4.2.4 Third-Party Reproduction

Third-party reproduction is a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. Such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child. Gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires.

Third-party reproduction may involve therapeutic donor insemination or use of assisted reproductive technologies, such as in vitro fertilization and embryo transfer. The biological and social relationships among participants in these arrangements can form a complex matrix of roles among gestational carrier, gamete donor(s), and rearing parent(s).

Third-party reproduction can alter social understandings of parenthood and family structure. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of his or her birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged women, and commodify *human gametes* and children. These concerns may be especially challenging when carriers or gamete donors are compensated financially for their services. Finally, third-party reproduction can raise concerns about dual loyalties or conflict of interest if a physician establishes patient-physician relationships with multiple parties to the arrangement.

Individual physicians who care for patients in the context of third-party reproduction should:

(a) Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest.

(b) Ensure that the patient undergoes appropriate medical screening and psychological assessment.

(c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled.

(d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships.

(e) Satisfy themselves that the patient's decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services.

Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children.

AMA Principles of Medical Ethics: I,II,IV

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 11-A-94 Surrogate mothers

Report of the Judicial Council C-I-83 Surrogate mothers

4.2.4 Third-Party Reproduction

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Third-party reproduction may involve therapeutic donor insemination or use of assisted reproductive technologies, such as in vitro fertilization and embryo transfer. *The biological and social relationships among participants in these arrangements can form a complex matrix of roles among gestational carrier, gamete donor(s), and rearing parent(s). [new content identifies range of parties who may be involved]*

Third-party reproduction can alter social understandings of parenthood and family structure. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of his or her birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged women, and commodify *human gametes* and children. These concerns may be especially challenging when carriers or gamete donors are compensated financially for their services. *Finally, third-party reproduction can raise concerns about dual loyalties or conflict of interest if a physician establishes patient-physician relationships with multiple parties to the arrangement. [new content addresses evolving practice]*

Individual physicians who care for patients in the context of third-party reproduction should: [new content sets off guidance for individual physicians]

(a) *Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest.*

(b) *Ensure that the patient undergoes appropriate medical screening and psychological assessment.[new content addresses gap in guidance]*

(c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled.

(d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships.

(e) Satisfy themselves that the patient's decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services.

Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children. [new content sets out obligations of the profession, consistent with Principles III, IV*]*

AMA Principles of Medical Ethics: I,II,IV

who are not part of the organ transplant team, (2) the parents of the infant desire to have the infant serve as an organ donor and indicate such in writing, and (3) there is compliance with the Council's Guidelines for the Transplantation of Organs (see Opinion 2.16: Organ Transplantation Guidelines).

In the alternative, a family wishing to donate the organs of their anencephalic infant may choose to provide the infant with ventilator assistance and other medical therapies that would sustain organ perfusion and viability until such time as a determination of death can be made in accordance with current medical standards and relevant law. In this situation, the family must be informed of the possibility that the organs might deteriorate in the process, rendering them unsuitable for transplantation.

It is normally required that the donor be legally dead before permitting the harvesting of the organs ("Dead Donor Rule"). The use of the anencephalic infant as a live donor is a limited exception to the general standard because of the fact that the infant has never experienced, and will never experience, consciousness.

(The Anencephalic Infants as Organ Donors Opinion will appear in the next edition of Current Opinions with Annotations as Opinion 2.162 and is derived from Principles I, III and V.)

11. SURROGATE MOTHERS*

HOUSE ACTION: FILED

"Surrogate" motherhood involves the artificial insemination of a woman who agrees, usually in return for payment, to give the resulting child to the child's father by surrendering her parental rights. Often, the father's infertile wife becomes the child's adoptive mother. The woman bearing the child is in most cases genetically related to the child, though gestational surrogacy (in which the ovum is provided by the father's infertile wife or other donor) is possible as well.

Ethical, social and legal problems may arise in surrogacy arrangements. Surrogate motherhood may commodify children and women's reproductive capacities, exploit poor women whose decision to participate may not be wholly voluntary, and improperly discourage or interfere with the formation of a natural maternal-fetal or maternal-child bond. Psychological impairment may occur in a woman who deliberately conceives with the intention of bearing a child which she will give up. In addition, the woman who has contracted to bear the child may decide to have an abortion or to refuse to relinquish her parental rights. Alternatively, if there is a subsequent birth of a disabled child, prospective parents and the birth mother may not want to or will be unable to assume the responsibilities of parenthood.

On the other hand, surrogate motherhood arrangements are often the last hope of prospective parents to have a child that is genetically related to at least one of them. In addition, most surrogacy arrangements are believed by the parties involved to be mutually beneficial, and most are completed without mishap or dispute. In light of the concerns expressed above, however, some safeguards are necessary to protect the welfare of the child and the birth mother. The Council believes that surrogacy contracts, while permissible, should grant the birth mother the right to void the contract within a reasonable period of time after the birth of the child. If the contract is voided, custody of the child should be determined according to the child's best interests.

In gestational surrogacy, in which the surrogate mother has no genetic tie to the fetus, the justification for allowing the surrogate mother to void the contract becomes less clear. Gestational surrogacy contracts should be strictly enforceable (i. e., not voidable by either party).

(The Surrogate Mothers Opinion will appear in the next edition of Current Opinions with Annotations as Opinion 2.18 and is derived from Principles I, II and IV of the Principles of Medical Ethics.)

C. SURROGATE MOTHERS
(Reference Committee on Amendments to Constitution and Bylaws, page 305)

HOUSE ACTION: ADOPTED

An opinion of the Judicial Council on the subject of "surrogate mother" arrangements was presented to the House of Delegates in Judicial Council Report B (I-82). The House referred Report B back to the Judicial Council. The House also requested that the Board of Trustees study the subject and report to the House.

The Judicial Council has carefully reviewed the information developed by the Board's Committee on Medicolegal Problems on the legal risks of physician involvement in surrogate parenting arrangements, as well as the article "Parenthood by Proxy," by the former AMA General Counsel, which appeared in JAMA on April 22-29, 1983. The Judicial Council has also carefully considered the excellent statement of the American College of Obstetricians and Gynecologists on ethical issues in surrogate motherhood. The Council noted the press reports in 1983 of an unfortunate incident in which a "surrogate mother" gave birth to a microcephalic child who was not the offspring of the semen donor. The Judicial Council is very much concerned about the potential legal and ethical jeopardy that physicians who participate in such arrangements face. When all considerations are brought together, these arrangements do not appear to serve societal interests.

Having received the considered views and comments of members of its panel of consultants, the Judicial Council has given additional consideration to the subject and has concluded that what have been described as "surrogate mother" arrangements do not provide a satisfactory reproductive alternative. The Judicial Council presents its opinion to the House of Delegates for information.

SURROGATE MOTHERS. "Surrogate" motherhood is an arrangement which involves the artificial insemination of a woman who agrees to give the child thus conceived for adoption by the man providing the semen and, usually, his infertile wife. The arrangement involves the services of an attorney who attends to the legal phases of the transaction, a physician who will perform or arrange for the medical services that may be required, and the person or persons seeking a child for adoption. The services of a woman who will enter into a contract for providing the services of bearing a child and delivering the child for adoption are sought. The contract customarily provides compensation for costs of the medical services and for living expenses of the surrogate mother during pregnancy, as well as for discomfort or inconvenience.

The Judicial Council is concerned about the ethical, social and legal problems that may arise in an arrangement in which a woman agrees to become pregnant through artificial insemination, to carry to term and to give the child thus conceived to other persons to serve as adoptive parents. The welfare of the child should be a foremost consideration. In ordinary adoption proceedings an appropriate agency usually investigates prospective adoptive parents to determine their fitness as parents. This precaution is not always present in surrogate motherhood arrangements.

The Judicial Council is also concerned that, if there is a subsequent birth of a defective child, a situation may arise in which prospective adoptive parents and the woman who gave birth to the child may not want to or will be unable to assume the responsibilities of parenthood.

Many other ethical, social and morally difficult situations can be envisioned. For example, the woman who has contracted to bear the child may decide to have an abortion or to refuse to give the child up for adoption. Another consideration which may be overlooked is the psychological impairment that may occur in a woman who deliberately conceives with the intention of bearing a child which she will give up.

The Judicial Council believes that surrogate motherhood presents many ethical, legal, psychological, societal and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents.