# Consideration of the gestational carrier: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Washington, DC

Intended parents engage with gestational carriers (GCs) to achieve their personal reproductive goals. All GCs have a right to be fully informed of the risks as well as the contractual and legal aspects of the gestational-carrier process. The GCs 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. In addition, GCs require separate independent legal counsel regarding the contract and arrangement. This document replaces the document of the same name, last published in 2018 (Fertil Steril 2018;110:1017–21). (Fertil Steril® 2023;119:583-8. ©2023 by American Society for Reproductive Medicine.)
**El resumen está disponible en Español al final del artículo.**

## KEY POINTS

- Gestational carriers (GCs) are the sole source of consent regarding their medical care from embryo transfer through prenatal care, labor, delivery, and aftercare.
- They 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.
- They should receive psychological evaluation before and have 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 and responsibility for costs.
- They require separate independent legal counsel regarding the contract and arrangement.
- It is ethically justifiable for GCs to receive financial compensation for their participation in a gestational-carrier arrangement.
- The intended parents (IPs) should be the legal parent(s) of any child born to a GC. Any potential gestational-carrier arrangement that might be subject to the laws of a jurisdiction that does not so provide, should be considered with caution by all parties, and only with the advice of independent legal counsel as well as agreement that the IP(s) can and will take all the necessary legal steps to secure their status as the legal parent(s) of any resulting child.
- Gestational-carrier arrangements are ethically justifiable if the GC is provided all material information about the associated benefits and risks, gives fully informed consent, and receives legal advice, health care, emotional support, and psychological counseling.
- Embryo transfer decisions in GCs should adhere to the practice guidelines that seek to maximize the chance of a healthy outcome for both the GC and the resultant child(ren). Single embryo transfer is the preferred approach for gestational-carrier cycles (1).

## DEFINITIONS AND TRENDS

Use of a GC is an option for family formation in which an individual agrees to gestate a child for individual(s) seeking this reproductive assistance to become a parent(s). The individual who bears the child is commonly referred to as the GC, whereas the individual(s) seeking reproductive assistance is referred to as the IP(s). Use of a GC in the modern era was made possible by the development of in vitro fertilization (IVF), which enables physicians to transfer an embryo received from the IP(s) (and/or donors) into the uterus of a GC. When first introduced in the 1980s, GCs were used primarily by cisgender heterosexual individuals who had fertility or medical problems that precluded carrying a pregnancy. Increasingly, the process also is used by unpartnered individuals and lesbian, gay, bisexual, transgender, questioning, intersex, asexual (LGBTQIA +) individuals 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. A "GC" is an individual who provides only gestation and does not provide gamete(s) for pregnancy. This contrasts with traditional or genetic surrogacy, which refers to situations in which the carrier gestates the pregnancy and also provides the oocyte(s). For this document, the discussion will be limited to GCs, as traditional surrogacy is rarely offered by most programs and is more ethically

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and legally complex (2). An IP is an individual contracting with a GC to achieve their reproductive goals and who plans to be the social and legal parent of the child(ren). A gamete provider is the source of the sperm and oocyte(s); they may or may not be an IP. Thus, gestational-carrier arrangements may involve embryos derived from donor sperm and/or donor oocytes, donated embryos, or embryos created from gametes of one or both IP(s).

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 GCs increased from 1% to 2.5%, further increasing to 5.4% in 2019 (2, 3). Longitudinal studies on GCs show that gestational-carrier cycles had higher rates of implantation, pregnancy, and live birth compared with non–gestational-carrier cycles.

The GC process requires IVF using the gamete(s) of an IP(s) and/or donor(s). Fertility drugs are typically used with an IP or donor to stimulate the production of multiple oocytes simultaneously. These oocytes are retrieved and fertilized with the sperm of an IP or donor. The resulting embryo is transferred into the GC. The GC usually, but not always, requires exogenous hormonal support to prepare and support the pregnancy. Once a pregnancy is confirmed, the GC has frequent, often weekly, follow-up visits that include laboratory investigations and ultrasound examinations before being discharged to regular obstetrical care.

## GC COMPENSATION

A range of viewpoints has surrounded the practice of payment for gestational-carrier arrangements since their inception. Arguments in support of payment 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 GC (4). Studies investigating the impact of these arrangements in the United States report that both GCs and IPs view their experience as positive and rewarding (5). Arguments in opposition to payment, focus on the potential for harm to the GC and the resulting child(ren). Some theorists have opposed contractual surrogacy as the commodification of the body (6). Others, emphasizing autonomy, have argued that contractual surrogacy is permissible, but only if the GC retains the right to choose to end the pregnancy as well as the right to revoke the agreement at any time (7). Defenders of more traditional family structures and methods of reproduction have argued that GC arrangements should be prohibited outright (8). 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 GC and the IP(s) are necessary to ensure that these arrangements are 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 GCs. These safeguards address the following issues: appropriate *selection* of GCs, *counseling* and *informed consent*, and *contractual* as well as *economic considerations*. Additional guidance on the use of GCs has been provided by the *American Society for Reproductive Medicine* Practice Committee in its document, "Recommendations for practices utilizing GCs: a committee opinion (9)."

## GC SELECTION

Carriers should be $\geq$21 years of age, healthy, have a stable social environment, and have had $\geq$1 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 the American society; for example, at age 18 an individual is considered old enough to join the military but not old enough to purchase alcohol. Given the very complex emotional tasks of the pregnancy and the postpartum period, as well as the demands of negotiating a relationship with the IP(s), it is reasonable to set the minimum age for a GC at 21 years.

## 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, and should make an autonomous decision that a mental health provider affirms is free of coercion. Moreover, GCs require appropriate medical care throughout treatment and pregnancy. Although the choice of obstetrician should ideally be mutually acceptable to the IP(s) and GC, the carriers are to be the sole source of consent for their treatment from hormonal preparation and embryo transfer through delivery and aftercare (2). This is critical as complications of pregnancy might result in situations where fetal or neonatal well-being could be compromised to preserve the health of a GC. Although the interests of the IP(s) are considerable, as they seek to achieve their reproductive goals, GCs retain ultimate decision-making authority over their own individual care. Contracts should address decision-making in the event of the loss of capacity of the GC.

It is also advisable to discuss with GCs, the broader social context within which the gestational-carrier arrangements takes place. Gestational carriers should be counseled to consider the potential impact on their own children and to think about what their children will be told about the pregnancy. They should be advised to think about their children's interests independently of their own motivation to be a GC. Although methodological limitations exist, evidence regarding the psychological outcomes of the children of GCs has been reassuring (10, 11). Nevertheless, GCs should be counseled to carefully consider the potential impact of the GC arrangement on their children and their children's possible feelings and reactions. Similar questions should be raised about the interests and concerns of the GC's spouse or partner, if any, and they should also undergo psychological evaluation and counseling. A GC's spouse or legally recognized domestic partner also should be involved with

consenting and agreeing to the arrangement, as the pregnancy has the potential to have emotional and practical demands on the family more generally. Ultimately, the decision to undergo collaborative reproduction rests with the GC. Care should be taken to avoid coercion. Coercion can be financial, emotional, or social. Physicians, mental health professionals, legal professionals, and agencies working with the GCs should be aware of the risk for coercion and discuss their concerns, if present, with them and the care team directly.

Although gestational-carrier arrangements have been in existence and active since the late 1980s, research on the entire experience has been extremely limited. The published data have found that GCs, despite some negative experiences, most arrangements are successful overall, appear to be a positive experience for GCs, and do not cause harm to their children (10–14). Further research in this area should be encouraged.

Based on the above considerations, the Committee believes that if the GC is given all material information about the benefits and risks of the arrangement, provides fully informed consent, and receives independent legal representation and advice, gestational-carrier arrangements are ethically justifiable.

## CONTRACTUAL AND ECONOMIC CONSIDERATIONS

It is essential that all parties are thoroughly counseled before entering an agreement. The IP(s), GC, and the GC's spouse or partner, if any, should all be parties to the contract. Once each participant has had the opportunity to anticipate and evaluate the risks as well as benefits of entering into a GC arrangement, each participant holds personal responsibility for that decision. Both the IP(s) and GC (and their spouse or partner, if any) 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 GCs appreciate that their participation in the arrangement is in support of the reproductive goals of the IPs. In addition, a GC should not engage in an agreement with the IPs in case a misalignment of goals exists and/or if there are identifiable areas in which the GC has difficulty supporting the IP(s)' expressed reproductive plans. One example is decision-making about termination in the face of multiple pregnancy or fetal anomalies. Another rare example is the IP(s)' plan to simultaneously engage an additional GC. This information should be discussed as each GC may have an interest only in providing exclusive assistance to the IP(s). Furthermore, GCs and IPs should be discouraged from entering into a collaborative arrangement if they anticipate that there is a lack of congruency or respect, and should discontinue the arrangement before embryo transfer if such issues become evident during the process.

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

## ELECTIVE SINGLE EMBRYO TRANSFER

Single embryo transfer is the preferred approach in an increasing proportion of IVF treatment cycles (1). Adherence to practice guidance that supports single embryo transfer is particularly important in the treatment of GCs (1), as these guidelines suggest the associated physical risk in support of the reproductive interests of the IP(s), as well as the risk of making difficult ethical decisions (9).

## SIMULTANEOUS PREGNANCY WITH TWO GCs

Rarely, situations arise in which $\geq 2$ simultaneous pregnancies are sought by the IP(s), each with a separate GC. Arguments in favor of such arrangements cite the reproductive freedom and autonomy of the IPs and the GCs; the fact that 2 singleton pregnancies incur less GC and fetal risk than a single twin gestation; and the potential shorter time to completion of a family, which may be particularly relevant in certain contexts (e.g., older IPs).

Arguments against the use of multiple simultaneous GCs cite the commodification of pregnancy; the potential for inequity and additional emotional stress for the GCs as well as IPs; and the additional psychological risks that the IPs would incur by having 2 infants at the same time (15, 16). Coordinating pregnancies, deliveries, and care of $\geq 2$ infants raises issues for all involved. In addition, IPs may have more difficulties bonding with multiple infants, as well as an increased risk of parental depression (17). For GCs, the reported motivation to do something special for someone else may be negatively impacted by being 1 of 2 or more, and comparisons to another GC may add pressure to meet the same expectations, relationships, and agreements as to prenatal care or delivery. Lastly, the assistance of a GC is intended to meet a medical need of IP(s), the inability to carry a pregnancy, and not to have multiple simultaneous pregnancies.

## INFECTIOUS DISEASE SCREENING AND TESTING

In addition, GCs need to understand the type of infectious disease screening that will be performed before participation and when any potential infectious risks might arise (9). Conversely, the IP(s) need to understand the limits of infectious-disease screening insofar as the GC could have disease exposures throughout the duration of the pregnancy.

## CONTRACTUAL AND ECONOMIC CONSIDERATIONS

This opinion is not intended to give legal advice; state laws on these arrangements vary enormously and must be consulted

in each case. The importance of specific legal protections, although beyond the scope of this opinion, compels the Committee to emphasize that GCs must have an independent legal counsel whose duty of care is to the GC alone. Because of the potential conflicts of interest of the parties involved in gestational-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, GCs must be free to choose their own counsel, with the appropriate level of skill and licensure. It is acceptable and common for the IP(s) to cover the costs of such counsel, although GCs should not be prohibited from funding their own legal representation should they so choose. Both GCs and IPs have important interests at stake in the arrangement. 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 their needs and/or expectations. If a disagreement should occur, the legal agreement should direct the resolution of the issue. The contract should address the consequences of a GC's refusal to a previously agreed upon procedure and/or receiving a procedure against the IP(s)' wishes (e.g., termination). In the rare event that a dispute over the child(ren) should occur (as only relatively few 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 GCs cannot anticipate their feelings about pregnancy and that pregnancy is a privileged experience that supersedes other considerations because of the special bond that forms between the GC and the fetus. The ethical counterargument is that GCs who have experienced pregnancy and have borne a child(ren), have the appropriate basis to honestly judge their capacity to participate in a GC role and to respect the interests of the IP(s). In such cases, intentionality properly laid out in advance in the legal agreement sets the appropriate expectations for the parties.

Compensation for GCs 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 GCs, therefore, is reasonable. In addition, GCs should receive adequate health care coverage for pregnancy care and for the treatment of sequelae of pregnancy complications. In addressing these matters, the GC 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 GCs for the time, inconvenience, and risk associated with embryo transfer, pregnancy, and delivery. It should not be contingent on the birth of a healthy child. Although 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 potential GCs to expose themselves to the physical and emotional risks that accompany any pregnancy. Compensation may induce potential GCs to undertake a pregnancy or to collaborate with a recruiter or IP(s) with whom they might otherwise not enter into 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 GCs to disclose fully their health conditions or family history (18).

Many argue that compensation, by definition, will entice economically disadvantaged individuals to undertake gestational-carrier arrangements, especially if they do not believe they have other reasonable and realistic choices in their lives. Ethical concerns may also arise from socioeconomic differences between IPs and GCs. The rising popularity of using GCs from less affluent or developing nations calls attention to these last 2 concerns (19).

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, infant-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 compensation be placed in an escrow account managed by an attorney or other professional. This escrow account can ensure that funds are available to cover agreed-upon expenses and compensation. For the GC, the arrangement ensures that expenses and compensation are covered. For both the IP(s) and the GC, the financial negotiations are kept separate from the ongoing relationship. In addition, the contract between the IP(s) and the GC routinely defines the parameters for how the escrowed monies can be distributed and removes the immediate burdens of financial negotiation between the parties (20).

Any compensation arrangements for GCs 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 (21). Moreover, IP(s) and GCs are encouraged to retain legal counsel with an expertise and background in this complex legal area to protect each party's best interests, as well as those of any resulting children.

## CONCLUSION

The nature of gestational-carrier arrangements are complex and raises questions about their ethical and legal acceptability, as well as the impact of the variety of stakeholders involved, including the GCs and their partner and/or child(ren), the IP(s), and the physicians who deliver the medical care required for these arrangements. The Committee concludes that GC arrangements are ethically permissible: so long as the parties undergo appropriate psychological, medical, and legal counseling as well as the GCs retain all rights to direct their own medical care, including any decisions regarding prenatal testing, pregnancy termination, or multifetal pregnancy reduction. Financial compensation is ethically justifiable but should not create an undue inducement or risk of exploitation. Compensating GCs for the time, risks, and inconvenience that they voluntarily and knowingly undertake on behalf of others can contribute to the mutual satisfaction of the parties. Legal aspects of a GC arrangement should be addressed by legal experts in the field, including separate and independent counsel for the GC and the IP(s).

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Futuros padres interactúan con las portadoras gestacionales (PG) para lograr sus objetivos reproductivos personales. Todas las PG tienen derecho a ser plenamente informadas de los riesgos, así como de los aspectos contractuales y legales del proceso gestacional-portadora. Las PG tienen autonomía para tomar sus propias decisiones con respecto a la atención médica y deben de ser libres de influencias indebidas por parte de las partes interesadas involucradas. Ellas deben tener acceso a recibir evaluación y consejería psicológica antes, durante y después de participar en el proceso reproductivo. Además, las PG requieren asesoría legal independiente con respecto al contrato y arreglos. Este documento reemplaza al documento del mismo nombre, publicado por última vez en 2018 (Fertil Steril 2018;110:1017–21).