

# Family members as gamete donors or gestational carriers: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Washington, D.C.

The use of adult intrafamilial gamete donors and gestational surrogates is generally ethically acceptable when all participants are fully informed and counseled, but consanguineous arrangements or ones that simulate incestuous unions should be prohibited. Adult child-to-parent arrangements require caution to avoid coercion, and parent-to-adult child arrangements are acceptable in limited situations. Programs that choose to participate in intrafamilial arrangements should be prepared to spend additional time counseling participants and ensuring that they have made free, informed decisions. This document replaces the document of the same name, last published in 2017. (*Fertil Steril*® 2024;121:946–53. ©2024 by American Society for Reproductive Medicine.)

**El resumen está disponible en Español al final del artículo.**

**Key Words:** Third-party reproduction, oocyte donation, sperm donation, gestational carrier, ethics

## KEY POINTS

- The use of adult intrafamilial gamete donors and gestational carriers (GCs) is generally ethically acceptable, except when such arrangements are consanguineous or coercive.
- Screening and counseling participants in familial gamete donor and GC arrangements is often complex and challenging, particularly when such requests involve intergenerational arrangements. Providers should be prepared to allocate sufficient time to all involved parties when assisting in such arrangements.
- Care should be taken to avoid coercion and ensure fully informed consent when coordinating intrafamilial gamete donor and GC arrangements.
- Mental health counseling by a professional experienced in third-party reproduction is recommended for the family member considering acting as a gamete donor or GC, that individual's partner (when applicable), and the intended parent(s).
- Intended parents, gamete donors, and GCs (with their marital partners, when applicable) should seek independent legal advice from attorneys with specific expertise in third-party reproduction to determine their legal rights and duties in entering into these arrangements. Similar to marital partners, nonmarital partners may also have interests, when not as clear as legal rights, in third-party reproductive arrangements.
- All assisted reproductive technology programs should develop policies and procedures for managing requests for the use of family members as gamete donors or GCs.
- Research on the long-term impact on parents, offspring, and relatives involved in intrafamilial reproduction should be encouraged.
- Gamete donation by a family member that involves consanguinity (i.e., reproduction between family members who are closely genetically related) incurs increased genetic risk for the resulting child and is never permissible.

## INDICATIONS FOR THIRD-PARTY REPRODUCTION

Collaborative or third-party reproduction is sometimes considered by couples or individuals who either lack oocytes,

sperm, or a uterus, or whose gametes or uterus cannot be used. Gamete donation is a recognized method to enable individuals or couples without viable oocytes or sperm to conceive. Gestational carriers (GCs) can be involved in situa-

tions in which a woman cannot carry a pregnancy for medical or anatomic reasons or in cases where a single male or same sex male couple uses assisted reproductive technology (ART) to have a child. The practice of genetic "traditional" surrogacy, in which the surrogate provides the oocyte as well as her uterus, is discouraged by this Committee (1) and will not be discussed in this opinion.

Although collaborative reproduction usually involves nonidentified or

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unrelated directed (known) gamete donors or unrelated GCs, some intended parents prefer to involve a family member in these arrangements. This may occur intragenerationally between siblings or cousins of similar ages, such as a sister providing oocytes for a sister or a brother donating sperm to a brother. It may also occur intergenerationally, as when a mother gestates her daughter's embryo or a father provides sperm to his infertile son.

Some possible collaborative reproductive arrangements that involve family members are listed in Table 1. This table and the following discussion involve primarily first-degree genetic relatives. The use of second-degree genetic relatives such as cousins, nephews, or aunts and uncles raises similar genetic risk and concerns over undue influence or coercion, but for simplicity, these arrangements are omitted from the table and most of the subsequent discussion. Although not

specifically elaborated in this opinion, some of the issues raised here are not dependent on genetic relatedness, and collaborative reproduction arrangements involving family relationships established through adoption or blended families should also be managed with special care.

Although familial collaboration may offer advantages over the use of unrelated donors and carriers, it may present unique challenges. A plan for a family member to act as a gamete donor or GC may be complicated by possible undue influence to participate (2-7). Limited data have been collected regarding the attitudes, motivations, and experiences of donors and recipients in such arrangements (8-10); however, there is some data suggesting that known oocyte donors (who may or may not be family members) do not differ from unidentified donors in terms of satisfaction with having donated (11). In addition, limited information

**TABLE 1**

**Possible collaborative reproductive arrangements that involve family members.**

<b>Gamete donation arrangement</b>	<b>Example</b>	<b>Genetic risk</b>	<b>Level of coercion</b>
<b>Sibling → sibling of same sex</b>	Sister → sister Brother → brother	No genetic risk	Low
<b>Sibling → sibling of opposite sex whose same sex partner provides gametes</b>	Brother → sister whose female partner provides oocytes Sister → brother whose male partner provides sperm	No genetic risk	Low
<b>Sibling → sibling of opposite sex providing gametes to genetic sibling</b>	Brother → sister using her oocytes Sister → brother using his sperm	Consanguineous and <b>impermissible</b>	n/a - <b>impermissible</b>
<b>Parent → genetic child of same sex</b>	Father → son Mother → daughter	No genetic risk	Moderate
<b>Parent → genetic child of opposite sex whose same sex partner provides gametes</b>	Father → daughter whose female partner provides oocytes Mother → son whose male partner provides sperm	No genetic risk	Moderate
<b>Parent → genetic child of opposite sex when the genetic child provides gametes</b>	Father → daughter using her own oocytes Mother → son using his own sperm	Consanguineous and <b>impermissible</b>	n/a - <b>impermissible</b>
<b>Genetic child → parent of same sex</b>	Son → father / daughter → mother	No genetic risk	Elevated
<b>Genetic child → parent of same sex when the genetic child provides gametes to a parent whose partner is genetically related to the child</b>	Daughter → mother being fertilized with sperm from daughter's genetic father Son → father fertilizing oocytes from son's genetic mother	Consanguineous and <b>impermissible</b>	n/a - <b>impermissible</b>
<b>Genetic child → parent of opposite sex when the genetic child donates gametes fertilized by the parent's same sex partner</b>	Son → mother Daughter → father	No genetic risk	Elevated
<b>Genetic child → parent of opposite sex when the genetic child provides gametes to a genetic parent for fertilization with the parent's gametes</b>	Son → mother fertilizing mother's oocytes with genetic son's sperm Daughter → father using father's sperm to fertilize genetic daughter's eggs	Consanguineous and <b>impermissible</b>	n/a - <b>impermissible</b>

*Ethics Committee of the American Society for Reproductive Medicine. Family members as gamete donors or GCs. Fertil Steril 2024.*

is available on the impact on children born as a result of such arrangements (12–14).

Gamete donation by a family member that involves consanguinity incurs increased genetic risk for the resulting child and is never permissible.

There is a paucity of data on the use of familial gamete donors and carriers in assisted reproduction. The number of requests for intergenerational familial gamete donation and the number of these procedures performed are unknown. The first reported case of an intrafamilial GC arrangement was reported in 1988 (15). Although much less common than gamete donation, a number of cases of intrafamilial GC arrangements have been reported (16–19).

## THE CASE FOR FAMILIAL COLLABORATION

Individuals and couples who use familial gamete donors and GCs face a novel set of issues as compared with those using non-identified gamete donors and unrelated GCs. The reasons for seeking a familial donor, or GC, are varied. Although some individuals opt to use an unrelated or nonidentified donor or GC, others would much prefer finding third-party reproductive assistance within the family. For some couples or individuals, gametes from family members may be preferred because they preserve a genetic tie. For others, a family member may be selected as a donor or GC to expedite the process or reduce costs. Additional reasons for seeking a familial gamete donor may relate to considerations surrounding the future interests of donor-conceived children in having access to their health or genetic information. Furthermore, using a familial gamete donor may increase the chance that a donor-conceived child could establish contact with or a relationship with their gamete donor, should they or their family desire this to occur.

Familial gamete donation ensures that some portion of the intended parent's genes will be passed to the offspring, thus maintaining a genetic tie that would be lost when an unrelated donor was used. Collaborative reproduction allows for a familial connection missing in unrelated arrangements. In one of the few reports about known sperm donors, family involvement was chosen so that the infertile man could feel a "genetic closeness" to his child (20). Using a sibling's gametes will result in rearing a genetic nephew or niece who has some, but usually <50%, of the infertile person's genes. Intergenerational donations, such as father-to-son sperm donation or daughter-to-mother oocyte donation, also involve the transfer of some of the recipient's genes to the offspring. The value of maintaining genetic kinship may influence the acceptability of anonymous oocyte or sperm donors for some. Family members who donate may also view the process favorably because it allows their genetic relatives the possibility of having genetically related children.

In the case of lesbian, gay, bisexual, or transgender individuals, who invariably require assistance from gamete donors or GCs, collaborative reproduction allows for a familial connection that would not be present when receiving gametes from a nonidentified donor or coordinating a pregnancy with an unrelated GC. For example, a brother donating sperm to his sister's female partner allows his sister to have a genetic connection to her child, whereas her female partner has

both a genetic and a gestational relationship with the child. Similarly, a sister may donate her oocytes to be fertilized with her brother's male partner's sperm, so that the child can have a genetic relationship with each of the fathers. In the case of a GC arrangement, a sister may carry an embryo created with a donor oocyte and either her brother's or his male partner's sperm, allowing for collaborative familial reproduction and cost savings.

Another motivation for selecting a familial donor or GC may be a reduction in costs and waiting times. Reproductive technologies are expensive and often not covered by insurance plans. Collaborative reproduction may also involve expensive nonmedical fees or costs, including payments to donors, GCs, and recruiting programs, which ultimately may prove prohibitively expensive for many individuals. Further, collaborative reproduction may require long waits or, in some areas, may be unavailable. In some cases, the involvement of a family member may result in significant financial and time savings for the intended parent(s), as well as enabling some to have a procedure that would otherwise be available to them. A man with oligozoospermia may prefer sperm donation from his identical twin rather than pay for in vitro fertilization treatment with intracytoplasmic sperm injection, in part because he considers that his twin brother's sperm are identical to his own. A sister donating oocytes may be less likely to request payment, and the recipients can avoid a potentially long waiting period for a nonidentified oocyte donor. Similarly, paid GC arrangements are legally prohibited in some jurisdictions and, where allowed, may be prohibitively expensive, leading some couples and individuals to turn to family members for assistance.

## CONCERNS ABOUT INTRAFAMILIAL COLLABORATIVE REPRODUCTION

Intrafamilial collaborative reproduction raises ethical concerns distinct from those raised by other gamete donors or GC arrangements. These include concerns regarding whether a donor or GC closely tied to and perhaps dependent on the recipient couple would be able to make a free and fully informed decision. In addition, concerning are questions surrounding the consequences of the novel resulting genetic or gestational relationships for the donor or GC, donor-conceived persons, and rest of the family that are made possible and which change family dynamics. The lack of information regarding these important questions illustrates the knowledge gaps that exist and highlights the importance of research studies that aim to understand the implications of these new family relationships for the various affected parties. In the meantime, providers should not hesitate to share these concerns in the course of counseling their patients.

### Undue Influence and Autonomous Decision-Making

A major concern in familial collaborative reproduction is protecting the autonomy of the contributing donor, or GC, from manipulative or undue influences by family members who stand to benefit from their participation. This may include

family members who wish to have a child or family members who strongly wish to have a grandchild, niece, or nephew. Manipulation or undue influence may be greater with intergenerational than with intragenerational collaboration but may occur with both arrangements. For example, a daughter may feel obligated to donate oocytes or act as a GC for her mother and the mother's partner because she is financially or emotionally dependent on her. Some individuals may exert great influence over their siblings and persuade them to be donors against their better judgment.

Current American Society for Reproductive Medicine (ASRM) recommendations and US Food and Drug Administration requirements governing infectious and genetic disease screening of nonidentified (anonymous) sperm and oocyte donors and GCs should also be followed for related gamete donors and GCs. When sperm or oocyte donation is chosen to prevent a certain genetic disease, it is also suggested that careful genetic counseling be undertaken before proceeding with intrafamilial gamete donation. In all cases, it is advised that individuals <21 years of age not serve as gamete donors and that GCs have given birth to at least one child of their own (21, 22).

The risk of undue influence may depend on cultural constructs of family, the physical and emotional closeness of the donor or GC to the recipient(s), the maturity of the participating family members, and other issues such as financial dependency. The ability to maintain independence in relationships and advocate for oneself is necessary for the donor or GC to make a free and fully informed decision. This may be especially difficult to achieve when a parent requests a child's involvement in collaborative reproduction. Some writers argue that because undue influence cannot be eliminated in child-parent relationships, a truly free decision to participate in such cases of collaborative reproduction is impossible (6). It would be ethically reasonable for ART programs to establish a policy that prohibits child-to-parent gamete donation and a daughter serving as a GC.

In cases of daughter-to-mother or son-to-father donations, emotional or financial undue influence, pressure, or coercion, whether overt or unconscious, may be extremely difficult to assess. Assisted reproductive technology programs that are open to considering child-to-parent gamete donation or daughters serving as GCs, should ensure that the highest level of care is taken to examine and avoid undue influence, pressure, or coercion.

All parties should have independent legal and mental health counseling to ensure that undue influence, pressure, or coercion do not factor into their decision-making and that all relevant legal implications of the arrangement are considered and addressed.

### Impermissible Collaborations

Laws against incestuous sexual relations and consanguineous marriages are ways in which society regulates reproduction. Sexual relations, marriage, and reproduction between two closely related individuals have long been taboo because of concerns about the risk of birth defects and genetic diseases, as well as concerns about social dis-

ruptions and conflicts that such relations could raise (23). Laws banning sexual relations and marriage between certain related individuals would not ban gamete donation or GC arrangements involving these same individuals because no sexual relations or marriage would have occurred. However, the risks of consanguinity are the same, and gamete donation in such situations is therefore impermissible. Under this approach, a sister may provide oocytes for a sister, or a brother may provide sperm for a brother, but a brother should not provide sperm to fertilize his sister's oocytes, and a sister should not provide oocytes to be fertilized by her brother's sperm. Similarly, a father should not provide the sperm to replace that of his genetic daughter's infertile husband. Nor should a daughter provide oocytes to replace those of her father's infertile wife. A different situation arises when a sister provides the oocytes for her brother's infertile wife to be inseminated by a donor, or a brother provides sperm to a sister to use with an anonymous oocyte donor. Neither case duplicates the results of incest or consanguinity and is therefore permissible.

Although this report focuses on first-degree relatives, the Committee notes that restrictions on fathers as sperm donors to daughters with infertile husbands should also bar the daughter's genetically related paternal or maternal uncles from serving as sperm donors to her. Similarly, the genetically related maternal or paternal aunts of a son with an infertile wife should not serve as an oocyte donor for the wife of that son if he would also provide the sperm. Sexual relations or marriage between first cousins is not illegal in some states. Rather than address the different combinations that might arise from gamete donation or GC arrangements among first cousins, we note that a recent review found that procreation between first cousins added a 1.7%–2.8% risk of major malformations and genetic diseases to a background risk of 3%–4% and should therefore be considered impermissible (22).

### Resulting Family Relationships

Collaborative reproduction among family members results in uncommon and potentially troubling relationships. Identification and discussion of resulting relationships are important for informed consent as well as promoting a positive outcome for all involved parties.

Child-to-parent donation, such as daughter-to-mother donation, is an example of a potentially troubling outcome in part because it results in a shared genetic connection between the donor child and the parent's partner. A donor-conceived child would be both a genetic half-sibling and an aunt or uncle to the donor's children, and the donor-conceived child would also be a half-sibling to their aunts and uncles. The emotional impact of these relationships for the donor-conceived person and the donor's children, whereas a primary consideration, has not been extensively studied and warrants considerable caution in a proposed reproductive plan. Assisted reproductive technology programs may conclude that they are not comfortable with a plan for child-to-parent donation and may decline to provide this type of third-party care.

Parent-to-child donation or GC arrangements are similarly complex in terms of resulting relationships but may feel more comfortable. For example, a father may decide to donate sperm to his son as an extension of his parental role in meeting his child's needs. Similarly, a mother who volunteers to be a GC for her daughter or son may view her involvement as a way to help her child achieve their life goals.

In all instances of familial collaboration in reproduction, the primary concern is the potential impact of these arrangements on the resulting children and families. Children can never consent to the circumstances of their conception, even when they suffer from conflicts or disruptions that those circumstances bring. Persons entering into these relationships should be especially sensitive to the social and psychological complications that might ensue and take special care to ensure that the child's welfare is primary and protected. Although studies have overall shown positive psychological outcomes for children born from the donation of gametes from family members or when a family member acts as a GC, these studies have involved a small number of individuals. Further studies examining the well-being of such children should be encouraged (12–14).

Special care should be taken when family members are being considered as gamete donors or GCs to ensure free and informed decision-making for all involved participants. As discussed below, such arrangements necessitate mental health consultation for all involved parties.

The importance of the goal to preserve genetic linkages through familial gamete donation may be questioned when the reproductive arrangements become extraordinarily complex and concerns emerge regarding possible undue influence, coercion, or a lack of agreement and comfort with plans for disclosure and framing of relationships. In each potential familial reproductive collaboration, the free and informed decision-making of all participants must be assured. The risk of undue influence in intrafamilial organ donation is well recognized and can be used as a model for avoiding coercion in intrafamilial reproductive collaboration. Screening and counseling procedures developed to ensure free and fully informed consent in intrafamilial organ donation, such as separate interviews and counseling of the involved parties, are transferable to intrafamilial reproductive situations.

### **Potential Emotional and Physical Harms to Gamete Donor or Gestational Carrier**

Gamete donors and GCs in these intrafamilial arrangements are exposed to emotional as well as physical risk. They may fail to receive the special recognition from family members and others that they feel they deserve. Gamete donation and GC arrangements are not always looked on favorably by the general public or even by other family members. When the procedures do not result in a pregnancy, the intended parents may direct anger or blame at the donor or GC. When the child is born with a congenital anomaly, the donor or GC may blame herself or himself or feel blamed by others; the long-term stresses associated with raising a disabled child may be projected on the involved donor or GC. There are

also potential physical risks to oocyte donors, including bleeding and infection from an oocyte retrieval or ovarian hyperstimulation syndrome. Gestational carriers carry the risks associated with pregnancy.

Gamete donors or carriers may have difficulty developing and maintaining healthy relationship boundaries that are acceptable for them, the child, and the intended parents, especially when they have a genetic link to the offspring of the arrangement. Yet, as noted in the discussion of legal counsel below, when the parties have been careful in drafting and signing the necessary documents to clarify legal parenting relationships consistent with applicable law, the familial donor or GC will have no more legal parenting or visitation rights than would an unrelated known or nonidentified (anonymous) donor. When conflict among family members develops, the situation could be especially painful for familial donors and carriers, who may no longer be allowed to contact or visit a genetically related child (24). Mental health counseling and legal consultation are necessitated in intrafamilial arrangements to mitigate these and other potential harms.

### **SCREENING, MENTAL HEALTH COUNSELING, INFORMED CONSENT, AND LEGAL COUNSEL**

The Committee finds the use of familial donors and carriers to be ethically acceptable. However, special care must be taken to ensure that the interests of all parties are protected. To do so, providers should be prepared to spend more time screening and counseling participants in familial gamete donor and GC arrangements compared with those involving nonidentified (anonymous) or unrelated gamete donors and carriers. Requests for intergenerational gamete donations or GC arrangements are especially challenging.

To enhance the likelihood that familial collaboration will be a positive experience, the involvement of professionals representing multiple disciplines, including physicians, third-party nurse coordinators, and mental health counselors with specific expertise in third-party reproduction, is crucial for a thorough assessment. Adequate time is essential to evaluating these proposed arrangements. Prospective donors or GCs should have a physician whose responsibility it is to care for them and be their advocate, although it is usually not necessary for separate physicians to oversee the care of the prospective donor or carrier and the intended parents. Clinics not equipped to provide these services should choose to refer patients to a clinic where these services are offered.

### **Mental Health Counseling and Screening**

When family members are involved as gamete donors or GCs, special care should be taken to promote a good outcome and ensure free and informed decision-making for all involved participants. Such arrangements necessitate mental health counseling by a professional experienced in third-party reproduction for the family member considering acting as a gamete donor or GC, that individual's partner, and the intended parents (23). These sessions should focus attention

on how participants will cope with the unique aspects of the proposed arrangement and on the consequences for the prospective child.

The ASRM Practice Guidelines “Guidance regarding gamete and embryo donation” and “Recommendations for practices using gestational carriers: a committee opinion” delineate the components of mental health consultation and evaluation for third-party reproduction, including gamete donors, GCs, intended parents, and their respective partners (22, 25). The Committee advises that this guidance be followed when family members may act as gamete donors or GCs.

Counseling should closely examine the extent to which each of the above individuals is comfortable with the collaborative reproduction plan. When any of the individuals expresses significant concerns or reticence, the mental health provider may advise that the collaborative reproductive plan not go forward until or unless the concerns can be resolved.

Mental health counseling should address the issue of disclosure. The ASRM ethics document, “Informing offspring of their conception by gamete donor” strongly recommends that the resulting child be informed about the use of donor gametes in their conception; this is particularly important when family members act as gamete donors. Disclosure is also important when family members act as GCs. Counseling should provide guidance on how disclosure can be accomplished. When children are informed of their intrafamilial conception or gestation, specialized counseling may be desirable as they get older, especially for arrangements that give any impression of incest or result in altered views of identity and family relationships.

Counseling should examine the potential emotional and psychological risks as well as novel and complex relationships for the resulting child, the intended parents, the family member acting as a gamete donor or gestational carrier, that individual’s partner, that individual’s children, and potentially additional family members. In particular, knowledge of the actual genetic relationships among the participants could profoundly influence views of identity and family relationships (Table 1). Medical and mental health professionals have raised concerns about the emotional consequences that could occur (5, 6) and have emphasized the need to pay special attention to the psychological needs of children born of such relationships. The counseling of all involved parties should include discussion of how the resulting relationships will be defined and how individuals will be addressed. For example, a sister donating oocytes to her sister may be referred to as an “aunt,” and the children of the two sisters may be referred to as “cousins” rather than half-siblings. A father donating sperm may be referred to as a “grandfather” rather than a father.

Psychological counseling should include discussion of how the donor’s or GC’s own children may be impacted. Psychological counseling should also include discussion that incorporates the potential reactions of their own partners to their involvement in the reproductive goals of a family member. In one survey of known sperm donors, including family donors, 25% said the donation process led to a deterioration of the relationship between the infertile couple and the donor, often resulting from the attitude of the donor’s

partner in cases when they were not involved in the decision to donate sperm (20).

### Legal Counsel

Legal counsel is an essential component of intrafamilial collaborative reproduction and is a prerequisite to the informed consent process. Together with the law of the state or jurisdiction in which the familial collaboration occurs, legal documents, including agreements signed concerning gamete donation and GC arrangements, will determine the legal parenting relations among recipients, donors, GCs, and resulting children. All participants in these arrangements, including donors and carriers, together with their respective legal spouses as well as nonmarital partners, should seek independent legal advice from attorneys with specific expertise in third-party reproduction to determine their legal rights and duties when entering into these arrangements.

### Informed Consent

The process of obtaining informed consent from the requesting individuals and the donor or GCs should involve a thorough discussion of potential medical and emotional risks to all parties and to the anticipated child. Clinicians should make efforts to ensure that gamete donors and carriers have made their decisions to participate in these reproductive arrangements voluntarily and free of manipulation or undue influence. Financial incentives, including direct and indirect payments as well as inheritance, should not be so substantial that they become inducements that may lead the prospective donor or GC to discount the risks associated with the procedure (26).

## CONCLUSIONS AND RECOMMENDATIONS

Assisted reproductive technology programs should develop policies and procedures for dealing with requests for the use of family members as gamete donors, or GCs. Although programs have no obligation to provide such services, the Ethics Committee finds that many intrafamilial reproductive arrangements, including both intragenerational and some intergenerational arrangements, are ethically acceptable and should include legal counseling and a legal agreement among all involved participants. Gametes from first-degree consanguineous relationships (e.g., brother-to-sister without donated oocytes) should never be used to initiate a pregnancy. Free, informed consent is essential in all intrafamilial reproductive arrangements. Because of potential undue influence by a parent, older sibling, or other relative, the Committee recommends that potential third-party participants (gamete donors) be at least 21 years of age and that GCs should also have had at least one live birth. The most problematic requests are usually a parent requesting the involvement of his or her child in gamete donation or GC arrangements. In these cases, and when the assessment reveals consistent concerns about undue pressures on the prospective donor or GC or about unhealthy family dynamics, the program is ethically justified in denying access to these procedures.

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**Miembros de la familia como donantes de gametos o portadores de gestación: una opinión del comité ético.**

El uso intrafamiliar de adultos donantes de gametos y gestantes subrogadas es por lo general éticamente aceptable cuando todos los participantes están plenamente informados y asesorados, pero deben prohibirse los acuerdos consanguíneos o que simulen uniones incestuosas. Los acuerdos entre padres e hijos adultos requieren precaución para evitar la coacción, y los acuerdos entre padres e hijos adultos son aceptables en situaciones limitadas. Los programas que decidan participar en acuerdos intrafamiliares deben estar preparados para dedicar tiempo adicional a asesorar a los participantes y asegurarse de que han tomado una decisión libre e informada. Este documento sustituye al documento del mismo nombre, publicado por última vez en 2017.