Ethical Decision-Making Regarding Termination in Gestational Carrier Pregnancies

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In a typical pregnancy, the pregnant person is the sole decision-maker regarding pregnancy termination. However, in a pregnancy involving a gestational carrier, both the gestational carrier and the intended parents may assert that they ought to have the authority to make decisions regarding pregnancy termination. Fundamentally, gestational surrogacy relies on promises made between gestational carriers and intended parents. These promises create ethical obligations, and as a result, there are circumstances in which the gestational carrier ought to make decisions regarding termination that are in line with the wishes of the intended parents, rather than her own wishes.

Nevertheless, there is a distinction to be made regarding what the gestational surrogate ought to do and what others may compel her to do. Ultimately, the intended parents do not have a right to authorize or refuse termination against the wishes of the gestational carrier. The gestational carrier's right to bodily autonomy as well as the ethical obligations of third-party medical providers results in a conclusion that the gestational carrier ultimately holds decision-making authority regarding pregnancy termination. Thus, while there are circumstances under which the gestational carrier ought not to exercise her right to make her own decisions regarding pregnancy termination, she always retains that right. Implications of these conclusions for gestational carrier contracts and alternative approaches for avoiding conflict are explored.

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Preface

In 2013, national media reported on a conflict between a gestational carrier named Crystal Kelley and intended parents Stanislav and Vesselina Stoyanov (Cohen, 2013). The conflict arose in 2012, when a prenatal ultrasound showed that the fetus Kelley was carrying had multiple congenital anomalies. These anomalies included a cleft lip and palate, a complex cardiac abnormality, and a cyst in the brain. The Stoyanovs, who were the genetic parents of the fetus, requested that Kelley terminate the pregnancy. According to Kelley, the intended parents expressed, “They didn't want to bring a baby into the world only for that child to suffer. ...They said I should try to be God-like and have mercy on the child and let her go.” For her part, Kelley says she “told them that they had chosen me to carry and protect this child, and that was exactly what I was going to do. I told them it wasn’t their decision to play God.” Notably, Kelley and the intended parents had, prior to the pregnancy, signed a contract stating that she agreed to “abortion in case of severe fetus abnormality,” although a definition of a severe abnormality was not provided.

The intended parents initially responded to Kelley’s refusal to terminate by notifying Kelley that if she continued the pregnancy, they would decline to accept legal parentage of the child. Later they offered her $10,000 to have an abortion. Kelley countered by asking for $15,000, which the Stoyanovs declined. The Stoyanovs then told Kelley that they would accept legal parentage but would immediately relinquish custody to the state of Connecticut. Because the parties involved were in Connecticut, where genetic parentage determines who is considered an infant’s legal parent, Kelley would have been unable to claim legal custody. Therefore, at the advice of her lawyer, she relocated to Michigan, where surrogacy contracts are not legally

enforceable and the birth mother is considered the child's legal mother. There, she planned to place the child for adoption. Legal wrangling continued until the case was settled three weeks after the child's birth when the Stoyanovs agreed to allow the adoption in Michigan to proceed.

As demonstrated by this case, when unanticipated complications develop during a pregnancy involving a gestational surrogate, the parties involved may disagree regarding the best course of action. Such conflicts can be deeply emotional, financially costly, and legally challenging. Disputes regarding pregnancy termination may be particularly contentious, with each party asserting that they should have the right to choose whether the pregnancy is continued. To resolve such disputes, it is vital to determine the ethical obligations and rights of the involved parties.

The aim of this paper is therefore to address the following questions:

I. Are there scenarios in which gestational carriers have an ethical obligation to make decisions about termination that match the preferences of intended parents even if they do not want to make that decision?
II. Are there circumstances in which the intended parents have a right to authorize or refuse termination against the wishes of the gestational carrier?
III. Are there moral constraints on what can be included in an agreement between gestational carriers and intended parents regarding decision-making about pregnancy termination?

To address these questions, Section 1 will provide background information regarding gestational surrogacy and circumstances that may prompt consideration of pregnancy termination in these pregnancies. Section 2 will consider who holds decision-making authority in a typical (i.e. non-gestational carrier pregnancy). Section 3 will outline that gestational carrier pregnancies have at

their foundation a promise between parties that generates ethical obligations. Section 4 will consider the ethical obligations of the parties within gestational carrier pregnancies when there is no specific pre-existing agreement regarding pregnancy termination, while section 5 will address how a pre-existing agreement regarding pregnancy termination alters these obligations. Section 6 will explore whether the parties' ethical obligations alter which party ultimately holds decision-making authority regarding termination. Section 7 will evaluate what ought to be included in gestational carrier contracts, and Section 8 will provide suggestions for avoiding disputes over pregnancy termination decisions beyond contracts.

This paper will, by necessity, reflect limitations. It is beyond the scope of this paper to address a wide range of ethical questions regarding gestational carrier agreements and decision-making within gestational carrier pregnancies. The discussion is limited to decisions regarding pregnancy termination. These situations are a crucible that require consideration of the parties' most strongly held values, including those that are foundational to an individual's identity. Further, they provide among the most permanent and long reaching consequences. Few things about a pregnancy can be considered more consequential than whether there is a baby at the end. This paper focuses on gestational carrier pregnancies within the United States and does not address issues related to international surrogacy. Legal issues related to gestational surrogacy and pregnancy termination are also outside of the scope of this paper. Instead, I aim to provide ethical guidelines for intended parents, gestational carriers, the medical professionals who care for them, and for those who write gestational surrogacy contracts. These guidelines also provide an ethical framework for considering the implications and limitations of such agreements.

With respect to terminology, I refer to gestational carrier "contracts" and "agreements" interchangeably, acknowledging that "contract" may imply additional legal obligations and rights

that are outside the scope of this paper. Moreover, I will refer to the "intended parents," while acknowledging that in some cases there may only be a single intended parent. In addition, for the sake of brevity, I will refer to the intended parents as a single party, acknowledging that there may be circumstances in which intended parents may have divergent perspectives or wishes. Finally, I refer to "maternal" health conditions or risks to distinguish these concerns from fetal risks, and use female pronouns to refer to the gestational carrier, while acknowledging that some gestational carriers may not identify as female or as having a "maternal" role. Because not all gestational carriers identify as women, I have opted to use the term "pregnant person," rather than "pregnant woman" throughout.

1.0 Background

The advent of assisted reproductive technology has allowed for a possibility that would have been difficult to envision several decades ago: a person carrying and birthing a child that bears no genetic relationship to herself, on behalf of another intended parent or parents. Such pregnancy arrangements are typically referred to as gestational surrogacy, and those who carry and deliver such pregnancies are known as gestational carriers (or sometimes, gestational surrogates). In gestational surrogacy, either the egg, sperm, or both may be supplied by the intended parents or by donors with varying levels of anonymity. This distinguishes these arrangements from more traditional surrogacy arrangements, in which the pregnant person is also the genetic mother of the fetus. Over the past two decades, pregnancies involving gestational carriers have become increasingly common in the United States. In 1999, only 727 assisted reproductive technology (ART) cycles involving a gestational carrier took place. By 2013, the most recent year for which data are available, more than 3400 gestational carrier ART cycles occurred (Perkins et al., 2016). This does not include pregnancies "commissioned" by American intended parents in which the gestational carrier lives in another country.

In any pregnancy, medical decision-making will be necessary. In most pregnancies, the pregnant person is the sole decision-maker regarding pregnancy termination unless extenuating circumstances call her decision-making capacity into question. In pregnancies involving a gestational carrier, in contrast, both the gestational carrier and the intended parents may assert that they have decision-making authority regarding termination. If the gestational carrier and the intended parents agree, then determining which party holds decision-making authority may not be strictly necessary. However, in the setting of increasing frequency of pregnancies involving

gestational carriers, disputes regarding which party or parties have a valid claim to decision-making authority are likely to arise with increasing frequency.

1.1 Scenarios that may lead to consideration of pregnancy termination

At the outset of a gestational carrier pregnancy, it is reasonable to assume that both the intended parents and the gestational carrier hope for a medically uncomplicated pregnancy leading to the live birth of a healthy newborn, who then is cared for and raised by the intended parents. During the pregnancy, however, a circumstance may arise that is outside of this hoped-for ideal, and pregnancy termination may arise as a potential course of action. Although the circumstances in each pregnancy are unique, such scenarios may fall into one of four categories:

I. Scenarios in which the life, health, or well-being of the gestational carrier is at risk

II. Scenarios in which the life, health, or well-being of the fetus and/or child after birth is at risk

III. Scenarios in which the life, health, or well-being of both the gestational carrier and fetus and/or child after birth is at risk

IV. Scenarios in which the circumstances of the intended parents have changed

We will now explore examples of each of these types of scenarios.

1.1.1 The life, health, or well-being of the gestational carrier is at risk

A wide range of circumstances may arise in which the fetus is healthy, but the health, well-being, or life of the gestational carrier is at risk from pregnancy continuation. Examples may

include a maternal medical diagnosis for which the typical treatment would be contraindicated during pregnancy (due to anticipated adverse fetal effects), such as certain cancers. Cancer is diagnosed in approximately 1 in 1000 pregnancies, and when it is diagnosed early in pregnancy, pregnancy termination to expedite treatment may be necessary to optimize maternal outcomes (Allen, 2020). There are also maternal cardiopulmonary conditions that are associated with extremely high levels of maternal mortality. For instance, pulmonary hypertension has been associated with a maternal mortality rate of upwards of 30-50% (Pieper & Hoendermis, 2011). If a gestational carrier were to be diagnosed with pulmonary hypertension in pregnancy, pregnancy termination would arise as a potential course of action.

Non-medical changes in circumstances could also alter the risks posed to the gestational carrier associated with pregnancy. For instance, the gestational carrier's marital, employment, or housing status could change during the pregnancy, and while carrying a pregnancy might have seemed feasible at the outset, it may no longer seem so given her new circumstances.

1.1.2 The life, health, or well-being of the fetus and/or child after birth is at risk

Scenarios in this category would occur in the event of a prenatal fetal diagnosis of a congenital anomaly or genetic condition. Conditions that can be diagnosed prenatally can have a wide range of anticipated impacts on the life or health of the fetus and/or child after birth, and the degree of certainty of the prognosis may also vary. At the minor impact end of the spectrum, for instance, ultrasound may identify conditions that are considered normal variants, such as an isolated pelvic kidney. In this condition, which occurs in approximately 1:1000 live births, one or both kidneys are abnormally located in the fetal pelvis (Bingham & Leslie, 2022). It is of no clinical consequence, except that should the child ever have surgery, the surgeon should be aware

of the pelvic kidney to avoid mistaking it for an abnormal growth. A slightly more impactful finding on ultrasound could include polydactyly, an extra finger. This is a common condition, occurring in 1:93 to 1:625 live births depending on the population studied. Typically, a minor surgical procedure is performed in infancy to remove the abnormal finger, and there are no further impacts on the child thereafter (Barnes & de Cicco, 2021). Continuing along a spectrum of severity, there are conditions such as clubfoot, in which months or years of low-risk interventions may be required. Treatment of clubfoot, however, has an excellent success rate, in which nearly all children attain normal or near normal function (Clubfoot, 2019).

There are also conditions that are clearly life-altering, although prolonged survival without significant invasive medical intervention would be anticipated, such as achondroplasia and some cases of trisomy 21 (Down syndrome). Other conditions, such as cystic fibrosis, may result in prolonged survival, but only with frequent and substantial medical interventions. Some potential prenatal diagnoses may come with substantially shortened life expectancy, such as Tay Sachs disease. Finally, there are conditions in which survival to live birth is unlikely, and if live birth occurs, survival is typically measured in hours. Such conditions may include ectopia cordis, in which the heart is formed outside of the fetal chest cavity; and limb-body wall complex, in which the fetus is formed fused to the placenta with openings in the fetal chest and abdomen exposing the internal organs, and severe abnormalities of the limbs and spine.

It is important to recognize that prenatal diagnoses do not always come with prognostic certainty, even when the abnormality is quite significant. For instance, while most babies born with anencephaly die within days to weeks, there have been rare cases of prolonged survival for months or even years (Dickman et al., 2016). Similarly, although the majority of fetuses with trisomy 13 and 18 do not survive to live birth, and >90% of those who are live-born die within the

first year of life, there are some children with trisomy 13 and 18 who have lived into their teens (Trisomy 13 and Trisomy 18 in Children, 2022). The prognosis may be even more uncertain in cases where there is a wide range of phenotypes associated with a particular genetic diagnosis, such as in osteogenesis imperfecta, or a wide range of reported neurodevelopmental outcomes in the setting of a structural abnormality, such as absence of the corpus callosum.

1.1.3 The life, health, or well-being of both the gestational carrier and the fetus and/or child after birth is at risk

The third subset of scenarios which may result in conflict regarding pregnancy termination would include situations in which the health of both the gestational carrier and fetus and/or child after birth are at risk. This would include situations in which obstetric complications have arisen, such as previable preeclampsia, previable rupture of membranes, and multi-fetal gestations. Preeclampsia is a condition characterized by a rapid rise in blood pressure and can lead to seizure, stroke, multiple organ failure, and potentially death of the pregnant person and the fetus. When diagnosed prior to fetal viability, pregnancy termination is typically recommended. If termination is declined, periviable or very preterm delivery would be likely, with associated risks to the neonate.

Previable rupture of membranes is another obstetric complication in which pregnancy termination is often considered. After rupture of membranes, maternal risks include heavy bleeding and infection, which can be life threatening. For the fetus, there is a risk of the placenta separating from the uterine wall, which can disrupt the supply of oxygen and nutrients resulting in stillbirth; infection; umbilical cord accidents; and preterm labor resulting in prematurity. In addition, amniotic fluid is integral to normal lung development. After previable rupture of

membranes, even if the pregnancy is carried uneventfully until near term, there is a significant chance that the fetus will develop pulmonary hypoplasia. Pulmonary hypoplasia has a spectrum of severity. In the most severe cases, death occurs shortly after birth. In other cases, neonates may require prolonged respiratory support via a ventilator, may require chronic oxygen supplementation, or may have reduced lung capacity that restricts activity. Whether pulmonary hypoplasia is present, and the degree of its severity cannot be determined prenatally.

Multiple gestations also are associated with increased risks to gestational carriers and fetuses and/or children after birth compared to singleton pregnancies. Risks of maternal complications, including gestational diabetes, preeclampsia, cesarean delivery, and postpartum hemorrhage, are increased with increasing numbers of fetuses. Fetal risks are also increased in multiple gestations, including risks of poor fetal growth and a significant risk of prematurity. Approximately 60% of twin gestations are born prematurely (prior to 37 weeks), while >97% of triplet and higher order multiple pregnancies are born prematurely (Multifetal Gestations: Twin, Triplet, and Higher-Order Multifetal Pregnancies, 2021). Both growth abnormalities and prematurity are associated with increased risks of neonatal death, as well as long term complications such as cerebral palsy, blindness, deafness, and developmental delay (Very Low Birthweight, 2022).

In pregnancies where fetuses share a placenta, there are also increased risks of congenital anomalies, as well as twin-twin transfusion syndrome. Twin-twin transfusion syndrome occurs in approximately 15% of pregnancies where fetuses share a placenta and can lead to death of one or both twins. This condition is often treated with a surgical procedure performed during pregnancy, but this treatment is not always successful. Multiple gestation pregnancies also require more monitoring than singleton gestations and are associated with increased rates of prolonged antenatal

hospitalization compared to singleton gestations (Multifetal Gestations: Twin, Triplet, and Higher-Order Multifetal Pregnancies, 2021). Multifetal reduction procedures, in which one or more fetuses are terminated, significantly reduce, but do not eliminate, these risks. Termination of all fetuses may also be considered in this setting.

1.1.4 Circumstances of the intended parents have changed

During pregnancy, an intended parent could die or become disabled, or be diagnosed with a significant medical condition that would make parenting more challenging or impossible. Employment or housing situations may change, or the relationship between the intended parents may change. Social supports that were anticipated may no longer be available. Each of these possibilities may influence the parties' feelings regarding the ongoing pregnancy.

1.2 Contracts

To prevent conflicts regarding pregnancy termination, often both parties sign a contract or agreement prior to the pregnancy, dictating the intentions and obligations of each party. These contracts are not standardized, and may vary in the level of detail with which the topic of pregnancy termination is addressed. They may not provide clear guidance for all of the wide variety of circumstances that may arise. For example, in the case of Crystal Kelley and the Stoyanovs, the contract did not clearly define "severe fetus abnormality," leaving open whether the prenatal diagnosis in this case fell into this category. Furthermore, even when a contract provides clear

guidance, the moral weight of these contracts is questionable, particularly when decisions must be made that affect the health of the gestational carrier, the fetus, or both.

The uncertain moral weight of gestational carrier contracts in determining medical decision-making authority is reflected in how lawmakers have varied in their approach to gestational carrier contracts and agreements. For instance, as noted in the case above, the surrogacy contract was legally enforceable in Connecticut, but not in Michigan. In Michigan, the Michigan Surrogate Parenting Act MCL Section 722.851 makes all surrogacy contracts, agreements, or arrangements "void and unenforceable as contrary to public policy" (Gestational Surrogacy in Michigan, 2020). Similar laws exist in Arizona, Indiana, and Nebraska. However, in most states, including Connecticut, there is no state statute addressing surrogacy contracts (The United States Surrogacy Law Map, 2020). In still other states, there are specific state laws that validate gestational surrogacy contracts. For example, in California, state statute lays out requirements for gestational surrogacy contracts, and then states that "an assisted reproduction agreement for gestational carriers executed in accordance with these provisions is presumptively valid" Cal. Fam. Code § 7962 (LegInfo, 2020).

1.3 Summary

Myriad situations may arise even in a planned and desired pregnancy, and thus the need to make decisions regarding pregnancy termination arises fairly frequently. In a pregnancy that does not involve a gestational carrier, these decisions are typically complex, taking into account not only the details of the situation that has arisen, but an individual family's values and preferences. In a gestational carrier pregnancy, the values and preferences of the gestational carrier may differ

from those of the intended parents, and conflict can arise. Given the complex ethical and legal landscape surrounding decisions about pregnancy termination in gestational carrier pregnancies, when disagreements arise, both the gestational carrier and the intended parents may lay claim to decision-making authority. One or both parties may look to the agreement signed by the parties prior to pregnancy, if one exists, as the arbiter of this authority. However, resolving the conflict requires examining the ethical obligations of gestational carriers and intended parents and determining who ultimately holds decisional authority.

2.0 Decision-making authority in non-gestational carrier pregnancies

Before we consider who has decision-making authority regarding pregnancy termination in pregnancies involving a gestational carrier, let us examine who holds this authority in pregnancies that do not involve a gestational carrier. In this section, I will argue that in this situation, the pregnant person has exclusive decisional authority regarding abortion. That is, assuming for the sake of the analysis that pregnancy termination is otherwise a legal and ethically acceptable option, no one other than the pregnant person has the moral standing to determine whether the pregnant person remains pregnant.

Before examining why the pregnant person has the moral standing to make this decision, however, let us first imagine this person outside of pregnancy. For the purposes of this discussion, I will limit my analysis to persons who have decision-making capacity. Decision-making authority, in the context of medical decisions for patients with decision-making capacity, is typically ascribed to the individual on whom a medical intervention is to be performed (or not). This authority stems primarily from the right to autonomy, and the corresponding ethical principle of respect for autonomy that medical providers are obligated to uphold. Further, the principles of beneficence and non-maleficence also support patient decision-making authority.

As Gauthier (1993) noted:

> "The fact [is] that it is the patient's own interest that is to be served…. The patient's bodily integrity, life-style, work and recreation, and personal relationships, and even life, itself, are all at stake. The personal nature and impact of these decisions make it important to respect the patient's own wishes concerning treatment."

It is patients who are best able to define what is in their own best interest. As the principle of beneficence requires medical providers to act in their patient's best interests, allowing the patient to define those interests furthers this goal. Similarly, it seems to be patients who are best positioned to determine whether a medical intervention would be harmful to their interests. As a result, the medical provider would be limited in their ability to practice non-maleficence without an understanding of the patient's wishes.

Nevertheless, it still requires justification that patients' autonomous decisions, that is, informed and voluntary decisions made by competent persons about their medical care, should be respected. Immanuel Kant argued forcefully for a deontological approach to justifying respect for autonomy in his Categorical Imperative, which as Gauthier (1993) noted, "provides a moral standard for the treatment of humans." Kant wrote, in all instances, "act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end." Kant argued that the rational nature of humans should always be seen as intrinsically valuable (an end in itself), and that respecting another's autonomy is necessary to respect that person's intrinsic value as a rational agent, and therefore their humanity (Hill, 1980).

John Stuart Mill, in contrast, offered a consequentialist justification for the importance of respect for autonomy ([1859] 1977).

> "The human faculties of perception, judgment, discriminative feeling, mental activity, and even moral preference, are exercised only in making a choice. …He who chooses his plan for himself, employs all his faculties. He must use observation to see, reasoning and judgment to foresee, activity to gather materials for decision, discrimination to decide, and

when he has decided, firmness and self-control to hold to his deliberate decision (p. 262-63)."

Mill also argued that the freedom of action is what promotes individuality, which he views as "quite the chief ingredient of individual and social progress." Mill contended that by respecting the liberty of others we allow them to employ the rational faculties essential for individuality, and thus promote the well-being of individuals and society. Although Kant and Mill offered different justifications, they reached the same conclusion: autonomous decisions ought to be respected.

Returning to our non-pregnant patient with decision-making capacity, to treat her rational nature as an end in itself, and to allow her to exercise her rational faculties and thus promote her individuality, her voluntary and informed decisions regarding her medical care ought to be respected. Importantly, both Kant and Mill predicated respect for autonomy on the conception of humans as rational beings. That is, it is the rational nature of humans that is the intrinsically valuable good to be protected by respect for autonomy. Modern conceptions of rationality required for decision-making in the medical setting are essentially the components of "decision-making capacity."

Decision-making capacity includes the ability to understand that there is a decision to be made; to understand information regarding the potential benefits and risks of a proposed treatment or intervention; to understand the benefits and risks of alternative courses of action, including no treatment; to appreciate how the information applies to her own situation; to use reasoning in making a decision in a manner supported by facts and the patient's values; and to communicate her choice (Barstow et al., 2018). If we assume, that prior to pregnancy, the pregnant person under consideration had decision-making capacity, then she would not lose this capacity by virtue of becoming pregnant. Absent decisive evidence to the contrary, there is no reason to think that

pregnancy has dramatically altered her cognition to the point where she no longer has the capacity to make choices about what happens in and to her body.

Further, the legal right to make decisions regarding pregnancy termination has, over the last 50 years in the United States, been ascribed to the pregnant person, at least until the recent Dobbs v. Jackson Women's Health Organization Supreme Court decision (597 U. S. ____ (2022)). As Ruth Bader Ginsburg explained, the ethical justification for this legal right had been, at least in part, that

> "The decision whether or not to bear a child is central to a woman's life, to her well-being and dignity. It is a decision she must make for herself. When Government controls that decision for her, she is being treated as less than a fully adult human responsible for her own choices."

Because the pregnancy is located within the pregnant person's body, decisions regarding pregnancy termination or continuation have major implications for her physical health, well-being, and her future circumstances. In other words, she is uniquely affected by these decisions in a way that other parties, such as her reproductive partner, is not.

In a typical pregnancy, then, putting aside the question of the legality of abortion, the pregnant person has a strong ethical claim to decision-making authority regarding pregnancy termination. Therefore, it might seem reasonable to assume that in a gestational carrier pregnancy, it would be the gestational carrier, as the pregnant person, who would have this authority. However, there are significant differences in a gestational carrier pregnancy that carry ethical implications. We can now turn to questions regarding decision-making about termination in gestational carrier pregnancies.

3.0 Gestational carrier pregnancies depend on a promise between parties

Two distinct questions can be considered in determining the appropriate party to make decisions regarding pregnancy termination in gestational carrier pregnancies. First, are there circumstances in which gestational carriers have an ethical obligation to make decisions about termination that match the preferences of intended parents even if they do not want to make that decision? Second, are there circumstances in which the intended parents have decision-making authority about termination (i.e., are there circumstances in which the intended parents have a right to authorize or refuse termination against the wishes of the gestational carrier)? We will initially consider the first of these questions.

As noted above, gestational carrier pregnancies differ from other pregnancies in several important ways. Prior ethical analyses regarding medical decision-making during pregnancy have assumed that the gestational mother has an interest in the health and well-being of the fetus, in addition to her own health and well-being. This is due to both her genetic relationship to the child, as well as her assumed plan to be a social parent to the child after delivery. In gestational surrogacy, the gestational carrier has no genetic connection to the fetus, and does not plan to be a social parent; however, she clearly is an interested party by virtue of her body being the site of the pregnancy and of any medical interventions undertaken during pregnancy. The intended parents, who may or may not have a genetic relationship to the fetus (due to the possibility of gamete or embryo donation), may feel a great connection to the fetus as the anticipated social parents. As Abrams (2015) wrote, gestational carrier pregnancies, "disrupt traditional expectations regarding pregnancy by separating gestation from maternity." As a result, our established frameworks to assess decision-making in these scenarios are called into question.

We can assume that in any gestational carrier pregnancy, the gestational carrier and intended parents have voluntarily entered an agreement for the gestational carrier to be implanted with an embryo, gestate the pregnancy, deliver the baby, and then transfer the baby to the intended parents. This agreement generates a specific relationship between the parties, and is necessary for a gestational carrier pregnancy to occur. In order to evaluate decision-making regarding pregnancy termination in a gestational carrier pregnancy, it is necessary to evaluate the ethical obligations generated by such an agreement. Although gestational carrier contracts may carry legal implications in a way that a simple promise does not, from an ethical perspective, a contract is essentially a promise, or set of promises, that two parties make to each other.

3.1 Why promises impose ethical obligations

It may seem intuitive that promises prima facie ought to be kept. That is, making a promise imposes an ethical obligation to carry out an action where no obligation would otherwise exist. Philosophers and ethicists have attempted to evaluate *why* promises impose ethical obligations, and in so doing, evaluate the limitations of these obligations.

Many philosophers and ethicists have proposed that the ethical obligations imposed by promising are grounded in the value of promising as a social convention (Habib, 2021). That is, when promises are kept, this promotes trust between people, and enables continuation of the social convention of promising. The ability to trust people when promises are made enables cooperation between people, which has numerous benefits in society. In particular, the practice of promising enables people to make plans based on the expectation that other people will keep their promises. In contrast, if promises are not kept, this erodes trust between people and therefore reduces social

cooperation to the detriment of all in society. This is, fundamentally, a rule utilitarian argument. As Rawls (1955) wrote:

> "Since the practice [of promising] is of great utilitarian value, and since breaking one's promise always seriously damages it, one will seldom be justified in breaking one's promise. If we view our individual promises in the wider context of the practice of promising itself we can account for the strictness of the obligation to keep promises. There is always one very strong utilitarian consideration in favor of keeping them, and this will insure that when the question arises as to whether or not to keep a promise it will usually turn out that one should."

In his later writing, Rawls took this argument one step further, by arguing that not only does breaking a promise damage the institution of promising, it is also unfair to everyone else who keeps their promises. As Habib (2021) explained, Rawls suggested that,

> "If you make a promise under a just promising institution, then you are obligated to uphold that institution (and obey its rules) because to do otherwise would be to 'free-ride' on the institution in a manner forbidden by the principle of fairness."

3.2 Limits on the ethical obligations generated by promises

Although many authors have weighed in on the philosophical grounds of the ethical obligations imposed by promises, few have attempted to seriously evaluate the limits of these obligations. At best, most philosophers have acknowledged only that these obligations *have* limits. For example, Conee (2000) raised the question of whether it is always wrong to knowingly break

a promise. He concluded that there are circumstances in which breaking a promise does not have "negative moral value." For instance, he wrote,

> "Suppose that at noon Alice promises Zoe to tell her in the evening an elaborate silly joke. In the afternoon Alice learns that a tragedy has befallen Zoe. Alice realizes that it would be horrible to tell Zoe the joke as promised, and comparably bad to ask Zoe in her grief to release Alice from the promise. Alice knowingly breaks the promise. This is not morally bad. The circumstances have rendered it worthless to keep."

Similarly, Conee argued that if one had made a promise to carry out "an evil plan," there would be no ethical justification for keeping that promise. In contrast to Rawls, Conee defended an act-virtue approach to promising. He wrote that for most, but not all, promises, keeping the promise exemplifies virtues such as integrity and respect for others, while breaking a promise would demonstrate a vice, such as selfishness. This alone, he argued, is enough justification for keeping most promises. However, he argued that unless the effects of keeping a promise somehow ethically justify its fulfillment, there is no good reason to keep the promise. That is, it is ethically justifiable to break a promise if doing so would be more virtuous than keeping it. Of course, an issue with such an act utilitarian view to promising is that determining the most virtuous option in any given situation is not always clear cut. This line of reasoning also becomes circular if it is taken to mean that it is ethically justified to break a promise when breaking a promise would be the most virtuous and therefore most ethically justifiable course of action.

Rawls' approach to the limits of promissory obligations differed from Conee's, but was also quite vague. Rawls took a rule utilitarian approach and proposed a "rule of promising," in society, which is that "[I]f one says the words 'I promise to do X' in the appropriate circumstances,

one is to do X, unless certain excusing conditions obtain (Rawls, 1971).” The question, of course, is what are the “appropriate circumstances,” and what are the “certain excusing conditions” that would justify breaking a promise. Rawls did argue that a promise must be made voluntarily and deliberately (Habib, 2021), and therefore we could assume that one does not have an ethical obligation to keep a promise that was coerced or made accidentally (although it is somewhat difficult to imagine accidentally making a promise).

Rawls (1955) also suggested that it is not adequate to use a purely act utilitarian defense for breaking a promise. That is, one cannot say that it is ethically justifiable to break a promise simply because on the whole, even taking into account the negative effect on the institution of promising, breaking the promise led to a better state of affairs. An integral part of the institution of promising, in fact, is that one *cannot* use this defense. As Rawls wrote, “Indeed, the point of the practice [of promising] is to abdicate one’s title to act in accordance with utilitarian and prudential considerations in order that the future may be tied down and plans coordinated in advance.”

However, Rawls did allow that there may be other defenses that *do* justify breaking a promise, and further, he believed these are in fact part of the practice of promising. He suggested that “there may be the defense that the consequences of keeping one’s promise would have been extremely severe.” In addition, he wrote that the practice of promising is justified only if it serves the interest of those who take part in it and that practices take place against “a background of circumstances” and if these circumstances change, “it may still be in accordance with the practice that one be released from one’s obligation (1955).”

Sidgwick, in *The Methods of Ethics* (1907), provided a detailed discussion of the limits of the moral weight of promises. He suggested that a promise is binding if the following conditions are fulfilled:

> "If the promiser has a clear belief as to the sense in which it was understood by the promisee, and if the latter is still in a position to grant release from it, but unwilling to do so, if it was not obtained by force or fraud, if it does not conflict with definite prior obligations, if we do not believe that its fulfilment will be harmful to the promisee, or will inflict a disproportionate sacrifice on the promiser, and if circumstances have not materially changed since it was made."

If any of these conditions is not met, Sidgwick wrote, "consensus seems to become evanescent, and the common moral perceptions of thoughtful persons fall into obscurity and disagreement."

With this context in mind, we can now turn to the more specific question about the moral weight of agreements between gestational carriers and intended parents when conflicts arise over pregnancy termination.

4.0 Ethical obligations in gestational carrier pregnancies without a prior specific agreement related to pregnancy termination

As noted previously, gestational carrier pregnancies require an agreement between the parties that the gestational carrier will gestate a pregnancy, then transfer the resulting baby to the intended parents. This agreement results in specific ethical obligations. For the time being, we will assume that the intended parents and gestational carrier do not have any prior specific agreements related to pregnancy termination. We will address the implications of specific prior agreements in section 5.

Conflicts regarding pregnancy termination in a gestational carrier pregnancy may occur in two forms, one in which the gestational carrier desires pregnancy termination against the wishes of the intended parents, and another in which the intended parents desire pregnancy termination against the wishes of the gestational carrier. We will start with the former.

4.1 Conflicts in which the gestational carrier desires pregnancy termination

If the gestational carrier wishes to terminate the pregnancy against the wishes of the intended parents, she would, in effect, be breaking her promise to gestate the pregnancy. Are there circumstances under which this would be acceptable?

4.1.1 The life, health, or well-being of the gestational carrier is at risk

Let us first consider a circumstance in which a gestational carrier wishes to terminate the pregnancy due to a threat to her life, health, or well-being. In these scenarios, the course of action to which the gestational carrier agreed, to gestate the pregnancy, now comes with new and unanticipated risks to her. Assuming the gestational carrier made a voluntary, informed decision to enter the agreement, she considered her values, needs, desires, and goals, as well as the risks and discomforts associated with a typical pregnancy, and determined whether pregnancy under the agreement served her best interests. However, although she promised to carry the pregnancy, absent an explicit commitment to the contrary, she has not agreed to risk her life, health, or well-being beyond the risks involved in a typical pregnancy. Therefore, circumstances that present an substantial risk to her life, health, or well-being may fall outside the scope of her existing agreement.

If, for example, she has been diagnosed with cancer prior to fetal viability, treatment cannot be performed during pregnancy, and delay in treatment would threaten her life, the decisional framework that she used in determining whether to freely enter into an agreement to carry a pregnancy arguably would no longer apply. As she has not agreed to risk her life beyond the risks inherent to a typical pregnancy, the circumstances at present are outside the scope of the initial agreement. Therefore, she is under no ethical obligation based on her prior agreement to continue the pregnancy. One question that may arise is what precise amount of harm to the gestational carrier rises to the level of putting the circumstances outside of the scope of the original agreement, and who decides if this is the case. This determination must be informed by the medical facts of the specific scenario, but it would also need to take into account potential harm to the gestational carrier's mental health and effects on her that different people may value differently. For instance,

some people might find the potential loss of future fertility to be "substantial harm," while others might not be very concerned about this risk at all. Therefore, it seems that the gestational carrier, in consultation with her medical team, would be best positioned to make this determination.

Importantly, this is not to suggest that the gestational carrier can be released from her promissory obligation to carry the pregnancy in a setting of truly minimal risk to herself by stating that she feels she would suffer substantial harm by continuing the pregnancy; this would be untruthful and ethically unjustifiable. In such a scenario, the gestational carrier would be bound not only by the ethical obligations generated by her prior agreement to carry the pregnancy, but also by the obligation to be what Thomson (1971) called a "Minimally Decent Samaritan." Thompson outlined that there is an important distinction between the Good Samaritan, who goes out of his way, at a significant cost to himself, to help another in need, and the Minimally Decent Samaritan who is merely willing to help another person, at least a little bit, when to do so would have minimal impact on his own life. Thomson argued that we are not ethically obligated to be Good Samaritans, but we are ethically obligated to be Minimally Decent ones.

In the setting of a gestational carrier pregnancy, the gestational carrier has an obligation to be a Minimally Decent Samaritan. That is, she ought to help the intended parents achieve their goal of having a healthy baby, if doing so would not significantly burden her. Consider a scenario in which a gestational carrier had freely entered into an agreement with the intended parents to carry their child, but was now considering pregnancy termination because she had developed carpal tunnel syndrome. Carpal tunnel syndrome is common in pregnancy due to hormone-induced swelling that causes compression of the median nerve in the wrist. The carpal tunnel syndrome was expected to be uncomfortable but temporary and would not prevent her from carrying out her daily activities. Imagine too, that the intended mother had been rendered infertile after cancer

treatment, and this was the final remaining embryo that would allow the opportunity for her to have a biological child. Although the gestational carrier might argue that she had not anticipated this particular discomfort, and therefore the current circumstances are outside of the scope of the original agreement, the gestational carrier still ought not to terminate in this situation. This short-term discomfort would not justify causing substantial harm to the intended parents resulting from loss of the opportunity to be biological parents. To terminate in such a scenario would be selfish and would not live up to the Minimally Decent Samaritan standard.

To summarize, assuming the gestational carrier has not explicitly agreed otherwise, she is under no ethical obligation to continue a pregnancy that now poses a significant threat to her life, health, or well-being. As well-being is a personal, subjectively determined state, only the gestational carrier can determine if the risk is substantial enough to fall outside of her prior agreement. If it does, even in scenarios like those described in section 1.1.3 in which there is also risk to the fetus and/or child after birth, she has no promissory obligations to the intended parents to continue to gestate the pregnancy. Nevertheless, she maintains the obligation to act as a Minimally Decent Samaritan toward the intended parents.

4.1.2 The life, health, or well-being of the fetus and/or child after birth is at risk, or circumstances of the intended parents have changed

We can now consider other scenarios in which the gestational carrier might consider pregnancy termination against the wishes of the intended parents. Such circumstances would include those in which the gestational carrier's life, health, or well-being is not at risk, and yet she desires to terminate the pregnancy, either because of risk to the health or life of the fetus, or because the circumstances of the intended parents have changed. In this case, the scenario would not fall

outside of her prior agreement. That is, she has agreed to carry the pregnancy, and doing so would not pose any unforeseen risks to her. Therefore, a decision to terminate the pregnancy would clearly involve breaking her promise to the intended parents. Would this be ethically justifiable?

Presumably, in such an instance, the argument from the gestational carrier would be that she felt that pregnancy termination would protect the fetus, or more precisely, the child after birth, from the harm of being born with significant medical complications or into a living situation that was not what she had envisioned for the child. She may feel that she has an obligation to protect the fetus from these harms, despite her promise to the intended parents to gestate the pregnancy. What basis might this obligation have?

We have established that the gestational carrier has made a promise to the intended parents generating ethical obligations to them, but the fetus was not a party to this agreement; she has not explicitly promised anything that would generate ethical obligations *to the fetus*. However, she might argue that she *has* made a promise to this fetus. Perhaps, like so many pregnant people, she has looked down at her belly and thought "I promise to keep you safe." This would not justify a decision to break her promise to the intended parents for multiple reasons. First, it is questionable whether such a "promise" to the fetus even *is* a promise. It not clear that a promise that the promisee is unaware of is much of a promise at all. After all, if I promise (silently, internally) to buy you a car if I win the lottery, and then I win, change my mind, and keep all the winnings for myself, can I really be said to have failed to keep a promise? One component of a legitimate promise seems to be that it generates expectations in the promisee. A fetus has no such expectations, and therefore "promises" made to a fetus do not generate the same ethical obligations as the promise the gestational carrier made to the intended parents.

Second, even if we consider her "promise" to the fetus to be a legitimate promise, it was only made possible via her original promise to the intended parents to gestate the pregnancy. Without the initial agreement with the intended parents, she never would have become pregnant in the first place. Therefore, her initial promise to the intended parents has created a prior obligation (to carry the pregnancy). Making a second promise, to the fetus, cannot release her from her prior obligation to the intended parents. Indeed, she ought not to make a promise that would require her to violate her prior obligations, as this will necessarily require her to break a promise.

The gestational carrier may also claim that her obligation to the fetus stems not from a promise to the fetus, but rather from a general obligation to protect fetuses from harm. It seems obvious that the gestational carrier should have no say regarding pregnancy termination in pregnancies that she is not carrying, regardless of whether a fetus has anomalies or is about to be brought into challenging family circumstances. The question then arises as to whether she has a special obligation to protect the specific fetus that she is carrying from harm after birth.

For pregnancies that are going to be continued, both the pregnant person and her medical providers have beneficence-based obligations to the fetus (McCullough and Chervenak 2008; Lyerly, Little, and Faden 2008). In gestational surrogacy, the gestational carrier has beneficence-based obligations to the fetus in her role as the pregnant person. After all, she has freely agreed to gestate this fetus under the assumption that she would attempt to bring a healthy baby into the world. However, she does not have an ethical obligation to promote the fetus' well-being beyond making reasonable attempts to deliver a healthy baby. She has not, importantly, promised to protect the fetus from *all* risks or potential harms. Such a promise would be impossible to fulfill and would put her in an untenable situation, as all choices she makes carry some degree of risk to the fetus.

Even attending her prenatal visits puts her at risk of being in a motor vehicle accident on her way there.

One question that arises is whether termination could actually be beneficial for the fetus or potential child. That is, are there some lives that are simply better not lived? This is a complex question, and full analysis of it falls outside of the scope of this paper. However, for the sake of the discussion that follows, our question is not *whether* there are lives that are not worth living, but *who should decide* whether a potential life is worth living. Although the gestational carrier may feel that she has a special obligation to protect this fetus, the gestational carrier is not well positioned to determine whether termination would promote the well-being of the fetus, it is not her role to do so, and she has no ethical obligation to do so. It is the intended parents, instead, who are generally better positioned to determine the appropriate course of action and who have an ethical obligation to do so.

If the child were born, it would fall to the intended parents to make medical (and other) decisions on the child's behalf. This authority stems from the fact that parents generally have an interest in the well-being of their children. This interest is central to what it means to be a parent, or at least what it means to be a "good" parent. It is not enough to provide food and shelter; rather, a parent has an ethical obligation to *care* about the child's well-being and make decisions that promote it. Further, ethical parents should make decisions to avoid unnecessary suffering for their child. In a gestational carrier pregnancy, it is the intended parents, not the gestational carrier, who have willingly taken on the ethical responsibility to care for the child's well-being after birth. Indeed, part of the agreement between the gestational carrier and the intended parents by necessity includes that that gestational carrier does *not* take on this role.

The intended parents would have the best understanding of what the child's living environment would look like, and their abilities to parent the child (excluding, of course, situations in which the intended parents are no longer capable of making such an assessment). The gestational carrier may not be aware of all the intended parents' social supports and resources. Given that she has agreed to transfer the baby to the intended parents at birth, she will have no role in the multitude of decisions that will affect the baby from birth forward. Once the child is born, she has no obligations to the child beyond that of any reasonable adult. Should she feel that the child is endangered by the living situation with the intended parents, for example, she has the ethical duty to report this to child protective services. Nevertheless, this concern would not justify her breaking her promise to the intended parents to carry the pregnancy.

Given that the gestational carrier has no promissory obligations to the fetus, no general obligation to protect all fetuses from abortion, and no obligation to this specific fetus' well-being that outweighs the obligations of the intended parents to this fetus, these considerations would not justify her breaking her promise to the intended parents to terminate the pregnancy. Although the gestational carrier may have a legitimate interest in the well-being of the fetus, and child after birth, this does not outweigh the interests of the intended parents. Her feelings about beneficence-based obligations to the fetus should therefore not override the views of the intended parents, who as noted above, have a specific interest in and obligation to the child this fetus may become. Although the gestational carrier may suffer moral distress related to continuing a pregnancy that she would have terminated if it were solely her decision, she is not being asked to submit to any procedures or risks that she had not previously agreed to by virtue of agreeing to carry the pregnancy, and she therefore has an ethical obligation to honor her prior agreement. Given that

she has agreed to gestate the pregnancy, and the intended parents believe that continuation of the pregnancy promotes the fetus' well-being, she ought not to terminate in this scenario.

4.1.3 The life, health, or well-being of both the gestational carrier and the fetus and/or child after birth is at risk

There is one additional set of scenarios worthy of consideration in this discussion: scenarios in which pregnancy continuation poses potential dangers to both the gestational carrier and the fetus. A paradigmatic example of this type of scenario would be previable rupture of membranes. As noted in section 1.1.3, once rupture of membranes occurs, continuing the pregnancy carries significant risks, such as infection and hemorrhage, for the gestational carrier. Continuation is also risky for the fetus, as there is a high chance of preterm delivery and its attendant complications, as well as a high chance of pulmonary hypoplasia, which may result in a prolonged stay in the neonatal intensive care unit and potential chronic lung disease.

In a scenario like this, in which there is substantial risk to the gestational carrier, she would be ethically justified in choosing to terminate the pregnancy, as discussed above in section 4.1.1. However, if the gestational carrier feels that the risks to her are acceptable, she ought not to terminate based on concerns about fetal risks. As noted above, while the gestational carrier can determine what risks to her own life are significant enough to justify termination, it is the intended parents who are generally better positioned to assess risks to the fetus.

4.2 Conflicts in which the intended parents desire termination

We can now consider scenarios in which the gestational carrier wishes to continue the pregnancy, while the intended parents desire a pregnancy termination. Such conflicts could occur in the setting of risks to the gestational carrier's well-being, but are more likely in other scenarios, such as risks to the fetus' well-being due to complications identified in pregnancy, or a change in the circumstances of the intended parents.

4.2.1 The life, health, or well-being of the gestational carrier is at risk

As we noted above, in a scenario where the gestational carrier's life or health is threatened, it is she alone who can determine whether the risk to her well-being justifies pregnancy termination. If she feels that the risk is acceptable to her and desires to continue the pregnancy, she would be under no ethical obligation to terminate the pregnancy due solely to the concerns of the intended parents. Certainly, adults with decision-making capacity are allowed to make decisions that others think are not in their best interest.

4.2.2 The life, health, or well-being of the fetus and/or child after birth is at risk

The more likely scenario in which conflict could arise is in the setting of risk to the fetus' health, due to a prenatal diagnosis or pregnancy complication. As noted above, it is the intended parents who are generally best positioned to determine whether termination promotes the well-being of the fetus. Although she has previously agreed to gestate a pregnancy, she has *not* agreed

(we stipulated in the outset of this chapter) to undergo a pregnancy termination. She therefore has no particular ethical obligation to proceed with pregnancy termination.

Nevertheless, she should not insist that her prior agreement to gestate the pregnancy *precludes* her from termination. As Rawls (1955) noted, if a promise no longer serves the interest of those who take part in it, the promisee can release the promisor from their obligations. In this case, the intended parents are releasing the gestational carrier from her promissory obligation to carry the pregnancy, and therefore she is not under any obligation *not* to terminate. As a result, she has no obligation based on her prior agreements to either terminate or continue the pregnancy.

It is important to note, however, that the gestational carrier does maintain the obligation to be a Minimally Decent Samaritan. If she does not feel that termination would be significantly burdensome to her, and the intended parents feel that that pregnancy continuation would cause them great harm, she ought to choose to proceed with termination. To that end, the intended parents ought to make efforts to minimize the burdens of seeking a pregnancy termination in this setting. For instance, it would be appropriate of them to compensate the gestational carrier with all fees that she otherwise would have been paid, cover the cost of the termination itself, and provide for incidental costs, such as travel. However, she is not required to be a Good Samaritan. If she feels that pregnancy termination would remain very burdensome (for example if she holds a strong moral opposition to termination), she is not ethically obligated to proceed.

4.2.3 Circumstances of the intended parents have changed

Scenarios in which the intended parents request termination against the wishes of the gestational carrier due to a change in their circumstances present some of the same issues. However, there is a notable difference, in that in these scenarios the major concern of the intended

parents may be not that they feel that termination would promote the well-being of the fetus but rather that termination would be in their *own* best interest.

Robertson (1983) argued forcefully that people have a fundamental right to choose whether and how to procreate, which he termed "procreative liberty." Importantly, Robertson explained that "full procreative freedom would include both the freedom *not* to reproduce and the freedom *to* reproduce when, with whom, and by what means one chooses." He specifically argued that procreative liberty ought to extend to people who require medical intervention to conceive and/or gestate a pregnancy, including that people should have the right to utilize gestational surrogacy for reproduction. The intended parents, following this line of argument, may suggest that they are exercising their procreative liberty both in the initial gestational surrogacy agreement and in requesting termination if their circumstances change. That is, they might argue that the gestational carrier ought to terminate at their request in such a circumstance because they have a right not to procreate.

This is, however, not an adequate argument. The right not to procreate is not a single right. Rather, it is more accurately described as a "bundle of rights containing three possible sticks: the right not to be a genetic parent, the right not to be a legal [or social] parent, and the right not to be a gestational parent"(Cohen, 2008). If the intended parents no longer wish to be the social parents of the child, should they be forced to do so against their will? Certainly not. However, pregnancy termination is not the only way for the intended parents to relinquish their ethical and legal obligation to parent the child. For instance, they could opt to place the child for adoption.

If the intended parents are the genetic parents of the fetus, they may feel uncomfortable with the idea of their genetic child being raised by others and prefer termination. They may, in essence, argue that the right not to procreate, includes their right to choose not to be a genetic

parent. However, while the right not to be a social parent is well established, the right not to be a genetic parent is not well established (Cohen, 2008). In some circumstances, there does appear to be this right. For example, in order for embryos created from in vitro fertilization to be used, typically both genetic parents must consent, or at least not express an objection (Cohen, 2008). However, the right to avoid genetic parenthood has also been called into question (Smajdor, 2007).

Smajdor (2007) outlined the issue in her analysis of a case in which a man objected to his ex-wife utilizing embryos created with his sperm and her eggs:

> "Mr. Johnston felt that simply by virtue of sharing some of his genes, a child born to Ms. Evans would impose a psychological burden on him. Even if he could be legally exempt from any financial or legal obligations, he believed that the existence of a biological link conferred an inalienable parental bond. Rather than submit himself to such a bond, he preferred that the embryos which contained his genes should be destroyed. The gestational or financial components of parenthood may cause obvious and objective harm when forced on unwilling people. But psychological pain caused solely by the existence of genetically-related children is far more subjective. The fact that some people choose to donate sperm or eggs demonstrates that not everyone feels the same way about this. Any moral or psychological harm involved solely in becoming a genetic parent is contingent on the personal beliefs of the adult involved. Clearly, Mr. Johnston's beliefs made him strongly averse to the prospect. But it is questionable how much credence such a view should be given. Ms. Evans had her own equally subjective view about the value to her of genetic parenthood."

Similarly, while the intended parents in a gestational carrier pregnancy may find placing their genetic child for adoption psychologically burdensome, it is not difficult to imagine that the gestational carrier might also find proceeding with a pregnancy termination to be psychologically burdensome. It is not clear whose psychological pain should be given more weight. As a result, if the gestational carrier feels that termination would be psychologically burdensome, she is under no ethical obligation to ignore her own distress in order to reduce the distress of the intended parents.

Furthermore, questions regarding the right not to be a genetic parent have generally focused on whether embryos, once created, could be implanted in a uterus without the consent of one of the genetic parents (Cohen, 2008; Smajdor, 2007). In contrast, here the question is whether the right not to be a genetic parent implies that an embryo implanted into a third party ought to be terminated if one of both genetic parents no longer wishes to bring the pregnancy to live birth. While the intended parents could have exercised their right not to become genetics parents prior to implantation of the embryo into the gestational carrier, once the embryo has been implanted and exercising their procreative liberties would come at the expense of the gestational carrier's liberty, this cannot be justified.

4.3 Summary of ethical obligations in the absence of a specific prior agreement regarding termination

In sum, when there is a significant threat to the health, life, or well-being of the gestational carrier, it is ethically justified for her alone to decide whether to have a pregnancy termination. There is no role for the intended parents in making this decision, and she has no ethical obligation

to substitute their judgement for her own. In contrast, even if there is a threat to the health, life, or well-being of the fetus, the gestational carrier ought not to terminate a pregnancy against the wishes of the intended parents. She has an ethical obligation not to do so based on her prior agreement with the intended parents, and they are better situated to determine whether termination could be considered to benefit the fetus (or potential child). However, if the intended parents request termination, the gestational carrier may choose to proceed, but has no ethical obligation to do so given that the parties' prior agreements have not created an obligation to terminate. Table 1 summarizes the conclusions reached in section 4.

Table 1 Ethical obligations in the absence of a specific prior agreement regarding termination

<table>
<tr><th></th><th>Threat to GC's well-being</th><th>Threat to fetus/child's well-being</th><th>Change in circumstances of the IP</th><th>Threat to GC and fetus/child's well-being</th></tr>
<tr><td>GC desires termination / IP desire pregnancy continuation</td><td>GC is ethically justified in choosing to terminate</td><td colspan="2">GC ought not to terminate</td><td>GC would be justified in choosing to terminate due to maternal risks, but if she feels risks to herself are acceptable, she ought not to terminate due to fetal risks alone</td></tr>
<tr><td>IP desire termination / GC desires pregnancy continuation</td><td>GC has no ethical obligation to terminate, but may choose to do so</td><td colspan="3">GC has no ethical obligation to terminate based on prior agreement, but ought to do so if she would not find termination to be burdensome</td></tr>
</table>

GC: gestational carrier; IP: intended parents

5.0 Ethical obligations in gestational carrier pregnancies with a prior specific agreement related to pregnancy termination

Our discussion in the last chapter focused on whether the gestational carrier ought to defer to the wishes of the intended parents regarding pregnancy termination in the absence of a clear, pre-existing agreement regarding termination. We have been assuming that the parties have agreed only that the gestational carrier will gestate the pregnancy and then transfer the baby to the intended parents. However, many gestational carrier agreements are substantially more complex and detailed than we have thus far acknowledged.

Gestational carrier contracts or agreements may have a multitude of sections establishing everything from who will be allowed in the room at the time of delivery to the agreed upon conduct of the gestational carrier during the pregnancy (Caballero, n.d.). More importantly for purposes of this discussion, such agreements typically include a section regarding pregnancy termination. These clauses typically anticipate two scenarios, first, a fetus affected by a severe congenital anomaly or genetic syndrome, or a multiple pregnancy in which fetal reduction is considered with the goal of improving outcomes for the surviving fetuses. These agreements typically state that in such circumstances, the gestational carrier will terminate the pregnancy at the intended parents' request. Agreements also generally include a clause that purports to restrict the gestational carrier's ability to terminate the pregnancy without the consent of the intended parents unless she faces substantial harm from continuing the pregnancy (Forman, 2015).

We may consider what these clauses imply has been promised by each party to the other. It seems that the gestational carrier has promised to carry the pregnancy (i.e., not to terminate the pregnancy), likely with a specification that she is released from this obligation if continuing the

pregnancy would cause her substantial harm. She has also promised that she will terminate the pregnancy under a set of specified circumstances. It is somewhat more difficult to determine what, if anything, the intended parents may have promised. Depending on the precise wording of the agreement, it could be argued that the intended parents have promised to "allow" the gestational carrier to make decisions regarding pregnancy termination in scenarios where her life or health is at risk, or where continuing the pregnancy would cause her substantial harm.

We can now consider how such a specific prior agreement can alter the ethical obligations of the parties when conflicts regarding pregnancy termination arise.

5.1 The life, health, or well-being of the gestational carrier is at risk

In section 4, we established that in the event a circumstance arises in which the gestational carrier would be at risk of substantial harm from continuing the pregnancy, she is under no ethical obligation to do so, because she has not agreed to risk her life, health, or well-being beyond risks of a typical pregnancy. As noted above, most gestational carrier contracts make this explicit, expressly releasing the gestational carrier from any promissory obligations to carry the pregnancy in such a scenario. Further, the intended parents may have promised to "allow" termination in such a situation. It is certainly worth questioning precisely what it means for the intended parents to "allow" her to terminate the pregnancy. It may mean that they have agreed not to attempt to coerce her into continuing the pregnancy or otherwise try to limit her ability to obtain a pregnancy termination. It may also mean that they agree to uphold other provisions of the contract, such as payment, even if the gestational carrier ends the pregnancy. Their precise obligations in this situation will depend on the wording of the contract.

What happens, however, if the agreement explicitly specifies that this is *not* an exclusion, but the gestational carrier desires pregnancy termination to prevent a substantial harm to her? In this event, the gestational carrier does have some promissory obligation to continue the pregnancy. That is, we can't say that her prior promise simply doesn't include the current situation. Terminating the pregnancy *would* require breaking a promise. The question is under what circumstances this would be ethically justifiable.

In such a circumstance, two of the considerations for a binding promise laid out by Sidgwick (1907) may not be met. In this case, keeping the promise, i.e., continuing the pregnancy, may conflict with the gestational carrier's definite prior obligations, or may inflict a disproportionate sacrifice on the promisor. In considering whether pregnancy continuation conflicts with definite prior obligations, one could consider both the prior obligation that the gestational carrier has to herself, to protect her own health and well-being, as well as obligations that she has to others. For example, in a scenario where the gestational carrier's life is at risk, the gestational carrier may reasonably conclude that to continue the pregnancy would be a dereliction of her duty to be present to care for her own children. In considering whether keeping her promise inflicts a *disproportionate* sacrifice on the gestational carrier, it would be necessary to consider both the impact keeping the promise would have on the gestational carrier and the benefits keeping the promise has to the intended parents. While it may be the case that the intended parents would greatly benefit from having a child, it is difficult to weigh this against the sacrifices that a gestational carrier would make in a setting where her life or health is at risk. If we imagine a scenario in which a person strongly desired to have a child, but the only way they could obtain one was by causing grievous injury to a third party, it seems that having that child would not be an ethically viable option. In other words, the benefits of having a child do not justify causing

substantial harm to another person; therefore, it seems that in such a scenario, the promise would not necessarily be binding.

Notably, Sidgwick (1907) did not argue that if his listed criteria were not met, the promissory obligations would be automatically released; instead he argued that if these conditions were not met, breaking a promise *may* be justifiable. In the case of a gestational carrier who desires to terminate a pregnancy due to substantial risk to her own health, her prior obligations to others and the disproportionate sacrifice that pregnancy continuation may justify, and indeed require, breaking her promise. Admittedly, the line for where the level of risk justifies breaking the promise is a gray area, but, as we noted in chapter 3 above, the gestational carrier is likely best positioned to determine the amount of risk to her well-being posed by any given situation.

In a scenario where the prior agreement to carry the pregnancy does not include a clause exempting scenarios in which the life and health of the gestational carrier are at substantial risk, it is important to note that the intended parents can still absolve the gestational carrier of her promissory obligations. In this event, should circumstances change such that the gestational carrier is facing the risk of substantial harm by carrying out her promise, the ethical choice for the intended parents would be to release her from her promise. Indeed, it seems, even a Minimally Decent Samaritan would do so. Not to do so, and to attempt to insist on the fulfillment of her obligations under the promise, fails to respect her humanity and treats her only as a means to their ends, rather than as an end in herself.

5.2 The life, health, or well-being of the gestational carrier is not at risk

We can now turn to scenarios in which termination is considered due to a threat to the well-being of the fetus or due to a change in circumstances of the intended parents. We have established that the gestational carrier should defer to the wishes of the intended parents if they desire pregnancy continuation. A pre-existing agreement specifying that the gestational carrier will not terminate in this event adds an additional layer of ethical obligation for the gestational carrier in support of this position, but does not change the conclusion.

In contrast, I argued in section 4.2 that in the absence of a prior agreement to the contrary, the gestational carrier does not have an ethical obligation to proceed with termination on request of the intended parents. However, if there is such a prior agreement, this creates different obligations. The first question in determining the gestational carrier's obligations under a prior agreement would be to determine whether the current situation is addressed by the prior agreement. For example, if the prior agreement states that the gestational carrier agrees to terminate the pregnancy in the setting of fetal anomalies, but now the intended parents wish for her to terminate due to a change in their circumstances, such as divorce, she has no promissory obligation to undergo a termination. She would be free to make whatever choice she felt was best under those circumstances, as in section 4.2.

One might ask who decides whether the circumstances at hand fall under the conditions set forth in the agreement. Although this may depend on the specific language in the agreement, we can consider the case of the Stoyanovs and Crystal Kelley from the introduction as an example. In that case, Kelley had agreed to terminate the pregnancy in the setting of a "severe fetus anomaly." The Stoyanovs and Kelley disagreed regarding whether the anomalies identified in the fetus constituted a "severe" anomaly. Importantly, it is the intended parents and the child (if born), who

would bear the consequences of the diagnosis, rather than the gestational carrier. Each set of intended parents might weigh the implications of a particular diagnosis differently. For example, some potential parents might see deafness as a major disability, while others might view it as a non-issue. While the gestational carrier has the right to determine what constitutes a substantial threat to her health, life, or well-being, it is the intended parents who ought to determine what constitutes a "severe" fetal anomaly, and therefore whether the agreement applies.

Once it has been established that the circumstances are such that they are addressed by the prior agreement, and therefore choosing to continue the pregnancy would constitute the gestational carrier breaking her promise to the intended parents, we must consider whether it would be ethically justifiable for her to do so. We must ask what might drive the gestational carrier to consider breaking her promise to terminate the pregnancy. She may feel that she has a duty to protect the fetus from pregnancy termination. However, as we established in section 4.2, any potential beneficence-based obligations the gestational carrier has to the fetus are outweighed by those of the intended parents. Further, if she felt that she had a general obligation to protect fetuses from termination, she should not have entered into an agreement that would obligate her to terminate a pregnancy.

Perhaps she is instead worried that she will not reap the financial or other benefits she anticipated from carrying the pregnancy if she undergoes pregnancy termination. She may be concerned that undergoing a pregnancy termination procedure would cause her physical or emotional harm, or she may have decided since making her promise that she finds pregnancy termination to be generally morally objectionable. Let us consider whether any of these would be a justifiable reason to break her promise to terminate the pregnancy.

In the case of the first reason, in which the gestational carrier chooses to break her promise because she desires the financial or other benefits that may accrue to her from pregnancy continuation, this would not be an ethically justifiable reason to break her promise. Ideally the agreement would be written in such a way that the gestational carrier would not suffer financial losses due to a pregnancy termination desired by the intended parents. Even if this were not the case, it is generally not acceptable to break a promise for one's own financial gain or other self-interest. If it were, the institution of promising would be severely damaged. Indeed, as Rawls (1955) noted, an integral component of promising is that the promisor gives up the right to decide whether to keep a promise based on the highest utility to the promisor at the time the promise is to be fulfilled.

If, however, the gestational carrier would be severely harmed by the financial implications of pregnancy termination, the initial agreement itself may have been unduly pressuring, and this would potentially release the gestational carrier from an obligation to terminate the pregnancy. In such a scenario, the most ethically justifiable approach would be for the intended parents to mitigate the financial harm to the gestational carrier associated with fulfilling her agreement to terminate the pregnancy by continuing to cover all expenses and providing compensation that had been previously planned. If the intended parents did so, financial self-interest would no longer be a potentially valid justification for the gestational carrier to break her promise to terminate the pregnancy. However, if the intended parents chose not to do so, the potential for grave harm to the gestational carrier, and the exploitative nature of the original agreement, would justify her breaking her promise.

The gestational carrier might argue that she is concerned about the potential risks of the termination procedure itself. In section 4.2, we noted that the gestational carrier alone could

determine whether the risks and benefits of the termination procedure were in her best interest, and that if she determined termination was not in her best interest, she was not obligated to have one. Although this determination can guide her decision-making when she does not have a prior agreement agreeing to termination, this is not a reasonable justification for breaking her promise to terminate the pregnancy. First, the medical risks of pregnancy termination are lower than the risks of pregnancy continuation. The risk of death associated with childbirth is approximately 14 times higher than the risk of death related to a legal pregnancy termination (Raymond & Grimes, 2012). Second, if the gestational carrier were concerned about the risks of pregnancy termination, she should have considered this prior to agreeing to pregnancy termination in this scenario. Assuming that she made a voluntary and informed choice to enter into this promise, and the risks to the gestational carrier of pregnancy continuation and termination have not changed, then she continues to have an ethical obligation to uphold her promise to proceed with termination.

Finally comes the possibility that the gestational carrier felt that she would be willing to proceed with pregnancy termination in the situations outlined in the agreement, but when these abstract discussions became reality, she found her moral landscape had shifted. Perhaps she now feels that pregnancy termination would be morally reprehensible. She may feel that the fetus has a right to life or that to proceed with pregnancy termination would radically alter her self-conception in a way that would be untenable. For instance, she may feel that proceeding with pregnancy termination would make her a "murderer." As previously noted, it is outside the scope of this paper to wade into questions regarding the morality of abortion; the question here is whether the gestational carrier's newfound beliefs justify breaking her promise to the intended parents.

Some might argue that this situation is akin to the "evil plan" example that Conee (2000) laid out. If the gestational carrier has promised to carry out an "evil plan," then Conee would argue

that she is under no obligation to keep her promise. However, Conee's argument is more specifically that breaking a promise is ethically justifiable if keeping it is of no moral value. In his examples however, it seems that both the promisor and promisee would agree that keeping the promise was of no moral value. In contrast, in the case of a gestational carrier who is considering breaking a promise to terminate a pregnancy, keeping the promise may in fact have significant moral value from the perspective of the intended parents.

The gestational carrier may also argue that in the context of her newly realized values, she would suffer emotional harm if she proceeded with termination. However, it is also likely that the intended parents would suffer emotional harm from her continuing the pregnancy against their wishes, and from the gestational carrier breaking her promise. It is difficult to determine which harm would be worse, and therefore not at all clear that the potential emotional harm to the gestational carrier justifies breaking a promise and causing emotional harm to the intended parents. In this setting, therefore, the gestational carrier ought to keep her promise to terminate the pregnancy.

5.3 The life or health of both the fetus and/or child after birth and the gestational carrier is at risk

As we have noted previously, in a scenario in which there is substantial risk to the gestational carrier, she has no obligation to continue the pregnancy. Although her prior agreement to carry the pregnancy likely exempts scenarios in which she is at significant risk of harm, she would be justified in breaking her promise to gestate the pregnancy if this exemption has not been provided. If, however, the gestational carrier does not feel that the risks to her health justify

termination, and she desires to continue the pregnancy, the scenario now shifts to one in which the risks to the fetus become the deciding factor. If the gestational carrier has agreed to terminate the pregnancy at the request of the intended parents in the event of significant fetal risk, she has promissory obligations to do so. In this setting, she would be ethically obligated to terminate the pregnancy if the intended parents felt that the circumstances fell under the terms of the agreement and warranted this action. All in all, in such a scenario, if either party desires pregnancy termination, the gestational carrier ought to proceed with termination. It is only if both parties agree to pregnancy continuation that such a course of action would be justifiable.

5.4 Summary of ethical obligations regarding termination generated by gestational carrier agreements

In short, a prior agreement between the parties carries significant moral weight. It can be viewed as a promise the gestational carrier makes to the intended parents to carry the pregnancy, except under specified conditions, as well as a promise to terminate the pregnancy on request of the intended parents under specified conditions. Promises, by their nature, generate ethical obligations on the part of the promisor. In most circumstances, the ethical course of action will be to keep one's promise. However, changes in circumstances may justify breaking a promise.

Importantly, if the health or well-being of the gestational carrier is at significant risk, breaking the promise to gestate the pregnancy, and proceeding with termination, is justifiable. In contrast, if the intended parents request that the gestational carrier proceed with termination under circumstances such as a change in the intended parent's circumstances or due to risks to the fetus that are addressed by the parties' prior agreement, she ought not to break this promise, and ought

to proceed with termination. The prior agreement regarding termination most specifically changes the ethical obligations of the gestational carrier in these scenarios.

Table 2 Ethical obligations in the presence of a specific prior agreement regarding termination

	Threat to GC's well-being	Threat to fetus/child's well-being	Change in circumstances of the IP	Threat to GC and fetus/child's well-being
GC desires termination / IP desire pregnancy continuation	GC is ethically justified in choosing to terminate	GC ought not to terminate		GC would be justified in choosing to terminate due to maternal risks, but if she feels risks to herself are acceptable, she ought not to terminate due to fetal risks alone
IP desire termination / GC desires pregnancy continuation	GC has no ethical obligation to terminate, but may choose to do so	GC ought to terminate if the prior agreement applies to the circumstances at hand		

GC: gestational carrier; IP: intended parents

6.0 Are there circumstances in which intended parents have decision-making authority regarding termination?

We have established that there are some circumstances in which gestational carriers have an ethical obligation to make decisions about termination that match the preferences of intended parents even if they do not want to make that decision. This includes the following:

- Scenarios in which pregnancy continuation poses a threat to the fetus or child after birth due to a prenatal diagnosis, or scenarios in which the circumstances of the intended parents have changed, and the intended parents desire pregnancy continuation.
- Scenarios in which pregnancy continuation poses a threat to the fetus or child after birth due to a prenatal diagnosis, or scenarios in which the circumstances of the intended parents have changed, and the intended parents desire pregnancy termination, *and* the gestational carrier has previously agreed to terminate the pregnancy in such a scenario.

We can now ask whether this implies that there are circumstances in which the intended parents have decision-making authority about termination. That is, are there circumstances in which the intended parents have a right to authorize or refuse termination against the wishes of the gestational carrier? Certainly, some gestational carrier agreements may suggest that this is the case, but the ethical validity of such a claim is dubious. In this section, I will argue that in both of the above scenarios, the gestational carrier cannot be compelled to terminate the pregnancy for several reasons.

6.1 The gestational carrier retains her ethical right to bodily autonomy

First, the gestational carrier ultimately retains the right to determine what happens to and within her body. During pregnancy she is not merely a static vessel for the fetus. Pregnancy alters numerous aspects of her physiology, and her lived experience of the pregnancy is deeply personal. She may have agreed to allow the use of her body for the purpose of gestating the intended parents' child. However, she has not given up her essential liberties. It would be wrong of the intended parents, or anyone else, to treat the gestational carrier solely as a means, rather than as an end in herself.

Importantly, while it could be argued that the gestational carrier has voluntarily agreed to be a means, if the gestational carrier desires pregnancy termination against the wishes of the intended parents, the gestational carrier is in effect deciding that she no longer wishes to be a means to the ends of the intended parents. In many ways, the gestational carrier is doing a job, and is employed by the intended parents. Workers, even those who have a formal agreement with their employers to use their bodies, time, and talents for the profit of their employer, cannot be forced to continue working against their will. While certainly employees may face consequences from quitting their job, they may ultimately choose to quit. Workers who are forcibly required to continue working against their will are in fact not employees at all; they are slaves.

In the event that the intended parents desire a pregnancy termination against the wishes of the gestational carrier, they might argue that because the potential burdens of caring for the child will fall on them, they should have the authority to compel a pregnancy termination. However, compelling the gestational carrier to have a pregnancy termination does not account for the fact that the intended parents have the option to relinquish custody of the child (to the state or to an adoptive family) and relieve themselves of this obligation. The intended parents may argue that

they will face psychological distress due to either parenting the child or relinquishing their parental role if the gestational carrier does not uphold her promises to them. However, enforcing the promise would almost certainly cause psychological distress for the gestational carrier. The potential psychological distress of the intended parents alone cannot justify causing psychological distress for the gestational carrier. Given the intended parents' ability to release themselves from their obligations as social parents, and the inability to weigh one party's psychological distress as more important than the other's, disregarding the gestational carrier's autonomous decision to decline a medical procedure (pregnancy termination) cannot be justified in this setting.

In other words, at that time that the gestational carrier decides that she no longer wishes to be in the employ of the intended parents, enforcing her obligations to either carry the pregnancy or terminate it cannot be ethically justified. While the gestational carrier can consent to the use of her body for gestating a pregnancy, and can consent to terminate a pregnancy under specified conditions, she retains the right to withdraw this consent at any time, even if it would be indecent to do so. Once she does so, the intended parents are ethically obligated to respect this decision.

6.2 Methods of enforcement would be unethical

We have noted as well that the gestational carrier has an ethical obligation to act as a Minimally Decent Samaritan toward the intended parents. Does it follow from this premise that the intended parents have a right to compel the gestational carrier to do so? No. Thompson (1971) argued that the premise that because "A ought to do a thing for B it follows that B has a right against A that A do it for him," is fatally flawed. One consideration that arises is how such a right could even be enforced. That is, if we assumed that the intended parents *did* have a right to compel

the gestational carrier to continue or terminate the pregnancy per their wishes, how would this be made to happen? Would the intended parents have the right to have the gestational carrier physically or chemically restrained so that she can undergo a termination? Should the gestational carrier be placed in jail to prevent her accessing a termination? Should she be forced to face severe losses that would compel her to acquiesce to the demands of the intended parents such as loss of her home or other children? None of these options seems ethically acceptable.

6.3 Medical providers are not a party to the gestational carrier agreement

An important note about gestational carrier contracts and agreements is that they are an agreement only between the gestational carrier and the intended parents. The gestational carrier's medical providers are not a party to the agreement, and therefore the agreement does not create any ethical obligations for them. The gestational carrier's medical providers have specific obligations to her because of their fiduciary duty within the doctor-patient relationship. The medical providers may also have an ethical duty to the fetus as a patient, under certain circumstances, but this issue is beyond the scope of this paper (see Chervenak & McCullough, 1996). However, the medical providers have no specific duty to the intended parents during the pregnancy, and no obligations under the gestational carrier agreement. In practical terms, this means that, assuming the gestational carrier otherwise has decision-making capacity, the medical providers are ethically obligated to respect her autonomy to make her own medical decisions, including regarding pregnancy termination. They are not obligated to seek consent from the intended parents, and in fact if they were to deny medical care to the gestational carrier because of

a lack of consent from the intended parents, or if they were to perform a procedure on the gestational carrier against her will, they would be violating their ethical obligations to their patient.

Despite the ethical obligations of the gestational carrier created by her prior agreements, and despite her ethical obligation to act as a Minimally Decent Samaritan, it is essential to note that the intended parents never gain the right to compel her to terminate the pregnancy nor to compel her to carry it against her will. Further, medical providers involved are not parties to the agreement, and therefore have no obligations under it. Instead, they are obligated to respect the autonomy of their patient, the pregnant gestational carrier. As such, the gestational carrier retains the ultimate right to decide whether to terminate the pregnancy, even in situations where she ought not to exercise that right.

7.0 Recommendations for gestational carrier agreements

Given our discussion regarding the ethical obligations generated by gestational carrier agreements, the question of what is necessary and appropriate to include in a written gestational carrier agreement can now be considered. Ensuring an appropriate agreement between parties is key to a preventive ethics approach, which aims to prevent ethical conflict before it occurs. Preventive ethics has two components: identifying the conditions in clinical practice that can lead to ethical conflict; and using the informed consent process to address and defuse conditions that create the potential for conflict (Chervenak, McCullough, and Brent 2010). The gestational carrier agreement itself, as well as discussions that occur in drafting and committing to such an agreement, can and should incorporate both of these components.

Although legal obligations generated by contracts are generally outside of the scope of this paper, it is important to note that gestational carrier agreements should be written taking local laws into account in order to avoid conflicts between ethical and legal obligations. For instance, in a circumstance in which the gestational carrier plans to terminate the pregnancy, and is ethically justified in doing so based on the arguments in prior sections, the agreement must not generate legal consequences that would be coercive and prevent her from exercising her autonomy.

7.1 Items that should be included in a gestational carrier agreement

Since conflicts may arise due to confusion as to what each party has, in fact, promised the other, the written agreement should be as clear as possible regarding circumstances under which

the gestational carrier's promise to carry the pregnancy does not apply. In these circumstances, it should be made clear that the gestational carrier is under no obligation to continue to carry the pregnancy and can decide to terminate without financial or other repercussions that could be coercive. This should include circumstances in which the gestational carrier's life, health, or well-being would be at substantial risk from continuation of the pregnancy. Importantly, the agreement should clarify that it is at the discretion of the gestational carrier, in consultation with her medical providers, to determine whether pregnancy continuation represents a substantial risk to her.

It is important to note that this type of exclusion is not only appropriate to include in a gestational carrier agreement, it would be inappropriate not to include it. As discussed previously, if such a clause is not included, and circumstances arise in which the gestational carrier's life, health, or well-being are threatened by continuation of the pregnancy, the intended parents have an ethical obligation to absolve the gestational carrier of her promissory obligations to carry the pregnancy. If they do so, the gestational carrier can choose to end the pregnancy without breaking a promise. However, if they choose not to do this, the gestational carrier is ethically justified in breaking her promise and ending the pregnancy. These steps can be skipped by making it clear up front that under such circumstances there are no promissory obligations. This avoids placing intended parents in a situation where they must decide whether to release the gestational carrier from promissory obligations, and if they don't, avoids the gestational carrier having to decide whether to break a promise. Considering these issues up front is a path toward avoiding conflict and moral distress for all parties involved. Further, including such a clause reduces the risk of the gestational carrier needing to break a promise, which would be potentially damaging to the institution of promising and, more specifically, to the trust required among parties to gestational carrier contracts.

The second type of clause that should be included in a gestational carrier agreement involves circumstances under which the gestational carrier agrees to terminate a pregnancy upon request by the intended parents. This is likely to include fetal indications, such as prenatal diagnosis of congenital anomalies or genetic syndromes. Ideally the parties would discuss in advance, and agree upon, the testing that the gestational carrier would agree to have during pregnancy for prenatal diagnosis, such as sampling of the gestational carrier's blood, ultrasound, or amniocentesis. Fetal interventions and treatments that might alter the fetal prognosis, such as in utero transfusions or surgeries, should also be discussed. The contract should note that whether this clause of the contract applies (that is, whether the fetal risk justifies termination), is at the discretion of the intended parents.

Similarly, the agreement should discuss whether the gestational carrier agrees to termination in the event of multiple gestation. To prevent conflicts, this should be as specific as possible, outlining whether the clause applies to all multiple gestations including twins, or only higher order multiples (i.e. triplets or more). The agreement should also indicate the number of fetuses that would be allowed to continue to develop (for instance, would a higher order multiple gestation be reduced to twins or to a singleton?). All parties should be informed that multifetal gestations carry additional risks to both the gestational carrier and the fetuses. Discussions should be had up front regarding the particular risks that the gestational carrier and intended parents are accepting of under their agreement. In addition, all parties should be informed that fetal reduction procedures can be complex and invasive, may require travel to specialized centers, and carry a risk of loss of all fetuses.

The agreement should also address possible changes in the circumstances of the intended parents that would potentially lead them to desire pregnancy termination. For example, the

agreement should address the possibilities of divorce or separation of the intended parents; death, disability, or change in health status of an intended parent; and possible job loss or employment change.

The intended parents have the authority to determine whether these clauses are relevant to the situation at hand, and whether they desire for the gestational carrier to undergo pregnancy termination in accordance with these clauses. The intended parents thus decide whether the gestational carrier has an ethical obligation to terminate the pregnancy under the circumstances. However, it must be made clear to all parties that this does not imply that the intended parents have the right to compel the gestational carrier to undergo termination. Ultimately, the gestational carrier retains the right to choose whether to terminate the pregnancy, even when she has ethical obligations to pursue a specific course of action.

In addition, to avoid conflict like that noted in the case of Crystal Kelley and the Stoyanovs discussed in the preface, agreements should outline that intended parents cannot attempt to pressure the gestational carrier to either to terminate or continue to carry the pregnancy against her will. For instance, additional payments or benefits that are offered specifically to attempt to influence decision-making should be expressly prohibited.

In contrast, it is reasonable and necessary to outline potential consequences that may occur if the gestational carrier breaks her promise to either carry or terminate a pregnancy. Much has been written about the power differential between gestational carriers and intended parents (see, for example, Abrams, 2015; Ber, 2000; Lahl, 2017; Tieu, 2009). These authors tend to assume that the intended parents hold more power than the gestational carrier, and that gestational surrogacy is, as Ber (2000) writes, "exploitation of the poor and needy by those who are better off." While it may be true that intended parents tend to have higher levels of education and greater financial and

social resources than gestational carriers, and that gestational carrier pregnancies have the potential to be exploitative, it is also the case that once the pregnancy commences, the gestational carrier holds immense power. Once the embryo is placed into the gestational carrier's uterus, the intended parents have extremely limited power to dictate what occurs. As the gestational carrier cannot be compelled to terminate or continue the pregnancy, her actions are constrained only by her sense of ethical obligation to uphold her agreement, unless other consequences are specified. As such, specifying consequences for breach of contract may restore a more appropriate balance of power between the parties during the pregnancy.

If the gestational carrier chooses to terminate a pregnancy in a scenario other than a threat to her life, health, or well-being (that is, for a reason that we have already determined does not justify breaking her promise to carry the pregnancy), it is not unreasonable for her to face consequences for breaking her promise to the intended parents. For instance, she may not be paid the full compensation that was planned for carrying the pregnancy to completion. If the gestational carrier chooses not to terminate a pregnancy under the terms of the agreement, not only would it be reasonable for further payments to her to stop, but the question of who will become the fetus' social parents should be addressed. Clearly, no party should be made to parent a child against their will. The process for determining legal guardianship will vary by state. However, it should be made clear in the contract that if the gestational carrier chooses not to terminate a pregnancy under the terms of the agreement, the intended parents have the option to relinquish custody to the state.

Lastly, it should be made clear to all parties involved that neither the intended parents' medical providers (if they are donating gametes/embryos, the intended parents will also have medical providers), nor the gestational carrier's medical providers are a party to the agreement. As such, it must be made clear that medical providers will have no obligations to the other party.

Medical providers involved in the care of either party are ethically obligated to respect patient autonomy and confidentiality as they would be for any other patient in their care regardless of any outside agreement.

7.2 Items that should not be included in a gestational carrier agreement

We have discussed what is necessary and appropriate to include in a gestational carrier agreement, but it is also important to discuss what should not be included in such an agreement. Gestational carrier agreements should not include stipulations that would create a promissory obligation to act unethically, nor should they include phrasing that implies rights or obligations that cannot be ethically justified. For example, agreements should not include language stating that intended parents must provide consent prior to a termination procedure. This suggests that the intended parents have the right to compel the gestational carrier to continue the pregnancy (by declining to consent), which, as we have discussed, is not ethically justifiable. Further, it implies that medical providers need to obtain informed consent from intended parents prior to proceeding with a pregnancy termination, which is not accurate, as medical providers are not a party to the agreement.

Similarly, language that outlines scenarios under which intended parents would "allow" termination should be avoided. Such statements would imply that there are other circumstances under which intended parents can disallow termination, which would be tantamount to compelling the gestational carrier to continue the pregnancy. In lieu of providing scenarios where the intended parents would "allow" termination, the agreement should outline scenarios under which the gestational carrier has not agreed to continue the pregnancy, as discussed at the start of this chapter.

Lastly, the agreement should not include provisions for financial or other penalties if the gestational carrier elects to proceed with pregnancy termination due to risk to her life, health, or well-being. This would create an incentive for the gestational carrier to take on risks that she otherwise would not find acceptable and may be coercive. Further, it suggests that the gestational carrier has an obligation under the agreement to continue the pregnancy even if there is substantial risk to her. This would suggest that her well-being is secondary to the goal of gestating the pregnancy and treats her as a means rather than an end in herself.

7.3 Summary of recommendations for gestational carrier agreements

Gestational carrier agreements should:

- Clearly define circumstances in which the gestational carrier has no obligation to continue the pregnancy, including situations in which there is a significant threat to her life or health. It should be noted that it is the gestational carrier who determines whether the risk is significant.
- Clearly define scenarios in which the gestational carrier agrees to terminate the pregnancy. It should be noted that it is the intended parents who determine whether changes in their circumstances or risks to the fetus and/or potential child justify termination.
- Avoid using language suggesting there are circumstances in which intended parents can "allow" termination or must consent prior to termination.
- Avoid creating penalties for termination due to risk to the gestational carrier's life, health, or well-being.

- Specify consequences for breach of contract if the gestational carrier opts to make a decision that is not in keeping with the terms of the agreement for reasons other than protection of her own life, health, or well-being.
- Explain that if the gestational carrier chooses not to terminate a pregnancy under the terms of the agreement, the intended parents have the option to relinquish custody to the state.
- Stipulate that medical providers are not a party to the agreement, and that they have no obligations under the agreement.
- Clearly document that in all circumstances, the gestational carrier will ultimately make all decisions regarding pregnancy termination, and explicitly prohibit the intended parents from attempting to unduly influence these decisions through creating new consequences for either upholding or breaching the contract.

These recommendations could be incorporated into updates to existing guidelines produced by organizations such as the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine. However, these organizations are primarily made up of physicians. As it is often lawyers who draft these agreements, I would suggest that a more effective mechanism to lead to widespread adoption of these recommendations would be through legal professional organizations issuing guidelines for their membership. For instance, the Academy of Adoption and Assisted Reproductive Attorneys (AAAA), which is the largest professional organization of its type (About AAAA, 2018), should incorporate these suggestions into education for their membership regarding best practices in drafting gestational carrier agreements.

8.0 Alternative methods of preventing conflicts or reducing their impact

Although gestational carrier agreements serve an important function in creating ethical obligations between the gestational carrier and intended parents, they are not adequate to avoid all conflict. In this section, we will discuss additional approaches to preventative ethics that serve to avoid conflicts, or reduce the impact of these conflicts, when decisions regarding pregnancy termination arise.

The most vital step in reducing the risk of conflict is finding an appropriate match between intended parents and gestational carriers. This involves an open and honest discussion between the parties regarding their values and beliefs. Each person has what Rawls (1993) referred to as their "comprehensive doctrine," that is, their

> "conceptions of what is of value in human life, and ideals of personal character, as well as ideals of friendship and of familial and associational relationships, and much else that is to inform our conduct, and in the limit to our life as a whole."

Discussion between the potential intended parents and potential gestational carrier prior to entering into an agreement is necessary to determine whether the parties' comprehensive doctrines are well aligned or diametrically opposed.

Importantly, discussion should include not only values and beliefs regarding pregnancy termination specifically, but also about issues that may seem peripheral at the outset, but may later play a vital role in decision-making, such as disability, risk tolerance, and medical interventions more generally. Formal values clarification exercises and psychological counseling for all parties involved may be beneficial in clarifying whether the parties share a common values system or

whether conflicts can be anticipated. If the parties do not share common values, it would be prudent for both parties not to enter into a gestational carrier agreement.

Having a common set of values and goals may also assist in preventing conflict through relationship building. The goal of the parties should be to build a relationship of caring, rather than a solely transactional relationship. Trust and mutual respect are key components of such a relationship, but may not be present immediately upon matching of intended parents with a gestational carrier. Each individual intended parent and gestational carrier will have different needs and desires for such a relationship, and as such, the precise method of developing this relationship between the parties will vary. However, the establishment of a relationship built on mutual respect, trust, and shared goals and values may serve to restrain any urge that might arise to treat the other party as merely a means to an end.

Although evaluation of legal issues is outside of the scope of this thesis, it would be prudent to note that to avoid conflict, it is essential for all parties to understand the legal context regarding both gestational carrier pregnancies and pregnancy termination in their state, before entering into a gestational carrier agreement. In particular, legalities surrounding pregnancy termination are currently undergoing major, rapid shifts in many areas of the country. In this setting, conversations and agreements regarding issues such as the potential need to travel long distances for pregnancy termination services will become vital. It would be difficult, if not impossible, for the parties to make informed decisions regarding these issues without an understanding of the legal landscape relevant to this area. Furthermore, legal guidance provided to the parties must be thorough, unbiased, and avoid conflicts of interest. To that end, the parties should be represented by separate and independent legal counsel (Family Building Through Gestational Surrogacy, 2016).

In addition to having separate legal counsel, the intended parents and gestational carrier should ideally have separate medical providers (Family Building Through Gestational Surrogacy, 2016). As noted above, medical providers have specific obligations to their patients that are not dependent on any agreement between the gestational carrier and intended parents. Having separate providers for the intended parents and gestational carrier avoids creating potential conflicts of interest.

One additional potential approach to reducing conflict or mitigating its harms may be development of insurance programs that specifically cover expenses that may accrue to either party in a scenario where pregnancy termination may be considered. Such a policy could reduce or eliminate any financial incentive for the parties to consider breaking the promises that they made under their agreement. Although medical insurance may cover the gestational carrier's direct medical costs, supplemental insurance policies could cover other costs that could influence decision-making. For instance, such policies might cover travel expenses or lost wages that occur as the result of either pregnancy termination or pregnancy continuation. Policies could also cover surrogate fees if termination for medical reasons occurs. The premiums for such a policy would most likely be paid by the intended parents. This is because the policy would primarily protect the intended parents from the consequences of the gestational carrier breaking her promises to them. To my knowledge, such a policy is not currently widely available, but development of this type of mechanism should be considered to reduce conflicts.

9.0 Conclusions

As gestational carrier pregnancies continue to increase in frequency, a concomitant rise in conflicts between intended parents and gestational carriers regarding pregnancy termination can be anticipated. Determining the ethical obligations of gestational carriers and intended parents, and understanding which party ultimately holds decision-making authority, in these circumstances is vital in resolving such disputes.

Current guidelines implore parties planning a gestational carrier pregnancy to create a formal agreement outlining each party's roles, intentions, rights, and obligations (Daar et al., 2018; Family Building Through Gestational Surrogacy, 2016). These agreements not only document the parties' ethical obligations, they also function to *create* these obligations, as the parties are in effect making promises to each other. Once promises are made, breaking them can only be ethically justified in the setting of significant extenuating circumstances.

When the intended parents and gestational carrier have not previously agreed to a course of action, and pregnancy termination is considered, the determination of the parties' ethical obligations can be complex. As we have seen, if the health, life, or well-being of the gestational carrier is substantially threatened by the pregnancy, no matter the terms of the contract or the wishes of the intended parents, the gestational surrogate does not have an ethical obligation to continue the pregnancy. However, in other scenarios, such as those in which pregnancy termination is considered due to prenatal diagnosis of a genetic or structural anomaly in the fetus, or due to a change in the intended parents' circumstances, the consequences of decisions regarding pregnancy termination fall most heavily on the intended parents. It is they who are best positioned to determine whether pregnancy termination or continuation is in their best interest and whether it

would promote the well-being of the fetus or potential child. In these scenarios, if the intended parents desire pregnancy continuation, the gestational carrier ought to follow the wishes of the intended parents. However, if the intended parents request termination, she is under no obligation to proceed with this if this was not part of the parties' initial agreement.

In contrast, given the moral weight of gestational carrier agreements as promises, if the intended parents request that the gestational carrier proceed with termination under circumstances that *are* addressed by the parties' prior agreement, she ought not to break this promise, and ought to proceed with termination. Similarly, she ought not to proceed with termination against the wishes of the intended parents under circumstances outlined by the parties' prior agreement, unless termination is obligatory to protect her from a substantial threat to her own life or health. Importantly, it is the gestational carrier, in consultation with her medical providers, who is best positioned to determine whether pregnancy continuation poses a substantial threat to her justifying breaking her promise to the intended parents.

Although there are circumstances in which the gestational carrier is ethically obligated to follow the wishes of the intended parents, it cannot be emphasized enough that the gestational carrier ultimately retains the absolute right to bodily autonomy. While it would be wrong to refuse to follow her prior agreement or the wishes of the intended parents in such a circumstance, it would also be unethical for another party, such as the intended parents, to compel her to a particular course of action. In other words, while there are circumstances where the gestational carrier ought not to exercise her right to make decisions about pregnancy termination, she ultimately retains that right.

A clear understanding of the ethical obligations and rights of the parties involved is necessary for informed decision-making about whether to enter such a gestational carrier

agreement in the first place. Although this understanding may enable conflict resolution, more importantly, it can reduce the chance of conflicts arising. To that end, all parties must be aware at the outset that it is the gestational carrier who ultimately will make all decisions regarding pregnancy termination in a gestational carrier pregnancy.

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