledge of early embryo development. There are good reasons to allow basic research in this area, subject of course to societal oversight and taking account of relevant ethical guidelines and (inter-)national legal regulations.

The research use of human somatic cells and (precursor cells of) gametes is less controversial than human embryo research *in vitro*. The Oviedo Convention categorically prohibits the making of human embryos specifically for research purposes ('research embryos'). Several European countries rely on the use of spare embryos left over after IVF procedures only. However, also from an ethical point of view, this prohibition may be contested. The use of research embryos could be morally justified, subject to ethical, legal and societal oversight, if the research question cannot be adequately addressed on the basis of spare embryos only and if research embryos are necessary to reach the aim(s) of scientifically sound and robust research, as elaborated in the Background document. Given the sensitivity of human germ-line interventions, the specific consent of the providers of the gametes and embryos to such use should be obtained.

II. Non-reproductive germ-line gene editing in preclinical research

Only after establishing a more robust knowledge acquired from basic research, might possible future clinical applications be considered which would require further societal and professional discussions. Both for scientific and moral reasons, as a precondition for any potential clinical applications of GLGE, adequate preclinical GLGE is necessary. Preclinical research, involving both animal research and human embryo research, is an important element of the moral framework for the introduction of new, experimental, reproductive technologies generally. Given the specific sensitivity of GLGE, such research would have to take place under thorough societal oversight. Pre-clinical GLGE research would involve investigation of the safety (e.g. possible off-target effects or epigenetic effects) and effectiveness of gene editing in view of possible future reproductive applications of GLGE in gametes,

zygotes or preimplantation embryos. Such research is important to identify and eliminate, or at least reduce, avoidable risks for those seeking to develop or to make use of such applications and any future children thus conceived.

Conceptually the term preclinical research may allude to potential application at least being considered, if not intended. However, preclinical research is a necessary, but not sufficient prerequisite for application, and application does certainly not automatically follow from allowing preclinical research as is outlined in the Background Document.

'Comprehensive' genetic testing (PGT) of embryos using whole genome sequencing might be an integral part of adequate pre-clinical research on the safety and specificity of GLGE to investigate potential off-target effects. The issue of how to handle possible incidental findings regarding the genetic make-up of the providers of the gametes or embryos should be addressed in the informed consent process, taking account of relevant guidelines.

III Reproductive germ-line gene editing

Potentially in the future, depending on the outcomes of basic and preclinical research and taking account of societal views, risks and implications (see below), the step to the clinic may be considered. If so, this should be embedded in a formal and rigid research trajectory. According to the Clinical Trials Regulation EU No.536/2014, Article 90 "No gene therapy clinical trials may be carried out which result in modifications to the subject's germ line genetic identity." The implication of this regulation, if interpreted strictly, may well be that adequate clinical GLGE research will be impossible in the EU. Meanwhile, these applications may take place outside the EU and in some cases may be carried out without proper research protocols. Given the technological development and the ethical analysis as given in the background document comparing GLGE to other available reproductive options, the time has come to discuss the rationale and consequences of this Clinical Trials Regulation.

If shown to be safe and effective, GLGE may come to have important benefits for prospective parents at high risk of having a child affected by a serious genetic disorder.

Categorical deontological objections to GLGE - in terms of being at odds with e.g. naturalness, human dignity, or the preservation of the human gene pool as a common heritage – are often used both in public debate and legal discourse. While these objections may be relevant for possible (mostly rather theoretical) enhancement-like applications of GLGE, they seem unconvincing when it comes to possible applications of GLGE with a clear therapeutic or preventive aim, as elaborated in the Background document. A better understanding of these objections, and the context in which they are used, is needed to inform future policy decisions, public debate and the counseling of individual patients.

Consequentialist objections to reproductive GLGE, regarding both A) health risks and B) societal concerns, need more scrutiny and debate.

A) Health risks

In this context health risks should be taken to refer to not only the first but also possible subsequent generations. Different types of possible adverse effects (off-target and pleiotropic, genetic and epigenetic) need investigation. In view of the many unknowns, any use of germline gene editing methods for clinical purposes, including any reproductive use of gametes derived from edited pluripotent somatic cells, should be regarded as premature and therefore at present unacceptable.

Clinical applications can only become morally justified if adequate pre-clinical safety research, including (human) embryo research, shows clinical GLGE to be sufficiently safe and efficient. The proper standard for the evaluation of possible residual risks ('how safe is safe enough for starting clinical applications?') needs further debate and clarification.

If comprehensive PGT of edited embryos on the basis of whole genome sequencing would be included as a safeguard in future clinical GLGE, this testing should be focussed at possible off-target effects. A possible broadening of the interpretation of the raw data generated by such PGT raises complex additional ethical issues and needs further multidisciplinary analysis and debate. The proportionality of such broader analysis should not be taken for granted.

Furthermore, any potential future reproductive GLGE would require prospective data collection of reproductive outcomes and long-term follow-up studies on the health of children thus conceived. Possible practical barriers and limits (in terms of for example lack of funding or tensions between long term follow up and familial and children's privacy) may render this challenging, as with long-term follow-up of children conceived through new reproductive technologies generally.

B) Societal concerns

The major societal risks often mentioned in this context are inequity, the undermining of reproductive autonomy, the position of people affected with impairments or disabilities, and possible misuse of GLGE for non-medical applications.

The disability rights critique forcefully reminds society of its responsibilities towards people with disabilities, more particularly its obligation to remove barriers for inclusion, but it should not be used as an argument against the development of medical therapies, including GE, irrespective of whether it regards somatic or germ-line GE.

Equal access to health care has to be decided at the level of society as a whole. Public funding, as some countries have provided for PGD, can mitigate the concerns regarding inequity. If limited funding is available for health care, prioritization is needed. It is conceivable that somatic gene editing will be prioritized over GLGE as many serious health problems could be targeted and it might be a proportionate approach to treatment.

Reproductive autonomy should be maintained and respected by both adequate counseling and provisions for disabled people. Moreover, while some fear the undermining of reproductive autonomy, it should be noted that GLGE may well promote the reproductive autonomy of prospective parents at high risk of having a child affected with a serious disorder, as it would increase the number of reproductive options (see below).

The experience with regulating PGD and other reproductive technologies should help the building of a sound strategy for regulating possible future clinical applications of GLGE, including a licensing system for clinics involved, quality controls and obligatory regular reporting by licensed clinics of their handling of requests for GLGE, in order to ensure strong societal and professional oversight. If clinical GLGE is considered to be sound, priority should be given to the editing of highly penetrant genes causing serious disorders. As the distinction between serious and less serious disorders is unclear, feeding fears of a slippery slope, further multidisciplinary reflection on the demarcation of serious disorders is needed. In addition, the distinction between therapy and enhancement is not always clear-cut and decisions will need to be made about intermediate subtypes of medical enhancement, such as strengthening the human immune system or editing carrier status for recessive disorders or structural aberrations. With regard to fears about possible future 'designer babies', it is important to acknowledge that the prospect of enhancing complex traits (like intelligence) is to a large extent science fiction, and that possible efforts to enhance traits would run a disproportional risk of antagonistic (harmful) pleiotropic effects. Public debate and education is needed to lower the risk of commercial companies seeking to exploit prospective parents' (unrealistic) preference for a 'perfect child'.

In view of the medical and societal risks of, and concerns regarding GLGE, it is important to take account of other reproductive options for people at high risk of having an affected child. Considering the preference of most prospective parents to have a healthy child who is genetically related to them both, PGD, aimed at a selective transfer of an unaffected embryo, may be a good 'preventive' option in most cases. Still, there may be situations where GLGE might be justified and cautiously considered, depending upon, amongst other factors, the genetic disorder under consideration, the prospective parent's genetic makeup, their experiences with clinical PGD, their weighing of the possible risks and burdens of a further cycle of IVF/PGD, and their moral preferences, including their possible wish to minimize embryo loss. A further ethical and societal evaluation of relevant aspects, including possible health risks of GLGE, is needed to define the potential future indications for clinical GLGE as an alternative to PGD aimed at selectively transferring an unaffected embryo.

Possible future routine comprehensive PGT of IVF-embryos using whole genome sequencing, aimed at selecting 'the best embryo' for transfer, needs proactive ethical and societal debate. Such testing could well, assuming a further improvement of the efficiency of editing (post-zygotic) embryos, function as a driver for future routine GLGE, at least among some (wealthy) social groups. After all, there will always be potentially pathogenic variants, as all embryos, like humans, are 'fellow mutants'. While this scenario would be problematic in view of the pleiotropic risks of GLGE, it does at the same time urge society even more strongly (than GLGE of one particular disease characteristic) to engage in a more principled debate about the ethics of and policymaking regarding the conceptually and morally grey area between therapeutic, preventive and enhancing GLGE.

III. Governance

A process of ongoing public debate about material and procedural ethical and societal issues raised by both non-reproductive and reproductive human GLGE is of the utmost importance. Such debate should be based on sound scientific evidence as well as sound, ethical, legal and social reflection in such a manner that many different stakeholders can understand and take part. A strategic plan,

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including funding, practical and temporal aspects should be devised to ensure that such debates are prioritized and undertaken at the same time the science and policy discussions evolve. Multi-stakeholder debates should be inclusive; apart from scientists and clinicians, other stakeholders should be invited to participate, including patients' organizations, different lay publics, policymakers, and scholars in the medical humanities.

These current Recommendations build a first, joint, contribution of both ESHRE and the ESHG to the suggested ongoing trajectory of public deliberations. The Recommendations have a provisional nature and are to be evaluated regularly and systematically.

DRAFT April 3, 2017