Misconduct in third-party assisted reproduction: a committee opinion

The Ethics Committee of the American Society for Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

Physicians who are told or discover information that would be material to another party's participation in an assisted reproductive technology (ART) arrangement (such as lawyer's, donor's, gestational carrier's, or intended parent's) should encourage disclosure to that party. In some instances, it is ethically and legally permissive for the physician to either disclose material information to an affected party or to transfer care of a patient to another willing provider. In all cases involving the legal status or rights of the parties, referral to legal professionals is advised. (Fertil Steril® 2014;101:38–42. ©2014 by American Society for Reproductive Medicine.)

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KEY POINTS

- Assisted conception arrangements involving gamete donors, gestational carrier (GC), agents, or attorneys can be complicated by misconduct on the part of these third-party participants.
- Physicians who become aware of misconduct on the part of an assisted reproductive technology (ART) participant 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 that a gamete donor, GC, or intended parent has breached or intends to breach a material provision of a pre-existing contract should counsel the breaching party to disclose his/her intent or behavior to the affected party(ies).
- A gamete donor's or GC's refusal to disclose material information to an intended parent or an intended parent's refusal to disclose material information to a gamete donor or GC should render it permissible for a physician to disclose the information to the affected party(ies). Disclosure is supported by the principle of avoiding harm to the party(ies) or offspring.
- Physicians who participate in third-party reproduction should inform themselves, to the extent possible, of the material provisions of the parties' agreement and should refuse to participate in any activity that involves wrongdoing.
- Physicians who become aware of third-party ART misconduct by health care professionals, attorneys, or agents should report their findings to appropriate sponsoring agencies, law enforcement, and/or licensing authorities.

Assisted reproductive technologies, by definition, pair intended parents with third parties who collaborate to fulfill the former's quest for parenthood. ART third parties can be divided into three categories: physicians and ancillary health professionals who provide medical care to intended parent(s) and collaborators participating in the reproductive process; gamete donors and GCs who provide services to aid in another's reproduction; and 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 first-party assisted reproduction. Arrangements in which intended parents collaborate with gamete donors and/or GCs is referred to as third-party assisted reproduction. In contrast to natural reproduction, which enjoys 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

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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 agreement in which all parties participate voluntarily, transparently, and in good faith. In the event such an agreement is absent or deficient, ART stakeholders can benefit from generalized analysis of common mishap scenarios. The aim of this report is to identify a few areas of potential misconduct by individuals participating in third-party reproductive arrangements and discuss the range of possible responses by affected parties, primarily ART practitioners. 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.

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). Including third parties in the intimacies of reproduction can also complicate the procreative process, especially when the interests of the parties come into conflict. Conflict-of-interest scenarios in third-party reproduction can involve the withholding or misrepresentation of material information that is later discovered in the course of treatment or engagement in expressly prohibited or harmful conduct. A physician who becomes aware of a conflict of interest may consider a range of possible responses discussed next.

Conflicts Involving Gamete Donors

Gamete donors are men and women who agree to provide sperm and 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, 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. In these cases of directed donation where the gamete donor is known to the intended parent(s), several problems can arise.

The Donor's Intent to Parent

Intended parents who solicit gamete donors commonly presume the donors will neither retain nor assert any parental rights with respect to a resulting child. A series of court cases reveal 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). Egg donors known to the intended parent(s) have disavowed signed consent forms waiving parental rights and later been declared a child's legal mother (5). These disputes over parental rights can draw in 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 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 no intent to share or yield rights to the donor, does the physician have a duty to inform the patient of the donor's intent? Inversely, 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?

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 (6, 7). 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 data and would not apply in the case of donor misrepresentation (8). 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. This duty, however, is not absolute and disclosure to third parties is permitted under certain circumstances, including express 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 (7). 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 (9). Professional gamete recruiters are well aware of the motivations and strategic thinking that bring donors into the market, and they are generally well-equipped to detect falsehoods 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, psychological, or social well-being that is potentially material to the donor's participation in the ART relationship? This scenario is in contrast with the above situation in which donors misrepresent their intent or lack of intent to parent. Donor misrepresentation about the assumption of parental rights may render a donor unsuitable in the eyes of an intended parent because of concerns about legal entanglements, but the donor could still be considered suitable from a clinical perspective. When a donor fails to disclose information that impacts his or her clinical suitability, such as family history of a hereditable disease, a bout with 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 guidelines would merit dismissal from the arrangement (2).

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 (10, 11). 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 guidelines 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.

Though not explicitly stated, the ASRM position assumes 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 relevant clinical findings will be disclosed to the intended parent(s) for their consideration. A candid and thorough discussion with all the parties should ensue.

CONFLICTS INVOLVING GC AND INTENDED PARENTS

Physicians providing fertility or obstetric care in the context of a GC parenting 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 (12, 13). 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 gestational carrier declaring her intent to claim parental rights over an in utero child 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 conception or even prior to pregnancy can be addressed along the same lines as matters of gamete donor misconduct discussed above. More problematic are instances of misconduct that occur 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 (12). 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 (13). In all cases, parties to a GC arrangement should enter into an agreement voluntarily, transparently, and in good faith. 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. Express waivers of confidentiality represent an exception to a physician's duty to maintain patient confidentiality. In the absence of an express waiver or

explicit contractual guidance in the face of newly discovered information, fertility and obstetric practitioners must weigh the benefits and burdens of nonconsensual disclosure. In some instances, physicians may consider withdrawing from the case so long as they provide sufficient notice to allow location of another willing provider.

Reported instances of breach by GCs and intended parents are relatively rare, but when they occur can present profound dilemmas for physicians. Two hypothetical scenarios are illustrative. First, what if a practitioner becomes aware that a gestational carrier 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 enforceable 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 the patient from being considered as a gestational carrier at the outset, the physician should take steps to inform the intended parent(s) of the GC's behavior. Initially, the physician should encourage the GC to self-disclose and after a brief period can discuss the GC's actions with the intended parent(s). In some instances, breach on the part of the gestational carrier may be so severe as to warrant rescission of the GC agreement. These and any other legal questions should be referred to the parties' 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 gestational carrier expressed as material to her consent to provide services? For example, what if the intended parents confide in the practitioner they have separated and plan to divorce prior to the birth of their child – but do not plan to share this fact with the GC? If a gestational carrier made clear that delivery to an intact couple was material to her consent, should the physician reveal this marital status update to the pregnant woman? Permissive disclosure to the GC may be more straightforward in this case for two reasons.

First, it may be that the physician is not in a patient/physician relationship with the intended parent(s) and thus owes no professional duty of confidentiality. Because professional guidelines discourage practitioners from simultaneously treating the GC and the intended parent(s) because of potential conflicts of interest, the physician may have never entered a professional relationship with the intended parent(s) who has/have no reasonable expectation of confidentiality on the part of the physician (12). Second, marital or relationship instability is considered an "absolute criteria for rejection of intended parents" to a GC agreement according to ASRM Practice Committee guidelines and thus would have barred formation of the arrangement from the outset (14). Disclosure to the patient by the physician in the manner set forth in the case of a gamete donor's failure to disclose material clinical information is a reasonable course of action.

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.

Misconduct involving the misappropriation of monies paid in connection with ART has been reported, verified, and processed. Law enforcement has investigated and prosecuted agencies and individuals who have absconded with funds paid for ART services or procured funds through active fraud and misrepresentation (15). Often physicians are not involved or aware of these schemes, but such conduct causes tremendous reputational harm to the entire ART community. Occasionally, physicians do become aware of financial malfeasance by agents or attorneys and should consider the best course of action in such instances.

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 "obliged to become as informed as possible about the financial and other arrangements between the GC mother and intended parents to make ethical decisions about providing medical care" (12). Thus, if a physician knows that a GC 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" (12). 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 (16).

CONCLUSION

ART physicians may find themselves in the unenviable 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 and legally permissive for the physician to either disclose material information to an affected party or to transfer care of a patient to another willing provider. In all cases involving the legal status or rights of the parties, referral to legal professionals is advised.

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