

Misconduct in third-party assisted reproduction: an Ethics Committee opinion

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Professionals who discover misconduct or other undisclosed information that would be material to the participation of another party (such as a donor, gestational carrier, intended parent, or lawyer) in an assisted reproductive technology arrangement should encourage disclosure to that party. In some instances, it is ethically permissible for the physician either to disclose material information to the affected party or to decline to provide care. In all cases involving the legal status or rights of the parties, referral to legal professionals is advised. This document replaces the document of the same name, last published in 2014 (Fertil Steril 2014;101:38–42). (Fertil Steril® 2018;110:1012–6. ©2018 by American Society for Reproductive Medicine.)

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KEY POINTS

- Assisted-conception arrangements involving gamete donors, gestational carriers (GCs), intended parents, agents, or attorneys can be complicated by misconduct on the part of these third-party participants.
- Physicians who participate in third-party reproduction arrangements should ascertain that the parties have a written contract governing their reproductive arrangement and should be familiar with provisions that are pertinent to patient care.
- Physicians who become aware of misconduct on the part of a participant in assisted reproductive technology (ART) arrangements may need to reconcile conflicting professional duties, including the duty to obtain informed consent and the duty to maintain patient confidentiality.
- Physicians who become aware of misconduct should seek guidance from the terms regarding confidentiality and disclosure in the third-party reproduction contract between the parties.
- In the rare situation where there is no contract or where the contract provides insufficient direction, physicians should advise the breaching party to disclose his/her intent or behavior to the affected party(ies). Disclosure is supported by the principle of avoiding harm to the party(ies) or to offspring.
- If a gamete donor or GC refuses to disclose material information to an intended parent or an intended parent refuses to disclose material information to a gamete donor or GC, the physician may ethically refuse to participate in the arrangement. Alternatively, depending on the circumstances, the obligation of confidentiality owed to the breaching party may be overridden by the threatened harm to the other party(ies) or to offspring, and may render it permissible for a physician to make a disclosure to the affected party(ies). It is advisable to seek legal consultation before disclosure.
- Physicians who become aware of third-party ART misconduct by health-care professionals, attorneys, or agents should report their findings to law enforcement, licensing authorities, or professional associations, as appropriate.

Assisted reproductive technologies, by necessity, pair intended parents with other persons and entities who collaborate to fulfill the former's quest for parenthood. These others can be grouped into three categories: (1) physicians and ancillary health professionals who provide medical care to intended parent(s) in the reproductive process; (2) gamete donors and GCs who provide services to aid in another's reproduction; and (3) enterprises and agencies such as egg banks, donor-egg matching firms, and GC agencies (hereafter, "agents") and attorneys who create and monitor formal legal relationships among parties to a collaborative reproduction plan. Assisted conception in which intended parents use their own gametes typically is referred to as

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first-party assisted reproduction. Arrangements in which intended parents collaborate with gamete donors and/or GCs are referred to as third-party assisted reproduction. In contrast to natural reproduction, which possesses the privacy and security of a closed two-party relationship, assisted conception is vulnerable to mishaps or malfeasance by the necessary presence of third parties in the reproductive equation. Conduct outside the standard of care by any ART stakeholder can produce physical, emotional, psychological, financial, and reputational harms.

Mishaps and malfeasance by ART practitioners have, in part, been previously considered by the ASRM Ethics Committee in its report discussing disclosure of medical errors involving gametes and embryos (1). This report focuses on misconduct by third parties grouped in the second and third categories mentioned previously—gamete donors/GCs and agents/attorneys practicing in the third-party ART field. Ideally, all potential conduct by the parties to a collaborative reproduction arrangement should be addressed by a preconception contract in which all parties participate voluntarily, transparently, and in good faith. In the event such an agreement is absent, deficient, or breached, ART stakeholders can benefit from generalized analysis of certain conflict scenarios. The aim of this report is to identify areas of potential misconduct by individuals participating in third-party reproductive arrangements and to discuss the range of possible responses by ART practitioners. Misconduct may include behavior that is illegal, unethical, or in breach of the parties' agreement. In some cases (e.g., child abuse), mandatory reporting requirements may be triggered. The Committee recognizes that each scenario involving third-party malfeasance is unique and will require an individualized response. Moreover, it is possible that certain situations will require professional outreach, including consultation with legal counsel.

In circumstances in which a physician is considering disclosing one person's health information to another person, the restrictions of the federal Health Insurance Portability and Accountability Act (HIPAA) may be implicated. Some third-party reproductive agreements may expressly authorize HIPAA disclosure vis-a-vis the clinic, but legal review may be advisable to interpret the applicability of the authorization, or to guide conduct when the agreement does not contain one.

MISCONDUCT BY GAMETE DONORS AND GCs

The growing use of gamete donors and GCs in assisted conception provides expanded opportunity for individuals and couples to become parents (2, 3). At the same time, it can complicate the procreative process, especially when the interests of the parties come into conflict. Conflict-of-interest scenarios in third-party reproduction may include the withholding or misrepresentation of material information or the engagement in expressly prohibited or harmful conduct. A physician who becomes aware of a conflict of interest may consider a range of possible responses.

Conflicts Involving Gamete Donors

Gamete donors are men or women who agree to provide sperm or eggs, respectively, to an individual or couple, often

with compensation for the time, effort, and expenses associated with gamete retrieval. In some instances, gamete donors are recruited by agencies and are not known to the intended parent(s) who select a donor based on available demographic information. In these cases of anonymous gamete donation, it is possible that neither the patient nor the treating physician will meet or encounter the donor, such as when the gametes are frozen upon retrieval and thawed for later use. In other instances, intended parents work openly with gamete donors who may attend medical appointments with the patient in order to coordinate the transfer of gametes. Several problems can arise in these cases of directed donation where the gamete donor is known to the intended parent(s).

The Known Donor's Intent to Parent

Intended parents who solicit gamete donors often presume the donors will neither retain nor assert any parental rights with respect to a resulting child. A series of court cases reveals that in some instances donors initially represent their lack of intent to parent any resulting child but harbor or later develop a desire to exercise parental rights over the donor-conceived offspring. Known sperm donors who initially agree to act purely as donors have been awarded parental rights after stepping into a parenting role once the child is born (4, 5). Egg donors known to the intended parent(s) have disavowed signed consent forms waiving parental rights and later have been declared the children's legal mothers (6, 7).

These disputes over parental rights can involve an ART practitioner who unwittingly becomes aware of the donor's intent to claim parental rights. What action, if any, should a physician take if an egg donor reveals during the informed consent process or elsewhere that, despite her representations to the intended parent(s), she plans to parent the child as her own? If the physician knows the intended parent(s) has/have no intent to share or yield rights to the donor, does the physician have a duty to inform them of the donor's intent? Similarly, what duties does a physician have when a sperm donor reveals that, while he agreed in writing to support any resulting child (making him an intended father rather than a sperm donor), he plans to abandon the intended mother upon a positive pregnancy test? Should the physician reveal this planned abandonment prior to initiating treatment or should the physician regard the revelation as private conduct between the parties that does not implicate the provider?

Physicians who become aware of potential conflicts between gamete donors and intended parents may face the difficult task of reconciling two longstanding professional duties—the duty to obtain informed consent and the duty to maintain patient confidentiality (8, 9). Obtaining informed consent from a patient means disclosing information that would be material to a person's decision to undergo or refuse treatment. While the doctrine of informed consent does permit withholding or postponing disclosure of material information in limited circumstances, these deviations are based on the patient's inability to process the information and would not apply in the case of donor misrepresentation (10). Standing alone, the duty of informed consent counsels in favor of disclosure of a donor's "true intent" because such

information would clearly be material to a patient's decision about assisted conception.

The disclosure analysis is less clear-cut when the concomitant duty to maintain patient confidentiality is considered. Physicians treating both a gamete donor and an intended mother, form patient-physician relationships in both instances and owe equal duties to both patients. Disclosures by gamete donors regarding parental intent can be considered within the physician's duty to maintain patient confidentiality. However, this duty is not absolute and disclosure to third parties is permitted under certain circumstances, including permission by the patient (as could be contained in a preexisting contract between the donor and intended parent[s]) or to avoid serious harm to a third party (9). In the absence of a contract provision waiving confidentiality by the donor, a physician should encourage the donor to discuss the issue of parental rights with the intended parent(s). If the donor is unwilling to disclose, the physician may consider revealing the confidential information to the intended parent(s) in order to avoid harm in the likely event the future child's parentage is disputed. Alternatively, the physician may consider withdrawing from the case, providing sufficient notice of withdrawal to permit the donor to secure another physician. A physician has no duty to participate in a patient's act of wrongdoing.

Newly Discovered Donor Health Information

Medical, psychological, and social screening of prospective gamete donors is a field unto itself, susceptible to a modest regulatory scheme and a highly competitive market environment that aspires to promote best practices (11). Professional gamete recruiters are well aware of the motivations and strategic thinking that cause donors to offer their services and are generally equipped to detect evasions and misrepresentations in the interview and screening process. Still, it is possible for an applicant to be placed into the pool of available donors having lied about or failed to disclose information that would be material to any intended parent. Moreover, it is possible for a physician or other ART health-care provider to discover this information in the course of interacting with the chosen donor.

What action, if any, should the ART provider take if he or she discovers previously undisclosed information about the donor's health, or psychological or social well-being that is potentially material to the donor's participation in the ART relationship? Federal and professional guidelines governing gamete donation clearly spell out exclusion criteria, including certain medical, genetic, psychological, social, and familial history, such that any donor who presents, at any point in the treatment cycle, with an excludable characteristic should be considered unsuitable for gamete donation (12, 13). When a donor fails to disclose information that impacts his or her clinical suitability, such as family history of a heritable disease, mental illness, or recent use of illicit substances, the physician should consider taking steps to dismiss the donor from the treatment plan. Likewise, discovery that a donor has undergone repetitive oocyte donation cycles in excess of ASRM practice guidance would warrant dismissal from the arrangement (2).

The scenario becomes more complex in the case of directed donation, when a donor is known to and selected by the intended parent(s). Published guidance and commentary present different views on whether the intended parent(s) should be informed about the discovery of exclusion criteria in known donors. Federal regulations do not require informing gamete recipients of a known donor's medical test results. In contrast, ASRM recommends that intended parent(s) be informed and counseled about the risk of proceeding with treatment. (ASRM PC, Recommendations for gamete-13).

Though not explicitly stated, the federal regulations assume that a known donor has already disclosed possible exclusion criteria to the potential recipients and the parties have agreed to assume the associated risks of treatment. The scenario discussed herein imagines that no such disclosure to the intended parent(s) or to the screening agency has been forthcoming, thus warranting action to dismiss the donor from the arrangement or to inform the intended parent(s) of the donor's unsuitability for gamete donation, or both. Once a known donor's previously undisclosed health-related information is verified, the physician should discuss these findings with the donor. A donor's request to withdraw from the arrangement without disclosing the clinical findings to the intended parent(s) should be honored. In such cases, the intended parent(s) can be informed that the prospective donor has been excluded as a directed donor, but specific health-related findings need not be disclosed. A donor who expresses a desire to continue in the ART process, and who would not be prohibited by law from serving as a donor, should be made aware that the donation cannot continue unless the relevant clinical findings are disclosed to the intended parent(s) for their consideration. A candid and thorough discussion with all the parties should ensue.

CONFLICTS INVOLVING GESTATIONAL CARRIERS AND INTENDED PARENTS

Physicians providing fertility or obstetric care in the context of a GC arrangement can become aware of deceptive practices on the part of the gestational carrier or intended parent(s). While professional guidelines recommend that GCs and intended parents obtain independent medical services, it may be that one physician will treat both parties at the same time (for example, during the preconception and early-gestation stages), thus entering a patient-physician relationship with both parties (14, 15). What if one party confides in the physician that he or she no longer intends to fulfill the terms of a preconception contract? This could mean, for example, a GC declaring her intent to claim parental rights over an in utero embryo or fetus, or an intended parent declaring the inability to fulfill a contractual term due to lack of financial resources. Discovery of one party's intended breach or malfeasance that occurs prior to reproductive treatment or pregnancy can be addressed in the same manner as matters of gamete donor misconduct discussed above. More problematic are the instances of misconduct that occur or come to light as the GC's pregnancy progresses.

Misconduct by the GC

Ideally, the parties to a GC agreement should discuss and memorialize all possible contingencies that can arise in the course of the relationship (14). In some jurisdictions, parties to a GC arrangement are required to be represented by separate, independent legal counsel in order for the agreement to be considered valid and enforceable (15). In all cases, parties to a GC arrangement should enter into an agreement voluntarily, transparently, and in good faith. Physicians who participate in third-party reproduction arrangements should inform themselves, to the extent possible, of the provisions of the parties' agreements that specifically address material aspects of a patient's care (14). A key component of a GC agreement is the scope of disclosure required and permitted by all the parties, including physicians and other health-care providers. Typically, parties to a GC agreement waive confidentiality to any material information discovered in the course of treatment and authorize disclosure to affected parties. Express waivers of confidentiality create an exception to a physician's duty to maintain patient confidentiality.

In the rare instances where there is no express waiver or explicit contractual guidance, however, the discovery of a breach by a GC or intended parents can present physicians with a profound dilemma, as they must weigh the benefits and burdens of nonconsensual disclosure. In some instances, particularly before embryo transfer, physicians may consider withdrawing from the case, so long as they provide sufficient notice to allow location of another provider in order to minimize the risk of a claim of abandonment.

Two hypothetical scenarios are illustrative. First, what if a practitioner becomes aware that a GC has breached the terms of a signed agreement by engaging in some prohibited conduct such as drug or alcohol consumption? Is disclosure to the intended parent(s) a breach of patient confidentiality owed to the carrier? Does the physician have a duty to maximize the well-being of the offspring, and if so, is nondisclosure a breach of that duty?

Practitioners who provide fertility or obstetric care to GCs do enter patient-physician relationships that include traditional duties of confidentiality. However, when a GC engages in conduct that is potentially harmful to the resulting child and would have excluded her from being considered as a GC at the outset, the physician should take steps to inform the intended parent(s) about the GC's behavior (16). Initially, the physician should encourage the GC to self-disclose, but after a brief period the physician should seek legal advice about confidentiality, HIPAA, and the option to discuss the GC's actions with the intended parent(s). In some instances, the intended parents may have grounds for a lawsuit against the GC and such legal issues should be taken up by the parties' legal counsel.

Misconduct by the Intended Parents

A second hypothetical situation illustrates potential wrongdoing by the intended parents. What if a practitioner becomes aware that the intended parents have breached the terms of a signed agreement by engaging in conduct that the GC expressed as material to her consent to provide services? For

example, what if intended parents who presented themselves as a married couple confide in the practitioner that they are not legally married and do not plan to share this fact with the GC? If a GC made clear that delivery to a married couple was material to her consent, should the physician reveal this marital status update to the pregnant woman?

If the information is obtained prior to embryo transfer, the physician may decline to participate in an arrangement tainted by misconduct. Before or after embryo transfer, however, the physician can seek to restore transparency by encouraging the intended parents to self-disclose. If they refuse, legal counsel is advisable to assess the confidentiality considerations surrounding disclosure to the GC.

MISCONDUCT BY AGENTS AND ATTORNEYS

In the United States, third-party ART involves lawful commercial activity in which intended parents pay compensation to gamete donors and GCs in exchange for agreed-upon services. The monies paid include fees paid to donors and GCs, as well as fees paid to agents who assist in bringing the parties together and attorneys who memorialize the parties' agreement through contracts and court filings. As a general rule, ART agents are not typically licensed by any local, state, or federal authority and thus are not subject to governmental credentialing or inspection. Attorneys are licensed by the state bar association in the jurisdiction in which they are authorized to practice law. It is not uncommon for attorneys to act as both agents and lawyers on behalf of ART patients, donors, and GCs.

There have been verified instances of misconduct involving the misappropriation of monies paid in connection with ART. Law enforcement has investigated and prosecuted agencies and individuals who have absconded with funds paid for ART services or have procured funds through active fraud and misrepresentation (17). Such conduct causes tremendous reputational harm to the entire ART community. Often physicians are not involved with or aware of these schemes, but if they are, the following examples may guide their response.

What if a gestational carrier mentions to her doctor at a routine appointment that the agency has failed to make an agreed-upon payment? As this can be the sign of deeper financial misconduct, should the physician advocate on behalf of the patient by contacting the sponsoring agency? Physicians treating parties to a GC arrangement are encouraged "to be familiar with pertinent preconditions and contingencies in [the] contract" (14). Preconditions to payment can include verification of pregnancy or progress to a certain stage in the pregnancy, all involving the physician's expertise. Thus, if a physician knows that a GC has met the terms of her contract and is experiencing financial or other mistreatment by the sponsoring agency, the physician should consider contacting the agency on behalf of the GC.

If the physician is unable to make contact with the agency, should law enforcement be contacted to flag potential fraud on the GC? At least one professional society admonishes physicians who provide medical care in connection with GC agreements "to be aware of the policies of the agency and avoid participation in arrangements in which the financial or

other arrangements are likely to exploit any of the parties” (14). Physicians who become aware of potentially exploitative conduct on the part of ART agencies are encouraged, and possibly duty-bound, to inquire and advocate on behalf of their victimized patient. This advocacy can take the form of contacting the sponsoring agency, notifying law enforcement, and/or reporting suspected misconduct to any relevant licensing authorities. Misconduct on the part of lawyers can and should be reported to the state bar association that issued the attorney’s license to practice law (18, 19).

CONCLUSION

ART practitioners may find themselves in the position of discovering deceptive or dishonest conduct on the part of individuals engaged in collaborative reproduction. When a third-party ART arrangement presents an actual or potential conflict of interest between the intended parent(s) and their collaborators, physicians should consider to whom and to what extent they owe professional duties. Physicians who are told or discover information that would be material to another party’s participation in the ART arrangement should encourage disclosure to that party. In some instances, it is ethically permissible for the physician to either disclose material information to an affected party or to withdraw from the case. In all cases involving the legal status or rights of the parties, referral to legal professionals is advised.

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