Consideration of the gestational carrier: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

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Intended parents engage with gestational carriers in an attempt to achieve their personal reproductive goals. All gestational carriers have a right to be fully informed of the risks as well as the contractual and legal aspects of the gestational-carrier process. Gestational carriers have autonomy in making their own decisions regarding medical care and should be free from undue influences by the stakeholders involved. They should have free access to and receive psychological evaluation and counseling before, during, and after participating. Gestational carriers require independent legal counsel regarding the execution of contracts. This document replaces the document of the same name, last published in 2013 (Fertil Steril 2013;99:1838–1841). (Fertil Steril® 2018;110:1017–21. ©2018 by American Society for Reproductive Medicine.)

KEY POINTS

- Gestational carriers are the sole source of consent regarding their medical care from embryo transfer through prenatal care, labor, delivery, and aftercare.
- Gestational carriers have a right to be fully informed of the risks of the gestational-carrier arrangement and of pregnancy. These should include known physical, psychological, and social risks that may occur because of participation.
- Gestational carriers should receive psychological evaluation before, and access to counseling during and after participation. The terms and limits of this care should be specifically defined as part of their contractual agreement, including liability for costs.
- Gestational carriers require independent legal counsel.
- It is ethically justifiable for a gestational carrier to receive financial compensation for her participation in a gestational-carrier arrangement.
- The intended parents should be the legal parents of any children born to a gestational carrier. In jurisdictions that provide otherwise, the intended parents must take all necessary legal steps to secure their status as the legal parents of any child born because of a gestational-carrier arrangement
- Gestational-carrier arrangements are ethically justifiable if the gestational carrier is provided all material information about the benefits and risks of the arrangement, gives fully informed consent, and receives legal advice, health care, emotional support, and psychological counseling.

Use of a gestational carrier is an option for family formation in which a woman agrees to gestate a child for a couple or individual seeking these reproductive services to become parents. The woman who bears the child is commonly referred to as the gestational carrier, while the couple or individual who seek(s) these reproductive services are referred to as intended parents. Use of a gestational carrier in the modern era was made possible by the development of in vitro fertilization (IVF), which enables physicians to transfer an intended parents' embryo into the uterus of a gestational carrier. When first introduced in the 1980s, gestational carriers were used primarily by intended opposite-sex parents who had fertility or medical problems that precluded the female partner from carrying the pregnancy. Increasingly, the process also is used by unpartnered individuals and same-sex couples desiring to become parents.

For purposes of clarity, the terms used in this document to describe the reproductive roles that each participant plays in a gestational-carrier arrangement will be defined. "Gestational carrier" refers to situations in which the individual provides only gestation and does not provide her gamete(s) for pregnancy. This contrasts with "traditional surrogacy," which refers to situations in which the gestational carrier provides the oocyte(s) and gestates the pregnancy. For this statement, the discussion will be limited to gestational carriers, since traditional surrogacy is rarely offered by most programs, and is more ethically and legally complex (1). "Intended parent(s)" are the individuals contracting with the gestational carrier to achieve their reproductive goals and who plan to be the social and legal parents of the child. "Gamete providers" are the sources of

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the sperm and oocytes; they may or may not be the intended parents. Thus, gestational-carrier arrangements may take place with embryos derived from donor sperm and donor oocytes, donated embryos, or embryos created from gametes of one or both intended parents.

The number of gestational-carrier cycles in the United States has grown steadily over the past decade and a half. Between 1999 and 2013, the percentage of assisted-reproduction cycles that involved gestational carriers increased from 1% to 2.5%, resulting in an estimated 18,400 live-born infants over that same period (1). In 2013, more than 3,400 gestational-carrier cycles were performed in the United States, comprising approximately 2.5% of all assisted-reproduction cycles (2). Longitudinal studies show that gestational-carrier cycles had higher rates of implantation, pregnancy, and live birth compared with nongestational-carrier cycles.

The gestational-carrier process requires IVF. Intended parents either use the oocytes of the intended mother or the oocytes of an egg donor. The woman contributing the oocytes in a case involving a gestational carrier is typically stimulated with fertility drugs to produce multiple oocytes at once. These oocytes are retrieved and fertilized with the intended father's sperm or the sperm of a donor. The resulting embryo is transferred into the gestational carrier. The gestational carrier usually requires exogenous hormonal support to prepare and support the pregnancy. These are usually self-administered. Once a pregnancy is confirmed, the gestational carrier has frequent, often weekly, follow-up visits that include blood work and ultrasounds before she is discharged to regular obstetrical care.

A range of viewpoints has surrounded the practice of payment for surrogacy or a carrier arrangement since its inception. Arguments in support of payment for a gestational-carrier arrangement emphasize the reproductive autonomy that each party is free to exercise in decision-making surrounding procreation, including a decision to engage or participate as a gestational carrier (3). Studies investigating the impact of these arrangements in the United States report that both gestational carriers and intended parents view their experience as positive and rewarding (4). Arguments in opposition to payment focus on the potential for harm to the gestational carrier and the resulting offspring. Some theorists have opposed contractual surrogacy as the commodification of the body (5). Others, emphasizing autonomy, have argued that contractual surrogacy is permissible, but only if the woman retains the right to choose to end the pregnancy as well as the right to revoke the agreement at any time (6). Defenders of more traditional family structures and methods of reproduction have argued that the practice of surrogacy should be prohibited outright (7). These longstanding controversies are rooted in deep conflicts of values. Regardless of how these arguments are resolved, it is apparent that certain safeguards for both the gestational carrier and the intended parent(s) are necessary for any form of surrogacy to be ethically acceptable, and to reduce the risk of legal disputes.

This statement considers the protective safeguards that need to be in place to ensure the ethical treatment of gestational carriers. These safeguards address the following issues: appropriate selection of carriers, counseling and informed consent, and contractual and economic considerations. Additional guidance on the use of gestational carriers has been provided by the ASRM Practice Committee in its document, "Recommendations for practices utilizing gestational carriers: a committee opinion" (8).

COUNSELING AND INFORMED CONSENT

Gestational carriers have a right to be fully informed of the risks of participation, including the risks known to accompany pregnancy and the gestational-carrier processes. Gestational carriers require appropriate medical care throughout treatment and pregnancy. While the choice of obstetrician should ideally be mutually acceptable to the intended parent(s) and carrier, the carrier is to be the sole source of consent for her treatment from hormonal preparation and embryo transfer through delivery and aftercare (1). This is critical as complications of pregnancy might result in situations where fetal or neonatal well-being could be compromised to preserve maternal health. While the interests of the intended parents are considerable, as they seek to exercise their own reproductive goals, the gestational carrier retains ultimate decision-making authority over her own care. In support of this, contracts should address decision-making in the event of the loss of capacity of the gestational carrier.

It is essential that all parties are thoroughly counseled prior to entering an agreement. The intended parents, gestational carrier, and her spouse, if applicable, should all be parties to the contract. Once each participant has had the opportunity to anticipate and evaluate the risks and rewards for entering into a gestational-carrier arrangement, each participant has the personal responsibility for that decision. Both the intended parents and gestational carrier and her spouse or partner should receive counseling regarding their expectations for the relationship and the risks of not having those expectations met. Efforts should be made to have the participants evaluate whether their goals and expectations are congruent. Specifically, issues related to embryo transfer, prenatal testing, and pregnancy termination should be addressed. In addition, advance consideration should be given to the management of potential obstetric complications such as preterm labor, dysfunctional labor, and the development of maternal morbidities such as preeclampsia.

It is particularly important that the gestational carrier appreciate that her participation in the arrangement is in support of the reproductive goals of the intended parents. A gestational carrier should not engage in an agreement with the intended parents if she identifies a misalignment of goals or areas where she anticipates difficulty supporting the intended parent(s)' expressed reproductive plans. An example would be decision-making about termination in the face of multiple pregnancy or fetal anomalies. Another example would be the intended parents' plan to simultaneously engage another gestational carrier. This information should be discussed as each gestational carrier may have an interest only in providing exclusive services to the intended parents. Carriers and intended parents should be encouraged to end a collaborative arrangement prior to embryo transfer should they anticipate that there is a lack of congruency or respect.

If there is a disagreement or dispute during the pregnancy, the terms reflected in the mutually agreed-upon contract should prevail. However, the carrier has the ultimate authority about any procedures on her body and cannot be compelled to submit to or decline a procedure regardless of the contract or consequences of a breach.

Single-embryo transfer is the preferred approach in an increasing proportion of IVF treatment cycles (9) Adherence to practice guidance supporting single-embryo transfer is particularly important in the treatment of gestational carriers, as they are assuming physical risk in support of the reproductive interests of the intended parents as well as the risk that difficult ethical decisions might arise (10).

Carriers also need to understand the type of infectious-disease screening that will be performed prior to participation and when any potential infectious risks might arise. Conversely, the intended parent(s) need to understand the limits of infectious-disease screening insofar as the carrier may be exposed to risks throughout the duration of the pregnancy.

Carriers should be at least 21 years of age, healthy, have a stable social environment, and have had at least one uncomplicated pregnancy that resulted in the delivery of a healthy child. To give true informed consent without the experience of a pregnancy and a delivery is problematic because of the prolonged, intense, and unique nature of the experience. Setting a minimum age limit for a variety of activities has proved controversial in American society; for example, at age 18 a woman is considered old enough to join the military but not old enough to drink alcohol. Given the very complex emotional tasks of the pregnancy and the postpartum period, as well as the demands of negotiating a relationship with intended parents, it is reasonable to adopt a conservative position about age in gestational-carrier arrangements by setting the minimum age at 21 years.

It also is advisable to discuss with carriers the broader social context in which they are participating in the gestational-carrier arrangement. Carriers should be counseled to consider potential impact on their own children and to think about what their children will be told about the pregnancy. Carriers should be advised to think about their children's interests independently of their own motivation to be a carrier. Though methodological limitations exist, evidence regarding the psychological outcomes of the children of carriers has been reassuring (11, 12). Nevertheless, carriers should be counseled to carefully consider the potential impact of the gestational-carrier arrangement on their children and their children's possible feelings and reactions. Similar questions should be raised about the interests and concerns of the carrier's spouse or partner, if any. A carrier's spouse or domestic partner also should be involved with consent, as the pregnancy has the potential to have emotional and practical demands on the family more generally.

Although gestational-carrier programs have been in existence and active since the late 1980s, research on the entire experience has been extremely limited. Although the research is limited and should be viewed with caution, recent studies have examined the gestational carriers' experience. These studies indicate that, despite some negative experiences, most arrangements are successful overall, appear to be a positive experience for the gestational carrier, and do not cause harm to her children (11–15). Further research in this area needs to occur and should be encouraged.

Based on the above considerations, the Committee believes that if the gestational carrier is given all material information about the benefits and risks of the arrangement, gives fully informed consent, and receives legal advice, health care, emotional support, and psychological counseling, it is reasonable to conclude that gestational-carrier arrangements are ethically justifiable.

CONTRACTUAL AND ECONOMIC CONSIDERATIONS

The importance of specific legal protections, while beyond the scope of this opinion, compels the Committee to emphasize that carriers must have independent legal counsel whose duty of care is to the gestational carrier alone. Because of the potential conflicts of interest of the parties involved in carrier arrangements and the potentially intensely emotional nature of the process, access to such independent advice is crucial. To protect against attorney conflicts of interest, the gestational carrier must be free to choose her own counsel with the appropriate level of skill and licensure. Costs of such counsel should not be borne by the gestational carrier, though she should not be prohibited from funding her own legal representation should she so choose. This opinion is not intended to give legal advice; state laws on these arrangements vary enormously and must be consulted in each case.

Both parties involved, intended parent(s) and gestational carrier, have important interests at stake in the arrangement. For intended parent(s), the agreement represents the attempt to accomplish their own reproductive goals. Resolution of disagreements will require assignment of roles and responsibilities among the parties. As an ethical matter, legal agreements must be in place to spell out and then protect each participant's roles and responsibilities. Counseling is an adjunct to the legal agreement to help each participant understand and communicate his or her needs and/or expectations. If a disagreement should occur, the legal agreement should direct the resolution of the issue. If the carrier chooses to refuse a procedure previously agreed upon or, conversely, chooses to undergo a procedure such as termination against the intended parents' wishes, the consequences should be addressed in the contract. In the rare event that a dispute over the child should occur (as only a relatively few number of cases have been documented), the documented intentions of all the parties should stand as recognized in the legal agreement.

Arguments have been advanced on both sides about using intentionality in this manner to determine parenthood. Those who argue against intentionality state that women cannot anticipate their feelings about pregnancy and that, in fact, pregnancy is a privileged experience that supersedes other considerations because of the special bond that forms between the gestational carrier and the fetus. The ethical counterargument is that, in the case of carriers who have

borne children, their experience should give them the appropriate basis to honestly judge their capacity to participate in a gestational-carrier role and to respect the interests of the intended parents. In such cases, intentionality properly laid out in advance in the legal agreement sets the appropriate expectations for the parties.

Compensation for gestational carriers is ethically permissible. It is also consistent with compensation for other situations, such as participation in medical research, in which individuals are paid for activities demanding time, stress, physical effort, and risk. A parallel position about compensation in the context of gestational carriers, therefore, is reasonable. In addition, gestational carriers should receive adequate healthcare coverage for pregnancy care and for the treatment of sequelae of pregnancy complications. In addressing these matters, the gestational carrier should take into account 9 months of possible illness, risks to employment, burdens on other family members, and the like, but compensation should not create undue inducement or risks of exploitation. Compensation should be aimed primarily at compensating women for the time, inconvenience, and risk associated with embryo transfer, pregnancy, and delivery. It should not be contingent upon the birth of a healthy child. While single-embryo transfer is very strongly encouraged, the additional risk, burden, and costs associated with a possible multiple pregnancy should be addressed in the gestational-carrier contract.

The concept of compensation for gestational-carrier arrangements has been controversial since its inception and has varied depending on region or country. At the core of concerns about compensation is the creation of undue inducements for women to expose themselves to the physical and emotional risks that accompany any pregnancy. Compensation may induce women to undertake a pregnancy or to collaborate with intended parents or a recruiter with whom they might otherwise not undertake an agreement. Risks may not be considered adequately in the service of financial need or opportunity. Payments may also create incentives that might encourage potential gestational carriers not to disclose fully about health conditions or family history.

Many argue that compensation, by definition, will entice economically disadvantaged women to undertake gestational-carrier arrangements, especially if they do not believe they have other reasonable and realistic choices in their lives. Ethical concerns also arise from socioeconomic differences between intended parents and gestational carriers. The rising popularity of using gestational carriers from less affluent or developing nations calls attention to these last two concerns (16).

Financial compensation also could be argued to be equivalent to assigning one's own reproductive rights to another, or to selling one's body for another's use, both impermissible even within a free-market economy. There is also the concern that financial compensation may give the appearance of, or mask the reality of, baby-selling, a morally and legally impermissible commodification with potential deleterious consequences for the child. Payments may also convey the impression that commodifiable individual characteristics such as weight, race, health, and diet, as well as willingness to engage in procedures such as prenatal testing, pregnancy termination, multifetal reduction, or elective cesarean birth, can have a monetary value attributed to them.

Increasingly, gestational-carrier contracts require that the compensation to the carrier be placed in an escrow account managed by an attorney or other professional. This escrow account protects the interests of all parties. For the gestational carrier, the arrangement ensures that expenses and compensation are covered. For both the intended parents and the carrier, the financial negotiations are kept separate from the ongoing relationship. In addition, the contract between the intended parents and the carrier routinely defines the parameters for how the escrowed monies can be provided to the carrier and removes the immediate burdens of financial negotiation between the intended parents and the gestational carrier (17).

Any compensation arrangements for gestational carriers must comply with state laws. In the United States, only about half of all states have formal law governing these agreements, with some states permitting the practice and others making it unlawful (18). Intended parent(s) and gestational carriers are encouraged to consult legal counsel with an expertise and background in this complex legal area in order to protect each party's best interests, as well as those of any resulting child.

CONCLUSION

Gestational-carrier arrangements offer family-formation opportunities to individuals and couples who are unable to carry a pregnancy on their own. The complex nature of these arrangements raises questions about their ethical and legal permissibility, as well as the impact of the variety of stakeholders involved, including the gestational carrier and her partner and children, the intended parents, and the physicians who deliver the medical services involved in these arrangements. The Committee concludes that gestational-carrier arrangements are ethically permissible so long as the parties undergo appropriate psychological, medical, and legal counseling. The gestational carrier retains all rights to direct her medical care, including any decisions regarding prenatal testing, pregnancy termination, or multifetal pregnancy reduction. Financial compensation is ethical but should not create an undue inducement or risk of exploitation. Compensating a gestational carrier for the time, risks, and inconvenience that she voluntarily and knowingly undertakes on behalf of another can inure to the mutual satisfaction of the parties. Legal aspects of gestational-carrier arrangements should be addressed by legal experts in the field, including separate and independent counsel for the gestational carrier and the intended parents.

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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.

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