

Consideration of the gestational carrier: a committee opinion

Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

Gestational carriers have a right to be fully informed of the risks of the surrogacy process and of pregnancy, should receive psychological evaluation and counseling, and should have independent legal counsel. (Fertil Steril® 2013;99:1838–41. ©2013 by American Society for Reproductive Medicine.)

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KEY POINTS

- Gestational carriers have a right to be fully informed of the risks of the surrogacy process and of pregnancy.
- Gestational carriers should receive psychological evaluation and counseling.
- Gestational carriers should have independent legal counsel.
- Reasonable economic compensation to the gestational carrier is ethical.
- The intended parents are considered to be the psychosocial parents of any children born by a gestational carrier.

A gestational carrier is a woman who bears a child who is genetically unrelated to herself for an individual or couple who intends to be the legal, rearing parent(s) of the child. This process is known as gestational surrogacy. Initially, gestational surrogacy was applied to cases of intended opposite-sex parents who had fertility or medical problems that precluded the female partner from carrying the pregnancy. Now, the process also is used for individuals and same-sex couples desiring to become parents.

For purposes of clarity, the terms used in this document to describe the reproductive roles each participant plays in a surrogacy arrangement will be defined. "Gestational carrier" or "gestational surrogacy" refers to situations in which the individual provides only for the gestation and does not provide her gamete(s) for the child(ren) she gestates. This contrasts with "traditional surrogacy," which refers to situations in which the gestational carrier provides the oocyte(s) and gestates the pregnancy. For the purpose of this statement, the discussion will be limited to gestational carriers, as traditional surrogacy is no longer offered by most programs. Furthermore, state laws may differ with respect to gestational surrogacy. "Intended parent(s)" are the individuals contracting with the gestational carrier and planning to be the social and legal parents of the child. "Gamete providers" are the sources of the sperm and oocytes; they may or may not be the intended parents. Thus, gestational surrogacy may take place with embryos derived from donor sperm and donor oocytes, donated em-

bryos, or embryos conceived from gametes of one or both of the intended parents.

According to the Centers for Disease Control and Prevention, gestational carriers were involved in 915 cycles, or 1%, of assisted reproductive technology (ART) cycles using fresh nondonor embryos in the United States in 2008 (1). An additional number of gestational carrier cycles employed transfer of embryos derived from donor oocytes or donated embryos, but data on the incidence of such cycles are not readily available.

The process of gestational surrogacy requires the use of in vitro fertilization. Intended parents either use the oocytes of the intended mother or the oocytes of an ovum donor. The woman contributing the oocytes in a case involving a gestational carrier must be stimulated with fertility drugs to produce multiple oocytes. These oocytes are retrieved and then 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 pregnancy usually requires exogenous hormonal support, and the gestational carrier will usually self-administer hormone preparations to help establish and support a pregnancy. Once a pregnancy is confirmed, the gestational carrier usually has frequent, often weekly, follow-up visits that include

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blood work and ultrasounds before she is finally discharged to regular obstetrical care.

Controversy has surrounded the practice of paid surrogacy since its inception. Some feminist theorists have opposed contractual surrogacy as the commodification of the body (2). 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 (3). Some courts have followed this view (4). Still others have argued that commercial surrogacy should be prohibited as conflicting with the interests of the child (5). Defenders of more traditional family structures and methods of reproduction have argued that the practice of surrogacy should be prohibited outright (6). 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 justifiable.

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: economic compensation, access to medical treatment, psychological support, and informed consent. The importance of specific legal protections, while beyond the scope of this statement, compels the Committee to emphasize that carriers have a right to independent legal counsel. Because of the potential conflicts of interest of the parties involved in surrogacy arrangements, and the intensely emotional nature of the process, access to such independent advice is crucial. To protect against attorney conflicts of interest, the gestational carrier should be free to choose her own counsel. Costs of such counsel should be borne by the entity responsible for arranging the surrogacy agreement or, by agreement, by the intended parents. This opinion is not intended to give legal advice; state laws on surrogacy vary enormously and must be consulted in each case.

REASONABLE ECONOMIC COMPENSATION

Gestational carriers should receive fair and reasonable economic compensation. Compensation should not be based on factors that stereotype or are otherwise problematic from the perspective of social justice. What is reasonable depends on a balance of considerations outlined below.

Compensation for gestational surrogacy 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 a gestational surrogacy 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 to lie about health conditions or family history.

Many argue that compensation by definition will entice economically disadvantaged women to undertake surrogacy,

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. Financial compensation also could be argued to be equivalent to selling one's body for another's use, an impermissible commodification 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 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, termination, multifetal pregnancy reduction (MFPR) or selective reduction, can have a monetary value attributed to them.

Alternatively, arguments for the acceptability of compensation are based on an evaluation of the time, inconvenience, risk and discomfort associated with pregnancy. Compensation for gestational carriers is consistent with recognition by the American Society for Reproductive Medicine (ASRM) that compensation for gamete donation is ethical. 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 surrogacy, therefore, is reasonable.

Payment to the gestational carriers should take into account 9 months of possible illness, risks to employment, burdens on other family members, and the like, but should not, however, create undue inducement or risks of exploitation or incentivize gestational carriers to lie about their own health conditions or family history.

Increasingly, surrogacy contracts require that the compensation to the gestational carrier be placed in an escrow account managed by an attorney or other professional. This escrow account protects the interests of both 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.

Any compensation arrangements for gestational carriers must comply with state laws. States have a legitimate interest in protecting children. Many states explicitly prohibit "baby selling" and insist that surrogacy compensation be limited to expenses, so payments to the carrier are not suggestive that the child is being purchased. Although a discussion of the ethical issues involved in protecting the interests of the child is beyond the scope of this statement, it should be noted that legal prohibitions of this kind may restrict what payments, if any, can be made to gestational carriers in these states, and thus influence the scope of protections available for the gestational carrier.

Social considerations also have played a role in the selection of gestational carriers. Payments to gestational carriers

based on what are considered to be especially desirable characteristics, such as physical beauty or intelligence, are problematic, as discussed in the ASRM Ethics Committee Report on financial compensation of oocyte donors (7). Such problematic considerations may be less likely in gestational than in traditional surrogacy, because in gestational surrogacy, the carrier is not the provider of the oocytes. However, even with gestational surrogacy, questions may remain about reimbursement patterns that stereotype gestational carriers of particular racial or ethnic backgrounds or gestational carriers with certain social or physical characteristics.

MEDICAL CONSIDERATIONS AND INFORMED CONSENT

Gestational carriers have a right to be fully informed of the risks of the process and of pregnancy. They also have the right to appropriate medical care during the treatment and pregnancy; and the choice of obstetrician should be mutually acceptable to the intended parent(s) and carrier. In the case of cycles in which transfer of more than 1 embryo is being contemplated, carriers need to be counseled about the risks of multiple pregnancy. This counseling and consent should take place prior to the initiation of any treatment cycle. As with other decisions that relate to her body, including pregnancy, the carrier should make the final decision regarding the transfer of more than 1 embryo. 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 pregnancy that resulted in a delivery of a 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 postpartum, as well as the demands of negotiating a relationship with intended parents, it is reasonable to adopt a conservative position about age and surrogacy by setting the minimum age at 21.

It also is advisable to discuss with carriers the broader social context in which they are participating in the surrogacy program. Carriers should be counseled to consider the potential impact on their own children and to think about what, if anything, their children should 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. There have been no data to suggest that carriers' children have any emotional sequelae from the experience. Given the absence of data concerning the consequences of surrogacy on the children of the carrier, carriers should be counseled to carefully consider the potential impact of the surrogacy 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. Carriers' spouses or domestic partners also should be involved with consent, as the pregnancy has potential to have emotional and practical demands on the family more generally.

PSYCHOLOGICAL CONSIDERATIONS

Although gestational carrier programs have been in existence and active since the late 1980s, research on the entire experience has been extremely limited. In an early study, researchers found that gestational carriers and the intended parents were unremarkable with regard to any pre-existing psychopathology (8). A few more recent studies have examined the intended parents' and gestational carriers' experience and report no issues or problems arising from the experience (9, 10). Gestational carriers were found to have no psychological problems as a result of their participation (11). Further research in this area is encouraged.

The relationship between the gestational carrier and intended parent(s) should be mutually respectful and collaborative. Each participant should receive counseling regarding their expectations for the relationship and the risks of not having those expectations met. Effort should be made to have the participants evaluate whether their goals and expectations are congruent. Specifically, issues related to antenatal testing, pregnancy termination, multiple pregnancy, MFPR, and selective reduction should be addressed. 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 mutually agreed-upon contract should prevail. However, it should be understood that the carrier has the ultimate authority about any procedures on her body and cannot be compelled to submit to a procedure regardless of the contract. If the carrier chooses to refuse a procedure heretofore 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.

Once each participant has had the opportunity to anticipate and evaluate the risks and rewards for entering into a gestational carrier pregnancy, each participant has the personal responsibility for that decision. 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. In the event that a disagreement should occur, the legal agreement should direct the resolution of the issue. In the rare event that a dispute over the child should occur (and only a very few cases have been documented), the 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 baby. 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. In such cases, intentionality properly laid out in advance in the legal agreement sets the appropriate expectations for the parties.

The gestational carrier, to be sure, may be expected to develop emotional attachments to the child she gestates. The intended parents likewise can be expected to have emotional attachments to the child, especially in the case in which one or both are the genetic parent(s) of the child. If the gestational carrier is adequately protected and compensated, gives fully informed consent, and receives health care and psychological and emotional support, it is reasonable to conclude that gestational surrogacy arrangements are ethically justifiable and that the intended parents should become the legal parents of the child.

Acknowledgment: This report was developed by the Ethics Committee of the American Society for Reproductive Medicine as a service to its members and other practicing clinicians. While this document reflects the views of members of that Committee, it is not intended to be the only approved standard of practice or to dictate an exclusive course of treatment in all cases. This report was approved by the Ethics Committee of the American Society for Reproductive Medicine and the Board of Directors of the American Society for Reproductive Medicine.

The following members of the ASRM Ethics Committee participated in the development of this document. All Committee members disclosed commercial and financial relation-

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REFERENCES

- Centers for Disease Control and Prevention. Section 2: ART cycles using fresh, nondonor eggs or embryos (part C) Available at: <http://www.cdc.gov/ART/ART2008/section2c.htm>. Accessed February 4, 2013.
- Ketchum SA. Selling babies and selling bodies. *Hypatia* 1989;4:116–27.
- Tong R. Feminist bioethics: toward developing a “feminist” answer to the surrogate motherhood question. *Kennedy Inst Ethics J* 1996;6:37–52.
- Steinbock B. Payment for egg donation and surrogacy. *Mt Sinai J Med* 2004; 71:255–65.
- Roberts MA. Good intentions and a great divide: having babies by intending them. *Law Philos* 1993;12:287–317.
- Alvare HM. Catholic teaching and the law concerning the new reproductive technologies. *Fordham Urban Law J* 2002;30:107–34.
- The Ethics Committee of the American Society for Reproductive Medicine. Financial compensation of oocyte donors. *Fertil Steril* 2007;88:305–9.
- Braverman AM, Corson SL. Characteristics of participants in a gestational carrier program. *J Assist Reprod Genet* 1992;9:353–7.
- Bravennan AM, Corson SL. A comparison of oocyte donors' and gestational carriers/surrogates' attitudes towards third party reproduction. *J Assist Reprod Genet* 2002;19:462–9.
- MacCallum F, Lycett E, Murray C, Jadva V, Golombok S. Surrogacy: the experience of commissioning couples. *Hum Reprod* 2003;18:1334–42.
- Jadva V, Murray C, Lycett E, MacCallum F, Golombok S. Surrogacy: the experiences of surrogate mothers. *Hum Reprod* 2003;18:2196–204.

