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WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Ethics

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Ethics. Member contributors included Ginny L. Ryan, MD. While this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Family Building Through Gestational Surrogacy

ABSTRACT: Gestational surrogacy is an increasingly common form of family building that can allow individuals or a couple to become parents despite circumstances in which carrying a pregnancy is biologically impossible or medically contraindicated. The practice of gestational surrogacy involves a woman known as a gestational carrier who agrees to bear a genetically unrelated child with the help of assisted reproductive technologies for an individual or couple who intend(s) to be the legal and rearing parent(s), referred to as the intended parent(s). Obstetrician–gynecologists may become involved in gestational surrogacy through caring for the gestational carrier or by caring for the intended parent(s). Although gestational surrogacy increases options for family building, this treatment also involves ethical, medical, psychosocial, and legal complexities that must be taken into account to minimize risks of adverse outcomes for the gestational carrier, intended parent(s), and resulting children. The purpose of this document is to provide an overview of gestational surrogacy and to describe the ethical responsibilities for obstetrician–gynecologists who take part in the care of women who participate in these arrangements.

Recommendations

On the basis of the considerations and principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (the College) makes the following recommendations:

- Because of the ethical, legal, and psychosocial complexities and potential medical risks to the gestational carrier, it is recommended that the use of gestational surrogacy be restricted to situations in which carrying a pregnancy is biologically impossible or medically contraindicated for the intended parent(s).
- Because the legal status of gestational surrogacy varies from state to state, obstetrician–gynecologists who assist in gestational surrogacy arrangements should encourage their patients, whether they are the gestational carriers or intended parents, to seek guidance from appropriately qualified legal counsel (ie, experienced in third-party reproduction arrangements and licensed to practice in the relevant state or states). To avoid potential conflicts of interest, it is recommended that the gestational carrier and intended parent(s) are represented by separate and independent legal counsel.
- Obstetrician–gynecologists should remain informed regarding the medical, ethical, and psychosocial complexities of gestational surrogacy because they may play one of several roles in gestational surrogacy arrangements, including counseling potential gestational carriers, caring for pregnant gestational carriers, and advising and referring infertile patients considering this treatment. Obstetrician–gynecologists participating in these arrangements may benefit from consultation with appropriately qualified legal counsel and colleagues with experience in reproductive endocrinology and infertility.
- Pertinent medical risks, benefits, and alternatives should be discussed by the physicians treating the gestational carrier and intended parent(s), and these physicians should be separate and independent, whenever possible, to optimize patient advocacy and avoid conflicts of interest.

- Separate and independent mental health counseling should be strongly encouraged for all parties involved. Mental health counselors can assist the intended parent(s) in anticipating issues surrounding disclosure of the pregnancy and the child's genetic lineage. For gestational carriers, mental health counselors can assist in anticipating issues surrounding questions and concerns from family and community as well as potential attachment issues for the gestational carrier during pregnancy and after delivery.
- In an attempt to decrease potential conflict during pregnancy, obstetrician–gynecologists who counsel women who are considering gestational surrogacy should encourage them to discuss with the intended parent(s) as many foreseeable decision-making scenarios in pregnancy as possible, and the plans for addressing these situations should be formally documented in the gestational surrogacy contract.
- Cross-border reproductive care refers to the rapidly growing practice of individuals seeking assisted reproductive technology treatment outside of their country of domicile. This practice includes Americans seeking gestational carrier arrangements abroad and foreign nationals seeking gestational carrier arrangements in the United States. Obstetrician–gynecologists should be aware of the existence of these types of gestational surrogacy arrangements, and those who counsel and care for these patients should encourage patients to seek legal advice from appropriately qualified legal counsel experienced in cross-border gestational carrier arrangements.
- Obstetrician–gynecologists are not obligated to participate in nonemergent medical care related to either domestic or cross-border gestational surrogacy arrangements. However, physicians who choose to care for gestational carriers should provide the same level of medical care as they would to any patient, regardless of the complexities of gestational surrogacy and their personal beliefs regarding a particular parenting arrangement.

Gestational surrogacy is a form of family building that is used with increasing frequency. The practice of gestational surrogacy involves a woman known as a gestational carrier who agrees to bear a genetically unrelated child with the help of assisted reproductive technologies for an individual or couple who intend(s) to be the legal and rearing parent(s), referred to as the intended parent(s). The embryos usually are derived from gametes from one or both of the intended parent(s) but also may be derived from donated oocytes, donated sperm, or both. This Committee Opinion does not address the practice of traditional surrogacy, in which the woman uses her own oocytes and undergoes insemination with sperm from an intended parent or a donor. Although traditional surrogacy can be less expensive than gestational

surrogacy, it is more legally and ethically complex because of the genetic link between the birth mother and the child. For this reason, many surrogacy programs no longer offer traditional surrogacy arrangements (1).

Of the 174,962 in vitro fertilization cycles reported to the Centers for Disease Control and Prevention in 2013, fewer than 2% involved gestational surrogacy. However, 85% of the in vitro fertilization clinics that reported to the Centers for Disease Control and Prevention offer this treatment, and its prevalence continues to grow (2). As gestational surrogacy becomes increasingly common in the United States and worldwide, it is important to explore the ethical, medical, psychosocial, and legal complexities that this form of family building presents. The purpose of this document is to provide an overview of gestational surrogacy and to describe the ethical responsibilities for obstetrician–gynecologists who take part in the care of women who participate in these arrangements.

Potential Benefits and Complexities

Potential Benefits

Gestational surrogacy can allow an individual or a couple to become a parent of a genetically related child when carrying a pregnancy is biologically impossible or medically contraindicated. This includes situations in which pregnancy would be unsafe because of underlying medical conditions or impossible because of reproductive health disorders, such as recurrent implantation failure, uterine factors not compatible with pregnancy, or an absent uterus. Gestational surrogacy also is used as a family-building option by single men and men in same-sex relationships for whom there is no other way to have a genetically related child.

Gestational carriers often derive satisfaction from helping intended parents fulfill their desire for a family and may participate in gestational surrogacy primarily for altruistic reasons. Monetary compensation that complies with state law should be ethical and appropriate for the time, effort, and risks taken by a gestational carrier (1, 3), and compensation may improve her quality of life and open future options for the gestational carrier and her family.

Potential Complexities

Because of the ethical, legal, and psychosocial complexities and potential medical risks to the gestational carrier, it is recommended that the use of gestational surrogacy be restricted to situations in which carrying a pregnancy is biologically impossible or medically contraindicated for the intended parent(s) (3–5).

Ethical Considerations

Because of the expense of gestational surrogacy, there often is a socioeconomic gap between gestational carriers and intended parents. Although this disparity does not invariably translate into undue inducement, it is important to understand that a given amount of compensation

may be appropriate in some social, economic, and geographic scenarios and may be effectively coercive in others. Some have suggested that gestational surrogacy trivializes reproduction through transactions that translate a woman's reproductive capacities and the resulting infants into commodities. (5) To guard against these concerns, potential gestational carriers must be fully informed regarding the details of the treatment and should be strongly encouraged to seek independent mental health counseling and independent legal representation by appropriately qualified legal counsel (ie, experienced in third-party reproduction arrangements and licensed to practice law in the relevant state or states) (6). Gestational carriers possess the same rights as those of any patient to independent care and autonomous decision making and to be informed of the risks to their health and well-being, as well as the resulting risks to their families, should they develop serious illness or require hospitalization (6).

Medical Risks

Unanticipated medical complications that can arise in the context of gestational surrogacy may include antenatal diagnosis of fetal disease for which treatment is necessarily invasive to the gestational carrier as well as serious pregnancy-induced disease in the gestational carrier whose treatment jeopardizes the health of the fetus. Preconception counseling should help clarify values and expectations of all parties, and specific scenarios and their resolution should be discussed with all independent legal representatives and documented in a signed, written preconception agreement. Topics to address should include, but are not limited to, questions of how many embryos to transfer during treatment, how to proceed if a high-order pregnancy is conceived or a serious fetal anomaly is discovered, what kind of prenatal testing will be sought, and how parties will respond to an unexpected birth defect in the newborn (1). Although preconception counseling and contract negotiation may help prepare involved parties to resolve such issues, it is important in these situations to remember the primacy of the gestational carrier's right to autonomous decision making related to her body and health.

Legal Considerations

In gestational surrogacy, the gestational carrier is one of at least three individual parties involved in the arrangement. Providers of gametes (sperm and oocytes) also are required. If these gamete providers are not the intended parents, as many as five parties may be involved. Different types of possible relationships—genetic, gestational, and rearing—give rise to conceptual and legal challenges regarding the nature of parenthood and the parties' responsibilities for rearing the resulting children.

In the United States, the law surrounding surrogate parenting arrangements resides primarily at the state level. Some states have formal laws governing surrogacy (7). Case law from a state may support this prac-

tice, but procedural issues regarding contracts and parentage may be less well defined. Statutes, where they do exist, range from prohibition of contracts and imposition of criminal penalties to specific permission and provision of a detailed regulatory structure (7–9). Because the legal status of gestational surrogacy varies from state to state, obstetrician–gynecologists who assist in gestational surrogacy arrangements should encourage their patients, whether they are the gestational carriers or intended parents, to seek guidance from appropriately qualified legal counsel (ie, experienced in third-party reproduction arrangements and licensed to practice in the relevant state or states) (6). To avoid potential conflicts of interest, it is recommended that the gestational carrier and intended parent(s) are represented by separate and independent legal counsel.

Parentage of children resulting from gestational surrogacy often can be arranged through prebirth orders (usually in states with statutory support of surrogacy, but also in states with no surrogate statute) or through postbirth orders or adoption procedures after delivery. However, legal requirements and procedures for establishing parentage vary widely by state (7, 8). Given the number of individuals involved and the complexity of the genetic and biologic relationships, courts asked to decide a dispute regarding parental rights or custody of a child resulting from gestational surrogacy may have inadequate guidance from existing statutes or case law (9). Courts have given preference to various factors, including the intent of the parties entering into the contract, whether there is a genetic link between the child and intended parents, the rights of the birth mother (regarded similarly to adoption cases), and the best interest of the child. However, there is little consensus in the legal or ethical communities as to how to prioritize these factors, and issues of parentage may be especially fraught when neither of the intended parents is genetically related to the offspring.

It is recommended that every gestational surrogacy arrangement be documented by a signed, written preconception agreement in which all parties participate voluntarily, transparently, and in good faith. Conversations that include the gestational carrier and intended parent(s) and are facilitated by independent, appropriately qualified legal counsel should clarify what medical information may be shared between the intended parent(s) and the gestational carrier and what information is to remain confidential (6). These mutual decisions regarding disclosure of information discovered in the course of treatment should be included in the written preconception agreement to provide guidance to the treating physician. Such written agreements are equally important in arrangements that involve gestational carriers who are friends or family members of the intended parent(s) (10).

Psychosocial Considerations

The psychosocial effects of gestational surrogacy on the resulting offspring as well as on the gestational surrogate

and her family are important considerations. Although there are few studies that provide clear evidence for either benefits or harms to the offspring resulting from gestational surrogacy, studies of families created by various reproductive technologies in which only one parent has a genetic link to the child are reassuring regarding psychologic adjustment of offspring (11, 12). Limited data on relationships within the gestational carrier's own family also are reassuring regarding the gestational carrier's long-term psychologic well-being as well as that of her own children (13, 14).

In a handful of cases, gestational carriers have claimed parental rights over gestated offspring and intended parents have refused to accept parental rights over offspring born as a result of gestational carrier arrangements. Although rare, parentage disputes can potentially cause psychosocial harm and trauma to the gestated offspring as well as to the other involved parties (15). Counseling of the gestational carrier and the intended parent(s) by independent, experienced mental health professionals and guidance from independent, appropriately qualified legal counsel are effective in anticipating and preparing for unplanned outcomes.

Role of Obstetrician–Gynecologists

Obstetrician–gynecologists should remain informed regarding the medical, ethical, and psychosocial complexities of gestational surrogacy because they may play one of several roles in gestational surrogacy arrangements, including counseling potential gestational carriers, caring for pregnant gestational carriers, and advising and referring infertile patients considering this treatment. Obstetrician–gynecologists participating in these arrangements may benefit from consultation with appropriately qualified legal counsel and colleagues experienced in reproductive endocrinology and infertility. Pertinent medical risks, benefits, and alternatives should be discussed by the physicians treating the gestational carrier and intended parent(s), and these physicians should be separate and independent, whenever possible, to optimize patient advocacy and avoid conflicts of interest (6). One generally unavoidable exception to this guideline is the management of the preconception and early pregnancy care of a gestational carrier by the same reproductive endocrinology and infertility subspecialist who is treating the infertile intended parent(s). Separate and independent mental health counseling should be strongly encouraged for all parties involved (6). Mental health counselors can assist the intended parent(s) in anticipating issues surrounding disclosure of the pregnancy and the child's genetic lineage. For gestational carriers, mental health counselors can assist in anticipating issues surrounding questions and concerns from family and community as well as potential attachment issues for the gestational carrier during pregnancy and after delivery.

Obstetrician–gynecologists should be aware that gestational surrogacy contracts may allow for sharing of

certain confidential health and social information. Those physicians treating a patient involved in a gestational surrogacy arrangement also may find themselves in receipt of confidential information about a real or potential conflict of interest between their patient and the other party that could affect participation in this arrangement, such as tobacco or alcohol use by the gestational carrier despite a contractual agreement to avoid exposure. Guidance from professional organizations may be helpful in such situations (16), and legal counsel may be sought by the physician or recommended to the patient as appropriate.

Responsibilities of Obstetrician–Gynecologists to Potential Gestational Carriers

As with any patient considering pregnancy, a potential gestational carrier must be fully informed of the potential benefits, risks, and complications of pregnancy and delivery. Obstetric history should be taken into account, as should the potential risk of twin or high-order multiple pregnancy if more than one embryo is transferred. Obstetrician–gynecologists who care for gestational carriers should provide the same level of care as they would to any patient. In addition, the obstetrician–gynecologist should address the ethical and psychosocial complexities that are unique to gestational surrogacy, including the possibility that the gestational carrier may experience psychologic stress and grief after giving birth, and help to facilitate and strongly encourage independent mental health counseling and independent legal representation by appropriately qualified legal counsel, especially if financial or familial coercion is suspected.

Obstetrician–gynecologists also may be asked by another physician, a gestational surrogacy agency, or the patient herself to assess the reproductive health, possible future pregnancy risks, and general fitness of a potential gestational carrier. It is the physician's responsibility to make an honest assessment, to share this information only when requested through a valid release form or disclosure agreement, and to receive only usual compensation for these medical services.

Responsibilities of Obstetrician–Gynecologists to Pregnant Gestational Carriers

Obstetrician–gynecologists caring for pregnant gestational carriers should communicate clearly to the patient the primacy of her right to autonomous decision making related to her health and her pregnancy, which includes the right to choose what information she does and does not wish to receive or share. The obstetrician should not look for input from the intended parent(s) when medical decisions are being made during pregnancy, labor, or delivery. In an attempt to decrease potential conflict during pregnancy, obstetrician–gynecologists who counsel women who are considering gestational surrogacy should encourage them to discuss with the intended parent(s) as many foreseeable decision-making scenarios in pregnancy as possible, and the plans for addressing these

situations should be formally documented in the gestational surrogacy contract. Once the gestational carrier is pregnant, it is helpful for the obstetrician–gynecologist to be familiar with pertinent preconditions and contingencies in her contract with the intended parent(s) that may specifically address certain aspects of her care. For example, an anticipatory plan often is made regarding prenatal genetic screening and response to abnormal findings on any ultrasound studies, pathology, or laboratory tests.

Regardless of the contractual details, however, the pregnant gestational carrier is the only one empowered and enabled to make independent decisions regarding any screening, testing, or procedure that may be indicated during her pregnancy. Such interventions include fetal chorionic villus sampling, amniocentesis, multifetal reduction, pregnancy termination, and invasive or fetal surgery. Similarly, the gestational carrier's decisions regarding the continuation of pregnancy when her health is at risk should take priority over the well-being of the fetus and the desires of the intended parents. Decisions counter to the contract may have financial or legal consequences, and the gestational carrier should be made explicitly aware of this fact and of the specific consequences that may result after a contract breach.

There must be a clear understanding of how appropriate medical details related to the health of the fetus will be communicated to the intended parent(s) during the pregnancy, keeping in mind that such communications must take place only with the express consent of the pregnant patient. In most instances, the gestational carrier's consent to disclose medical details about her pregnancy-related health status and the health of the fetus will be contained in the preconception agreement. In the absence of such a provision, the treating physician must obtain the pregnant patient's informed consent before any disclosure regarding the health of the patient or fetus is made to the intended parent(s). Establishing where delivery will take place also is important because of the practical and legal ramifications of this decision.

Obstetrician–gynecologists caring for pregnant gestational carriers are encouraged to assist in the development of hospital policies to address labor, delivery, postpartum, and neonatal care in anticipation of deliveries in their facilities involving gestational surrogacy arrangements. It is particularly important to establish who will make decisions regarding care of the newborn from the time of delivery and to communicate this decision-making plan to the entire health care team. Although it is important to know whether any prebirth orders establish parentage of the newborn at the time of delivery, it is common and acceptable to allow the intended parent(s) to immediately take the lead in making decisions for the newborn (1). Difficulties may arise if the newborn is transferred to a different hospital before final establishment of legal parentage, and this may require further efforts to inform all health care providers involved about the gestational surrogacy arrangement.

Responsibilities of Obstetrician–Gynecologists to Intended Parents Considering Gestational Surrogacy

When an individual or a couple is considering gestational surrogacy, the obstetrician–gynecologist should provide counseling regarding the potential benefits and risks and the alternatives for family building. The unique ethical, medical, psychosocial, and legal complexities of gestational surrogacy may best be presented to intended parent(s) by an experienced subspecialist in reproductive endocrinology and infertility, a mental health counselor, and an appropriately qualified attorney, and this should be encouraged and facilitated. There also are many nonprofit and for-profit agencies offering legal and administrative assistance to parties involved in gestational surrogacy arrangements. A reputable, ethical, and experienced agency may assist in coordinating travel and communication between parties, medical care, escrow payments, and psychosocial support. An obstetrician–gynecologist may contract with a private gestational surrogacy agency to provide adjunctive services (such as laboratory testing and ultrasound monitoring) to the intended parent(s) if the physician has a good faith belief that the agency is medically and ethically reputable and the physician receives no more than standard compensation for these services.

Cross-Border Reproductive Care

Cross-border reproductive care refers to the rapidly growing practice of individuals seeking assisted reproductive technology treatment outside of their country of domicile (17). This practice includes Americans seeking gestational carrier arrangements abroad and foreign nationals seeking gestational carrier arrangements in the United States. Individuals may seek cross-border reproductive care to access more affordable treatment, to have a broader array of high-quality treatment options, to avoid legal restrictions in their country, or to protect their privacy (17). The benefits of U.S. citizenship, acceptance of same-sex partnership, and legality of gestational surrogacy in many U.S. states have led increasing numbers of foreign intended parents to seek cross-border reproductive care and the birth of resulting offspring in the United States.

Compared with domestic gestational surrogacy, cross-border reproductive care is particularly fraught with ethical and legal challenges and involves obstacles to ensuring optimal medical safety, preventing undue inducement of gestational carriers, and establishing parentage and citizenship status for offspring (3, 17). Political, religious, and legal norms, as well as attitudes regarding assisted reproductive technologies, vary widely among involved countries, which makes it difficult to create an internationally acceptable framework for this global phenomenon (18). Individual gestational carriers in countries outside of the United States may face

severe stigma in their communities because of negative public opinion of this practice (17). Although there is no ethical obligation for obstetrician–gynecologists to assist infertile patients seeking cross-border reproductive care, obstetrician–gynecologists should be aware of the existence of these types of gestational surrogacy arrangements, and those who counsel and care for these patients should encourage patients to seek legal advice from appropriately qualified legal counsel experienced in cross-border gestational carrier arrangements. Patients should be counseled that the quality of health care may differ in other countries, and it may be difficult to ensure appropriate prenatal care for the gestational carriers with whom they have contracted and the resulting newborns. Physicians who treat pregnant gestational carriers from abroad have a duty to provide the same level of care to international patients as they would to their domestic patients. However, this duty to international patients may be complicated by many factors, such as a lack of access to foreign medical records.

Conclusion

Gestational surrogacy is an increasingly common form of family building that can allow individuals or a couple to become parents despite circumstances in which carrying a pregnancy is biologically impossible or medically contraindicated. Obstetrician–gynecologists may become involved in gestational surrogacy either through caring for the gestational carrier or for the intended parent(s). Although gestational surrogacy increases options for family building, this treatment also involves ethical, medical, psychosocial, and legal complexities that must be taken into account to minimize risks of adverse outcomes for the gestational carrier, intended parent(s), and resulting children. State laws surrounding these arrangements vary and are evolving. The gestational carrier and the intended parent(s) should be cared for by independent obstetrician–gynecologists when possible. These physicians should take care to avoid potential conflicts of interest and may benefit from consultation with appropriately qualified legal counsel and experienced colleagues in reproductive endocrinology and infertility. Likewise, potential intended parents and gestational carriers should be encouraged to seek independent expert medical, legal, and psychosocial advice when considering this family-building option. Cross-border reproductive care involving gestational surrogacy involves special legal and sociocultural complexities. Obstetrician–gynecologists are not obligated to participate in non-emergent medical care related to either domestic or cross-border gestational surrogacy arrangements. However, physicians who choose to care for gestational carriers should provide the same level of medical care as they would to any patient, regardless of the complexities of gestational surrogacy and their personal beliefs regarding a particular parenting arrangement.

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