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Fiduciary Duties and Commercial Surrogacy

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Graduate Program in Philosophy

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Abstract

Since the 1980's, surrogacy has become a popular reproductive alternative for individuals experiencing infertility. The ethical and legal analyses of surrogacy have been rich and varied. Some bioethicists have charged the commercial surrogacy industry with the exploitation of global southern women or with the impermissible commodification of children and women's reproductive capacities. Others have praised the potential for economic empowerment and bodily autonomy that surrogacy may accord to women. However, throughout these explorations of the ethics of surrogacy, comparatively little attention has been paid to the moral status of a crucial actor: the fertility doctor. Without doctors willing to provide prenatal and postnatal care to surrogates and make use of assisted reproductive technologies (ARTs), commercial surrogacy would not take place. Yet, doctors' involvement in surrogacy is far from morally neutral. In my thesis, I aim to explore what duties doctors have in the context of commercial surrogacy. To do so, I take up the framework of fiduciary obligation. I argue that doctors have fiduciary obligations to surrogates, and that these obligations shape if and when doctors can ethically facilitate surrogacy.

My thesis is divided into four chapters. The first defends the view that the doctor-patient relationship is fiduciary in nature. The second chapter extends this view to the realm of commercial surrogacy, arguing that doctors also owe the surrogates they treat fiduciary obligations. The third chapter addresses a challenge posed by my view, namely that surrogacy seems to place doctors in positions where they constantly face conflicts of interest, and are therefore unable to uphold their fiduciary duty of loyalty to surrogates. I address this

concern by arguing that conflicts of interest are not inherent in surrogacy, but that surrogacy arrangements must be substantially rethought in order to safeguard the doctor-surrogate fiduciary relationship. The final chapter considers the obligations doctors have to the children they help create through surrogacy and through assisted reproduction more generally.

Keywords

Surrogacy, Commercial Surrogacy, Gestational Surrogacy, Fiduciary Relationships, Doctor-Patient Relationships, Reproductive Ethics, Bioethics, Feminist Bioethics

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Introduction

Background

The ethics of surrogacy—a practice wherein a woman gestates a baby for another individual or couple¹—have been hotly debated since at least the 1980's, when the Baby M custody case² attracted a great deal of attention in the news. Since then, commercial surrogacy has become a booming transnational industry. The legal status of surrogacy is variable, leading infertile individuals or couples to travel with increasing frequency from countries such as Japan or France, where commercial surrogacy is illegal, to more permissive countries such as Ukraine and South Africa to hire women to gestate babies for them. This has created a lucrative global market for surrogacy services.³

¹ As I will explain below, using the term 'surrogacy' to describe this practice is somewhat controversial.

² The Baby M case was a custody case wherein a woman named Mary Beth Whitehead, who had agreed to be a traditional surrogate for a couple named William and Elizabeth Stern, made a parental claim over the child she gave birth to, known as Baby M. After a protracted legal battle, custody was awarded to the Sterns, and visitation rights were granted to Mary Beth Whitehead.

³ For instance, prior to recent changes in their surrogacy legislation, the surrogacy industry in India alone was estimated to be worth between 445 million and 2 billion dollars a year (Knoche 2014).

Opinion has remained deeply divided on the moral status of surrogacy. Some have been optimistic about surrogacy's potential, both to help infertile individuals form families (Gostin 1988) and also to economically empower women (Teman 2001). However, many others have decried surrogacy, claiming that it exploits and commodifies women or that it amounts to 'baby-selling' (Anderson 1990, 2000; Tong 1990; Radin 1996). Although many feminists have considered ways to ameliorate surrogacy practices, especially as they occur transnationally, their work often begins not with an affirmation of surrogacy's moral permissibility, but rather with a reluctant admission that surrogacy will not stop any time soon (Parks 2010, Overall 2015).

In my thesis, I discuss surrogacy in a manner that moves away from this seemingly intractable debate about the moral status of surrogacy. Instead of arguing about whether surrogacy is permissible all things considered, I aim to explore whether surrogacy is a practice in which it is permissible for fertility doctors to become involved. Fertility doctors play an integral role in surrogacy arrangements, making use of a range of assisted reproductive technologies (ARTs) to enable surrogate pregnancies and providing surrogates with pre- and postnatal care. Without the participation of health care professionals, surrogacy simply would not take place.⁴

⁴ That is, gestational surrogacy would not take place. It may still be possible for some traditional surrogacy arrangements to take place, but this form of surrogacy is far less popular. I explain the gestational/traditional distinction below.

Doctors' participation in surrogacy arrangements raises many potential concerns. As I will explain, fertility doctors may often find themselves torn between the interests of the commissioning couple and the interests of the surrogate when it comes to decisions about the number of embryos to transfer, what genetic tests should be performed, what birth method to pursue, and whether to recommend selective reductions in cases of multiple pregnancy. How should doctors navigate these difficult situations? What duties do doctors have if they become involved in surrogacy, and to whom do these duties attach? Is it possible for doctors to uphold their duties to all of the parties involved in surrogacy arrangements? I aim to answer these questions in my thesis.

There have been a few discussions of doctors' role in surrogacy in the bioethics literature. To the best of my knowledge, the earliest bioethical work on this topic comes from Karen Rothenberg (1988, 1990), who considers various moral and legal questions brought up by the Baby M case. She argues that health care providers should ultimately refrain from participating in surrogacy, claiming that the ethical and legal risks inherent in surrogacy cannot be minimized (Rothenberg 1990, 350). In a later paper on surrogacy in Israel, Rosalie Ber (2000) suggests, among other things, that it is not necessarily unethical for doctors to participate in surrogacy arrangements, but that the same doctor should not simultaneously treat both the surrogate and the commissioning couple to avoid conflicts of interest. Judith Daar (2014) and Samia Rafique and Alan DeCherney (2014) also address doctors' role in surrogacy, but they consider a narrower question: what should fertility doctors do when a surrogate discloses that she has engaged in behaviour that violates her surrogacy contract? Daar argues that the doctor is justified in informing the commissioning couple of the breach without the surrogate's consent, and Rafique and

DeCherney claim that a doctor should not agree to hold the disclosure back from the surrogate's medical record, despite knowing that the commission couple would have access to it.

Although these discussions engage with some troubling aspects of doctors' participation in surrogacy, none provide a clear foundation for grounding fertility doctors' duties in the surrogacy context.⁵ I suspect that this lack of foundation helps explain why these bioethicists draw such different conclusions about doctors' participation in surrogacy. Ber seems to suggest that doctors' involvement in surrogacy is not inherently problematic, while Rothenberg concludes that their involvement is always morally dubious. On the other hand, Daar and Rafique and DeCherney seem to take for granted that there is nothing wrong with doctors facilitating surrogacy arrangements, and focus more on how to resolve specific conflicts between surrogates and commissioning couples. Without a normative framework for specifying and justifying fertility doctors' duties, it is difficult to determine what—if any—of doctors' actions are permissible in the surrogacy context.

⁵ Ber, at times, references principlism—a moral system that appeals to the principles of autonomy, beneficence, non-maleficence, and justice—in her discussion of surrogacy (154, 160, 165). However, as Ber points out, principlism alone does not provide guidance as to how various conflicts in surrogacy should be resolved. For example, she claims, “When one speaks of autonomy—whose autonomy?—That of the genetic parents or that of the surrogate mother? When one deals with beneficence—beneficence toward whom?—the genetic parents or the surrogate mother or the child?” (160).

To provide such a foundation, I will employ the framework of fiduciary obligation. This approach takes inspiration from a claim Rothenberg makes regarding the possibility that fertility doctors might feel obliged to monitor surrogates' conduct to ensure that they live up to the terms of their surrogacy contracts. Rothenberg states, disapprovingly, that the doctor ends up taking on "the role of spy, rather than the fiduciary role to the patient" (1990, 350). The notion that fertility doctors act as fiduciaries to surrogates provides a promising start for grounding doctors' duties. Rothenberg does not provide any further comment as to what it means to be a fiduciary or how taking on the 'fiduciary role' should guide doctors' conduct.⁶ However, as I will argue, if fertility doctors truly are fiduciaries to the surrogates they treat, then their obligations extend far beyond a duty of confidentiality, which of course prohibits 'spying.' I contend that the framework of fiduciary obligation, properly understood, can provide a robust normative basis for grounding doctors' duties in the surrogacy context.

Following legal theorists such as Paul B. Miller, I will argue that fiduciary relationships are normative relationships that arise when an individual (the fiduciary) exercises discretionary authority over the significant practical interests of another (the beneficiary). Being in such relationships imposes strict obligations upon fiduciaries. In particular, fiduciaries are obligated to uphold the duty of loyalty, which includes the

⁶ Rothenberg seems to treat the term 'fiduciary' as merely a byword for a relationship of confidence. In general, bioethicists often use 'fiduciary' to simply mean a doctor-patient relationship or a relationship of trust (Pellegrino 1991; Zaner 1991). Yet, as I will argue, the term 'fiduciary' has a much more precise meaning.

requirement that fiduciaries use their discretionary power for the sole benefit of their beneficiaries and the duty to avoid conflicts of interest (Frankel 2011). I will argue that the relationship between doctors and surrogates meets P. B. Miller's definition of the fiduciary relationship, and that recognizing doctors' duty of loyalty offers guidance as to what constitutes permissible and impermissible conduct in the context of surrogacy arrangements. Importantly, I will argue that although many surrogacy practices undermine doctors' ability to act as loyal fiduciaries, their participation in surrogacy can be acceptable if significant reforms of those practices take place.

Outline of Chapters

Chapter 1:

In the first chapter, I defend the fiduciary characterization of the doctor-patient relationship. I begin by outlining both what it means for a relationship to be fiduciary and why fiduciaries are obligated to act loyally to their beneficiaries. Then, I explain why the doctor-patient relationship should be understood as a fiduciary relationship, and respond to two objections to this view. The first objection is that fiduciary relationships appear to be paternalistic and are therefore at odds with the goal of promoting patient autonomy (the *paternalism* objection). I respond to this worry by arguing that although a degree of paternalism may be present in fiduciary relationships, some forms of paternalism are not incompatible with patient autonomy. The second objection is that in the contemporary health care system (especially with the rise of managed care), doctors' allegiances will be necessarily divided, leaving them unable to act as loyal fiduciaries (the *divided loyalties* objection). I respond to this concern by claiming that having multiple loyalties is not

synonymous with having divided loyalties. Doctors' loyalties are only divided when, I claim, they are motivated by self-interest or by other interests that do not stem from their professional role *qua* doctors. I conclude that the relationship between doctors and their patients is indeed fiduciary in nature.

Chapter 2:

In the second chapter, I argue that the relationship between doctors and surrogates should also be viewed as fiduciary. First, I provide an account of the doctor-surrogate relationship in practice, and give a provisional explanation as to why surrogates should be viewed as patients. In light of my arguments in Chapter 1, I claim that if the doctor-surrogate relationship is a doctor-patient relationship, then it too should be viewed as fiduciary. Then, I consider an objection to this view, the *difference position* objection, which holds that the moral duties doctors have towards their patients do not necessarily apply to their relationship with commercial surrogates since the two undertakings have distinct goals and natures. To respond to this objection, I argue that regardless of whether the goals of commercial surrogacy are distinct from those of therapeutic medical practice, doctors still wield discretionary authority over surrogates' significant practical interests. Therefore, the doctor-surrogate relationship satisfies the fiduciary principle, and fertility doctors should owe surrogates fiduciary obligations.

Chapter 3:

In the third chapter, I explore the implications of viewing the doctor-surrogate relationship as fiduciary. Given the conflicts of interest that abound in surrogacy, I question whether it is possible for doctors to actually act as loyal fiduciaries to

surrogates. That is, I address whether it is ever ethical for doctors to agree to participate in commercial surrogacy arrangements. First, I explore some of the most troubling threats to doctors' fiduciary loyalty that appear in surrogacy. These include conflicts that arise in cases of 'dual treatment' (where the same doctor treats a commissioning individual or couple and their surrogate simultaneously), conflicts that result from the influence of commissioning couples' interests, and financial conflicts of interest. I argue that although these conflicts appear to be ubiquitous in surrogacy arrangements, they are not intrinsic to surrogacy. Drawing from literature on two other 'dual obligation' contexts—live organ donation and sports medicine—I propose solutions aimed at insulating the doctor-surrogate fiduciary relationship from conflicts of interest. These include creating greater financial and clinical distance between the commissioning couple and the surrogate's doctor, and adopting a standard of single embryo transfer to avoid the risk that clinics will aim to improve pregnancy success rates by transferring multiple embryos. Bringing these recommendations into effect may make commercial surrogacy a more uncertain prospect for commissioning couples since they would be unable to have direct input into medical decisions made about the surrogate's conception or pregnancy. Moreover, my recommendations would also likely increase the costs associated with surrogacy because having sufficient clinical distance requires the involvement of additional medical professionals to provide parties with independent care. However, I argue that these changes are needed to enable doctors to participate in commercial surrogacy without violating their fiduciary obligations to surrogates.

Chapter 4:

In the final chapter, I consider whether fertility doctors have obligations to the children

they help create through surrogacy and also through assisted reproduction more generally. First, I argue that the interests of future children are at stake in decisions about who is granted access to assisted reproduction and how those technologies are employed. I then explore, but ultimately reject, a causal account of why doctors might be responsible for protecting future children's interests. I argue that it is not the causal role that doctors play in the creation of children, but rather the discretionary power doctors wield over potential future children's interests that is relevant when considering doctors' duties. I argue that this power can be understood as fiduciary authority when it is granted to doctors by the state out of recognition that future children's interests are highly vulnerable to the uses (or misuses) of assisted reproductive technologies. Thus, I conclude that fertility doctors have a fiduciary mandate to act in the interests of the future children they help create. However, I argue that this authority only extends over pre-conception decision-making, and therefore would not provide justification for doctors' overriding pregnant women's autonomy.

Finally, I address two objections to this account. The first is another form of the *divided loyalties* objection. The interests of prospective fertility patients (surrogates or infertile individuals) and of the future children potentially created through assisted reproduction may not align. (They would not align, for example, if the infertile individual was demonstrably unfit to parent a child.) If a fertility doctor has fiduciary obligations to both parties, then this may give rise to a conflict of interest, which the duty of loyalty proscribes. To address this objection, I return to my earlier claim that not all instances of multiple loyalties result in conflicts of interest. Multiple loyalties only amount to divided loyalties when a fiduciary is influenced by a secondary interest for reasons external to the

fiduciary's professional role (for instance, if the fiduciary is motivated by self-interest). I argue that fertility doctors are entrusted with the responsible use of assisted reproductive technologies, which includes considering the welfare of future children created through them, as part of their professional mandate to act in the public good. Just as lawyers are not disloyal to their clients when they act as officers of the court, fertility doctors are not disloyal to their patients when they refuse to use ARTs in a manner that would harm potential future children.

The second objection concerns an issue that falls under the umbrella of the 'non-identity' problem. That is, my view has the counterintuitive implication that a fertility doctor could act in the best interests of a future child by refusing to bring him or her into existence. I address this problem by arguing that fertility doctors' duties to future children are structural rather than interpersonal. In other words, doctors' duties attach to whoever ends up occupying the position of 'future child,' not to any particular, identifiable future person.

Terminology

Before I launch into my first chapter, it is useful to clarify some of the terms I will use.

First, the term 'surrogacy' is not uncontroversial. As Amrita Pande (2010) notes,

The origin of the term "surrogacy" and its social and political implications have been widely discussed by feminists (Stanworth 1987; Snowdon 1994; Rothman 2000). Generally, a surrogate is defined as a substitute or a replacement, implying that the surrogate is a substitute mother. Critics have argued that this terminology suggests that the woman who is paid to give birth is somehow less than a mother

and that this disparages her efforts and objectifies her by reducing her to her reproductive capabilities. (970)

Similarly, Deborah Satz (1992) rejects the term 'surrogate' on the grounds that it has loaded implications regarding who is a 'real' mother. However, following Pande, I use the terms 'surrogacy' and 'surrogate' for the sake of brevity and because they are widely used in the literature. At the same time, I acknowledge that other terms, such as 'contract pregnant women' or 'women who give birth/gestate for pay' may be conceptually preferable.

There are also distinctions drawn between different types of surrogacy. One distinction is between traditional and gestational surrogacy. Traditional surrogacy involves the use of a surrogate's own eggs, in conjunction with the sperm of either a commissioning man or third party donor. On the other hand, gestational surrogacy involves the use of either a contracting woman's eggs, or eggs from a third party donor, in conjunction with the sperm of either a commissioning man or third party donor. Another distinction is between paid and altruistic surrogacy. Altruistic surrogacy arrangements often occur within families or amongst friends, while paid arrangements primarily occur between strangers. In altruistic arrangements, surrogates can sometimes receive reimbursements, such as for medical expenses, but they are not paid for providing gestational services. Both traditional and gestational surrogacy can be either paid or altruistic.

I focus here on paid gestational surrogacy, and use the terms 'surrogacy' or 'commercial surrogacy' to connote paid gestational surrogacy arrangements. I focus on

this form of surrogacy for two reasons. First, gestational surrogacy is more common than traditional surrogacy, and much of the recent surrogacy research concerns gestational surrogacy. Second, the commercialization of surrogacy can introduce potential conflicts that aren't present, or are present to a lesser degree, in altruistic surrogacy. That said, some of the ethical issues I will discuss will certainly transcend the gestational/traditional or altruistic/commercial divisions, and many of the arguments I make will likely be relevant for discussions of altruistic and traditional surrogacy, not just for commercial and gestational surrogacy. Moreover, I acknowledge that altruistic surrogacy can take place within commercialized fertility markets.

I use the term 'commissioning individual or couple' to refer to the individual(s) who hire surrogates for the purposes of gestating their future children. Some other terms are used in the literature, such as 'intended parents.' However, I use the language of 'commissioning individual or couple' because I am specifically discussing paid surrogacy arrangements, and also because the term is neutral when it comes to the parentage of the children produced through such arrangements. Sometimes, I simply write 'commissioning couple' for brevity, but a single person may, of course, also hire a surrogate.

Finally, when I refer to the infertile individuals seeking out surrogacy services, this may include not only individuals who face fertility issues as a result of medical conditions, but also those who wish to have children but cannot for social reasons (for instance, single individuals or gay couples). This is often referred to as 'social infertility' (Heyder 2015).

Chapter 1

1 Doctors as Fiduciaries

The moral underpinnings of the doctor-patient relationship have long been a topic of heated debate amongst philosophers, legal theorists, and healthcare professionals. It is generally accepted that doctors have ethical duties to their patients. However, specifying the content and nature of these duties has proven controversial. In this chapter, I argue that the doctor-patient relationship is *fiduciary* in nature, and that doctors therefore owe their patients fiduciary obligations. I begin by explaining what a fiduciary relationship is, and why it matters whether a relationship counts as fiduciary. I defend the position advocated for by Paul B. Miller (2011), which defines the fiduciary relationship as a relationship wherein “one person exercises discretionary authority to set or pursue practical interests... of another” (278). I then explain why the doctor-patient relationship ought to be regarded as fiduciary. I argue that doctors are authorized to wield considerable discretionary power over the health interests of patients, and that the doctor-patient relationship is therefore normatively fiduciary. Then, I respond to two concerns one may have with the fiduciary understanding of the doctor-patient relationship. The first is that fiduciary relationships are paternalistic and therefore at odds with the goal of promoting patient autonomy (the *paternalism* objection) (Dworkin 2003). I will respond to this worry by arguing that although some paternalism is present in fiduciary relationships, a degree of paternalism is not necessarily incompatible with patient autonomy. The second concern is that in the contemporary health care system (especially

with the rise of managed care), doctors' allegiances will be necessarily divided, leaving them unable to act as loyal fiduciaries (the *divided loyalties* objection) (Rodwin 1995). I will respond to this concern by claiming that having multiple loyalties is not synonymous with having divided loyalties. What is important, I claim, is that doctors are not motivated by self-interest, or by other interests that do not stem from their professional role *qua* doctors.

1.1 What Are Fiduciary Relationships?

There is a great deal of disagreement amongst philosophers, legal theorists, and lawmakers as to the precise definition of the fiduciary relationship. As Matthew Harding (2013) claims, "Isolating that which makes a relationship fiduciary is one of the great unfinished tasks of modern legal scholarship" (85). According to Sonia Allan and Meredith Blake (2013), "[t]he term 'fiduciary relationship' has consistently escaped definition" (316). Similarly, Tamar Frankel (2011) points out that "[r]arely do court decisions and legislation provide a general definition of fiduciary relationships" (1). Fiduciary relationships are roughly understood as relationships wherein one party exercises power over another, and wherein the empowered party undertakes to act in the interests of the other. However, such an understanding is too vague to provide precise guidance as to what particular relationships ought to count as fiduciary.

Historically, courts have adopted one of two common approaches to identifying relationships as fiduciary: the status-based approach and the fact-based approach. The status-based approach is the older of the two, and is most widely used across jurisdictions. As the name implies, it classifies relationships as fiduciary based on status

or convention (Gold and P. B. Miller 2014, 2). It proceeds by categorizing a given relationship and then determining whether the category of relationship itself is typically regarded as fiduciary (P. B. Miller 2011, 241). For instance, a court may look at a given relationship between Person A and Person B and determine that Person A is acting as a trustee for the benefit of Person B. Since the relationship between trustees and beneficiaries is conventionally regarded as fiduciary, courts would recognize the relationship between Person A and Person B as fiduciary, and therefore as falling under the scope of fiduciary law. According to this approach, new types of fiduciary relationships are recognized by analogy. That is, in order for a type of relationship to be considered fiduciary, it must be shown to be sufficiently analogous to paradigm examples of fiduciary relationships.

However, this approach to fiduciary relationships has been criticized on the grounds that it is overly narrow and rigid, and that it offers no clear explanation as to why these types of relationships should be treated as distinctive. In the landmark Supreme Court of Canada case *Guerin v. The Queen*, Justice Dickson argues in the majority holding that the range of relationships that ought to be regarded as fiduciary are “not exhausted by the standard categories of agent, trustee, partner, director, and the like” that are picked out by the status-based approach (*Guerin v. The Queen* [1983] 2 SCR 335, qtd. in P. B. Miller 2011, 242). He claims that the specific category of actor involved is not what gives rise to fiduciary duties. Rather, it is the nature of the relationship itself that is important (*ibid*).

Yet, rather than attempt to provide a precise definition of what makes a relationship fiduciary, Canadian courts developed an approach to identifying fiduciary

relationships that looks to the specific facts of given relationships, rather than the status of the actors involved. This approach, referred to by P. B. Miller as the *fact-based* approach, views fiduciary obligations, as Justice La Forest puts it, as potentially arising “as a matter of fact out of the specific circumstances of a relationship” (*LAC Minerals Ltd v. International Corona Resources Ltd* [1989] 2 SCR 574). This approach seeks to identify fiduciary relationships by virtue of their “possession of certain characteristics or indicia of recognized fiduciary relationships” (P. B. Miller 2011, 243). In *Frame v. Smith*, Justice Wilson provides an initial list of potential fiduciary indicia:

- (1) The fiduciary has scope for the exercise of some discretion or power.
- (2) The fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary’s legal or practical interests.
- (3) The beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion or power.⁷ (*Frame v Smith* [1987] 2 SCR 99, qtd. in P.

⁷ Frankel (2011) provides another example of an approach based in recognized indicia.

She proposes identifying fiduciary relationships by a set of common factors:

First, fiduciaries offer mainly services (in contrast to products). The services that fiduciaries offer are usually socially desirable, and often require expertise, such as healing, legal services, teaching, asset management, corporate management, and religious services. Second, in order to perform these services effectively, fiduciaries must be entrusted with property or power. Third, entrustment poses to entrustors the risks that the fiduciaries will not be trustworthy. They may

B. Miller 2011, 243).

However, since *Frame v. Smith*, Canadian courts have remained divided as to whether or not these are suitable indicia for fiduciary relationships. Many Supreme Court of Canada cases on fiduciary relationships have been fraught with disagreement as to what features are essential to fiduciary relationships. The relevance of vulnerability, for instance, is a point of contention, with Justice Sopinka affirming its central importance to fiduciary relationships in *LAC Minerals Ltd. v. International Corona Resources Ltd.* and Justice La

misappropriate the entrusted property or misuse the entrusted power or they will not perform the promised services adequately. Fourth, there is likelihood that (1) the entrustor will fail to protect itself from the risks involved in fiduciary relationships; (2) the markets may fail to protect entrustors from these risks; and that (3) the costs for the fiduciaries of establishing their trustworthiness may be higher than their benefits from the relationships. (19-20)

While much more detailed than the *Frame v. Smith* indicia, Frankel's criteria are nonetheless intended to be more descriptive than explanatory. Some of the emerging fiduciary relationships she discusses, like relationships between spouses, would likely not be covered under her proposed definition since these relationships do not involve the provision of services that require expertise. Although Frankel's definition is useful insofar as it highlights some common features of many fiduciary relationships, it still stands to be supplemented by a definition with more explanatory force.

Forest rejecting its necessity for the establishment of a fiduciary relationship in *Hodgkinson v. Simms* (P. B. Miller 2011, 244-246).⁸

Thus, although the fact-based approach marks progress insofar as it directs attention to the essential characteristics of fiduciary relationships, it nonetheless fails to provide a fiduciary principle (P. B. Miller 2011, 249). The absence of such a principle is problematic because it leaves courts without a clear way of determining what makes a given relationship fiduciary (or indeed, why fiduciary relationships should be viewed as a distinctive kind of relationship at all). Since lawyers and judges treat the fiduciary relationship as the basis for imposing fiduciary obligations, like the duty of loyalty (which I will explain below), an approach that makes clear why the fiduciary relationship is distinctive is needed (P. B. Miller 2015, 69).

To fill this explanatory gap, P. B. Miller proposes a principled definition of fiduciary relationships that focuses on the importance of discretionary power. He claims that, “a fiduciary relationship is one in which one party (the fiduciary) enjoys discretionary power over the significant practical interests of another (the beneficiary)” (P. B. Miller 2011, 262). He asserts that although the Supreme Court of Canada has been committed to the status-based and fact-based approaches, it “has repeatedly suggested that the essential characteristic of fiduciary relationships lies in the discretionary power wielded by fiduciaries over beneficiaries” (P. B. Miller 2011, 261). For example, in

⁸ See Duggan (2010) for a summary of the intellectual disagreements in Canadian courts about the nature of fiduciary relationships.

Norberg v. Wynrib, Justice McLachlin states that “the essence of a fiduciary relationship ... is that one party exercises power on behalf of another” (*Norberg v. Wynrib* [1992] 2 SCR 226, qtd. in P. B. Miller 2011, 261). In particular, P. B. Miller stresses the ruling made by Justice Cromwell in *Galambos v. Perez*, which states that because the appellant did not wield discretionary power over the practical interests of the respondent, there was no fiduciary relationship between them (P. B. Miller 2011, 263). This emphasis on discretionary power is consistent with Harding’s (2013) view that reliance on discretion is the common feature of fiduciary relationships.

P. B. Miller offers some refinements to this general definition of the fiduciary principle. First, he clarifies that by ‘fiduciary power’, he means the *authority* to act relative to an individual’s practical interests (P. B. Miller 2011, 272). In arriving at his understanding of ‘power as authority’, P. B. Miller distinguishes between three conceptions of the word ‘power’. ‘Power’ can be understood as simply having access to the practical interests of another; as having the capacity to affect or influence the practical interests of another; or as having the authority to act relative to the practical interests of another. Although these understandings are mutually consistent, P. B. Miller favors the third definition of power as authority. To have the ‘authority to act relative to the practical interests of another’ means to have the power to stand in substitution for another in exercising a legal capacity (P. B. Miller 2015, 70). A legal capacity consists in both the ability to act in a legally effective way and also to be held legally responsible for that action. Legal capacities can include, for example, the capacity to enter into a legally binding relationship or the capacity to make decisions relating to one’s health and welfare. In the context of a fiduciary relationship, fiduciaries are granted the authority to

exercise certain legal capacities on behalf of their beneficiaries. Fiduciary power, understood in this way, consists in “the substitutive exercise of legal capacity” (P. B. Miller 2015, 71).

According to P. B. Miller, this view of fiduciary power as authority best coheres with certain requirements of fiduciary relationships.⁹ For instance, fiduciary power is purposive. Regardless of whether a fiduciary relationship is established through agreement, undertaking, or decree, it is initiated for a reason (i.e. to advance or set the interests of the beneficiary) (P. B. Miller 2011, 273). Therefore, when a fiduciary exercises power, that exercise must be consistent with the purposes for which it is held (Fox-Decent 2005, 301). While individuals can have access to or influence over another’s practical interests by chance (as the first two conceptions of power would allow), the same cannot be said for authority. Authority does not, as P. B. Miller puts it, “subsist at large;” rather it “must be reposed, undertaken, or prescribed” (2011, 273). It would make no sense to claim that someone could exercise a legal capacity on behalf of another

⁹ Lionel Smith (2014) makes a somewhat similar claim about fiduciary power in his discussion of the duty of loyalty. Smith understands fiduciary relationships as relationships wherein a given individual has the authority to exercise decision-making power on behalf of another. He claims that “the requirement of loyalty is not imposed to control mere power *over* another person; it is imposed to control decision-making power held for, or on behalf of, another person” (Smith 2014, 8). Smith emphasizes the importance of having the authority to act on behalf of someone, rather than simply having the power to affect someone’s interests.

merely by chance. Viewing fiduciary power as authority also makes it clear why fiduciary relationships entail such strong, prophylactic duties, such as the duty to avoid conflicts of interest (as in detail discussed below). When one party has authority over another's interests, there is a considerable imbalance of power. This imbalance makes the person over whom the authority is held uniquely vulnerable to the use, or abuse, of that power, and thus in particular need of protection (P. B. Miller 2011, 274, 281). Finally, P. B. Miller adds that authority, in the fiduciary context, is relational. Fiduciaries do not have unlimited discretion in the exercise of their authority. Rather, the scope of their discretionary power lies precisely within the limits of the authority reposed in or undertaken by them (P. B. Miller 2011, 275).

Having refined his understanding of fiduciary power as authority, P. B. Miller then explains what he means by significant 'practical interests'. He claims that "an interest is practical where it connotes a real, ascertainable matter of personality, welfare, or right in relation to which one person may be uniquely and materially susceptible to the exercise of authority by another" (2011, 276). By matters of personality, P. B. Miller means aspects of an individual's *legal* personality. Legal personality is an individual's ability to hold legal obligations or rights, and it is a prerequisite for having legal capacities. Matters of personality are not limited to capable individuals, but can also pertain to incapable or artificial persons, such as children, comatose patients, or corporations. Unlike matters of personality and rights, matters of welfare are limited to natural persons, and include aspects of their personal integrity and well-being, such as their physical and mental health. Defining practical interests as such is important since it limits what interests can legitimately be subject to the exercise of fiduciary power (P. B.

Miller 2011, 275). Understanding practical interests in this narrow way prevents the category of fiduciary relationships from being overly inclusive. Granting your personal trainer the power to choose on your behalf what kinds of exercises you will do, for instance, would not count as a conferral of fiduciary authority since the interest you have in doing particular kinds of exercise is a relatively trivial interest.

P. B. Miller also elaborates upon the use of fiduciary powers within a fiduciary relationship. He explains that “[f]iduciaries have variously been deemed to hold power to *serve*, to *protect*, or to *promote* or *advance* the practical interests of beneficiaries, or to exercise them *for* or *on behalf of* beneficiaries” (2011, 276). All of these expressions, he claims, attempt to get at something fundamental, which is that fiduciary power is legitimately exercised in service of beneficiaries’ practical interests. There are two ways in which this can occur. A fiduciary can either exercise her powers in the pursuit of her beneficiaries’ ends (such as a lawyer working to get her client a favorable settlement) or for the sake of setting her beneficiaries’ ends (such as a corporate director determining a company’s ends when developing long-term business strategies) (P. B. Miller 2011, 277). Thus, P. B. Miller arrives at a more focused definition of the fiduciary relationship: a relationship in which “one person exercises discretionary authority to set or pursue practical interests (including matters of personality, welfare or right) of another” (2011, 278).

Understanding fiduciary relationships in this way makes it clear why they are different from other relationships that involve the exercise of discretionary power over another’s interests. Trust between friends is a useful comparison. Imagine that my friend, knowing that I am a financially savvy person, asks me to help her pick out a financial

advisor. She trusts that, as a good friend, I will use my knowledge to help lead her in the right direction. In this case, I have a form of discretionary power over her interests since I could harm her financial interests if I intentionally led her astray (for instance, by recommending she hire an advisor whom I know to be incompetent). However, our relationship does not satisfy the fiduciary principle. Although she trusts me to help her achieve her ends, I don't have the power to set or pursue her interests. I am advising her based on my personal experience with financial advisors, but I am not acting on her behalf. Therefore, the power I have cannot be meaningfully understood as authority. The influence I have over her interests is a somewhat natural result of our trusting friendship. It is not something she has bestowed upon me for the purpose of achieving her ends.

Comparing P. B. Miller's fiduciary principle to other attempts at defining the fiduciary relationship also highlights this explanatory advantage of Miller's account. Take, for instance, a view expressed by Maxwell Mehlman (2015). Mehlman (2015) claims that,

Fiduciary obligations are imposed in relationships in which one party, the fiduciary, is in a position to take advantage of the other party, called the beneficiary, principal, or "entrustor," and in which the interests of the entrustors that are at stake are important to society and sometimes vital to the entrustors' welfare. (2)

On a certain interpretation of this definition, Mehlman's view is compatible with P. B. Miller's; indeed in footnote 2, he presents his understanding of the term 'interests' as reflective of P. B. Miller's understanding of 'significant practical interests.' However,

Mehlman's definition is less refined and generally less useful than P. B. Miller's. For one thing, it is overly broad. It is possible for someone to be in a position to take advantage of another party with regards to their vital interests in the context of a relationship that ought not to be considered fiduciary. Imagine a Jack and the Beanstalk-esque example. The old man in the fairy-tale who is attempting to sell Jack magic beans in exchange for his cow (which represents his family's entire livelihood) is clearly in a position to take advantage of him. Jack's interest in being able to support himself and his family, which is vital to his welfare and important to society, is at stake. But it would make little sense to think of the relationship between Jack and the old man as fiduciary, even though Jack trusts him, and he can take advantage of that trust in a way that harms Jack's vital interests. On its own, then, Mehlman's view fails to pick out what exactly makes the fiduciary relationship distinctive from other relationships of trust, power, vulnerability, or influence. P. B. Miller's view, on the other hand, imbeds within the definition of the fiduciary relationship an account of the distinguishing quality of fiduciary power—having the authority to set or pursue someone's significant practical interests.

It is interesting to note that fiduciary relationships, understood in this way, can arise in the absence of any contract between parties, or even in the absence of explicit consent. For instance, many jurisdictions recognize the relationship between parents and children as fiduciary, even though most children never agree to being in such a relationship. Evan Fox-Decent (2005) explains,

[I]n the parent-child case, it is the law itself which deems the fiduciary to act on the basis of the beneficiary's trust... It is sufficient, in appropriate circumstances, that the fiduciary has discretionary control over the vulnerable interests of another

party which themselves are capable of forming the subject matter of a fiduciary obligation. (294)

This feature of the fiduciary relationship makes clear how a fiduciary model of the doctor-patient relationship will differ from a contractual model. Unlike contractual relationships, fiduciary relationships can arise from the circumstances of a situation. If one party is intentionally exercising discretionary authority over the significant practical interests of another, then she is acting as a fiduciary, regardless of whether or not she is aware of that fact or has consented to it.

Such a discussion illuminates how fiduciary relationships have both legal and moral dimensions. As Frankel (2011) points out, fiduciary duties carry with them an “aura of morality” (104). She claims that, “as compared to breach of contract, a breach of fiduciary duties carries a moral stigma and stricter legal consequences” (*ibid*). For instance, she points to *United States v. Iannone* (184 F.3d 214 [3d Cir. 1999]), a case where the defendant defrauded his investors by using their money for his own personal expenses. Pursuant to the United States Sentencing Guidelines, the U.S. District Court for the District of Columbia ruled to enhance the sentences for Iannone’s crimes in part because they found that he abused the trust of his victims, who had relied upon his integrity. In other words, the violation was punished harshly not just because it was a criminal offense (i.e. fraud), but also, it seems, because it was a moral offense (i.e. a betrayal of trust).

Finally, although it is the law that enforces fiduciary obligations, it is possible for a relationship to satisfy the fiduciary principle (and thus be normatively fiduciary) in

jurisdictions where that particular relationship is not recognized as fiduciary by the law. When it comes to the doctor-patient relationship, I will focus primarily on the argument that normatively speaking, the relationship between doctors and their patients is fiduciary, regardless of whether this is reflected in the law. This is an important point moving forward since not all jurisdictions will treat the doctor-patient relationship as falling squarely within the category of ‘fiduciary.’ Given this diversity across jurisdictions, I restrict my claims primarily to the normative dimensions of the fiduciary relationship.¹⁰ However, I contend that the law ought to recognize the doctor-patient relationship as fiduciary (though providing a thorough legal argument for this claim is beyond the scope of my project).

Having outlined P. B. Miller’s fiduciary principle, I now turn to briefly fleshing out the obligations entailed by the fiduciary relationship. Like the fiduciary principle, the precise set of fiduciary duties has also been the topic of much debate. Fiduciary duties aim at protecting beneficiaries who are vulnerable to the misuse or abuse of discretionary powers. Frankel’s work on fiduciary duties provides a useful starting point for understanding these obligations. She divides fiduciary duties into two broad categories—those relating to the ‘duty of loyalty’ and those relating to the ‘duty of care’. However, there is debate as to whether the duty of care is a distinctively fiduciary duty, given that non-fiduciary agents can be obligated to exercise a duty of care. For instance, landowners

¹⁰ See section 1.2 below for a discussion of how different jurisdictions approach the question of whether the doctor-patient relationship is fiduciary.

can have a duty of care towards people who come onto their premises, but the relationship between a landowner and a person who happens upon their property is not fiduciary.¹¹ On the other hand, virtually all commentators agree that loyalty is the most important or defining fiduciary duty (Smith 2014, 2). Therefore, for my purposes, I will focus primarily on the duty of loyalty.

According to Frankel, the duty of loyalty comprises two aspects—the requirement that fiduciaries use their discretionary power for the sole benefit of their beneficiaries, and the prohibition on fiduciaries from acting in conflict with the interests of their beneficiaries (insofar as those actions relate, that is, to the interests over which the fiduciary has discretionary power) (Frankel 2011, 108).¹² The duty of loyalty, she

¹¹ See Conaglen (2011) for a more detailed discussion as to why the duty of care isn't necessarily a fiduciary duty.

¹² A fiduciary may, of course, act contrary to her beneficiary's interests when those interests have nothing to do with their fiduciary relationship. My divorce lawyer may humiliate me by trouncing me in a tennis match without thereby violating her fiduciary obligations to me. Complete selflessness on the part of the fiduciary is not what loyalty requires. Rather, loyalty requires that whenever a fiduciary exercises the discretionary power she has over her beneficiary's interests, she does so only to achieve the ends for which she was granted that power in the first place—that is, to set or pursue her beneficiary's relevant practical interests.

claims, grounds a number of additional duties, including the duty to act in good faith, the duty of confidentiality, and the duty to disclose relevant information to the beneficiary.

Why is it that fiduciaries are obligated to act loyally? In particular, why must fiduciaries avoid conflicts of interest, rather than just skillfully navigate them? The duty of loyalty is commonly viewed as being founded upon a beneficiary's vulnerability to her fiduciary (P. B. Miller 2011, 255). Given the structure of the fiduciary relationship, there is a clear power imbalance between the beneficiary and the fiduciary. The beneficiary must depend upon the fiduciary's exercise of discretionary power, and her interests may be severely harmed if that power is misused or abused. The duty of loyalty is a response to this particular kind of structural vulnerability that is inherent in fiduciary relationships. As P. B. Miller explains,

The duty of loyalty conditions the exercise of discretionary power, requiring it not to be exercised other than for the benefit of the beneficiary. It responds to and reflects a kind of vulnerability peculiar to the fiduciary relationship; namely, the inherent susceptibility of the beneficiary to exploitative exercise of discretionary power by the fiduciary. (2011, 280)

In other words, the duty of loyalty aims to protect beneficiaries from the risk that fiduciaries will use their power to advance some end other than the beneficiary's interests (for example, personal profit). This duty includes the obligation to avoid conflicts of interest in order, as Irit Samet (2008) puts it, to prevent fiduciaries "from getting involved in situations in which the chances of committing a breach of duty are high" (764). That is, conflicts of interest must be avoided because they threaten not only a fiduciary's

willingness to use her discretionary power solely in the interests of her beneficiary, but also her capacity to do so. As Samet points out, given what moral psychology has taught us about self-deception, even virtuous fiduciaries should refrain from placing themselves in situations where there is a clear risk that a secondary interest may, on some level, unduly shape their exercise of discretionary power.¹³

The duty of loyalty is also what sets fiduciary obligations apart from other types of obligations that stem from the exercise of discretionary power. For instance, recall the example of my friend asking for advice about selecting a financial advisor. Since our relationship is not fiduciary, I'm not obligated to give her advice in a way that is free from self-interest. I could legitimately recommend that she look into an advisor who I think is excellent, and who I know also invests in companies that align with my moral commitments (even if I know my friend doesn't care much one way or the other about these particular commitments). Acting in this partially self-interested manner—encouraging my friend to invest in a way that both benefits her and also advances my other ethical commitments—wouldn't violate my obligation to my friend since trust relationships, unlike fiduciary relationships, don't require strict loyalty.¹⁴

¹³ See Samet (2008) for a more in-depth exploration of conflicts of interest and the risk of self-deception.

¹⁴ As an honest friend, however, I should likely inform her that my moral commitments influenced my recommendation.

1.2 The Fiduciary Characterization of the Doctor-Patient Relationship

Having outlined the fiduciary relationship, I now turn to defending the view that the doctor-patient relationship is fiduciary. In the law, there is considerable disagreement across jurisdictions about whether or not the doctor-patient relationship falls into the fiduciary category. This disagreement may stem from the aforementioned lack of clarity in courts surrounding what exactly makes a relationship fiduciary. In Canadian law, the doctor-patient relationship is often recognized as fiduciary. For instance, in *McInerney v. MacDonald*, the ruling makes it clear that the doctor-patient relationship is understood as fiduciary. It held:

The physician-patient relationship is fiduciary in nature and certain duties arise from that special relationship of trust and confidence. These include the duties of the doctor to act with utmost *good faith and loyalty*, to hold information received from or about a patient in confidence, and to make proper disclosure of information to the patient. (*McInerney v. MacDonald* [1992] 2 SCR 138, my emphasis)

Thus, *McInerney v. MacDonald* seems to establish that the doctor-patient relationship is fiduciary. Another influential Canadian case is *Norberg v. Wynrib*. In this case, the appellant was addicted to painkillers, and had been receiving them from her doctor in exchange for sexual favors. She sought “general and punitive damages against the respondent on the grounds of sexual assault, negligence, breach of fiduciary duty and breach of contract” (*Norberg v. Wynrib* [1992] 2 SCR 226). Although she was awarded

damages, the majority stopped short of recognizing the relationship in question as fiduciary. The previous court of appeal was unwilling to categorize their relationship as fiduciary, and since the Supreme Court of Canada ruling dealt with the case as a matter of assault, the potentially fiduciary nature of the relationship was not revisited. However, in a concurring minority opinion, Justice McLaughlin does engage with the fiduciary question. She upholds the decision from *McInerney v. MacDonald* about the fiduciary status of the doctor-patient relationship, claiming that “the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature. All the authorities agree that the relationship of physician to patient also falls into that special category of relationships which the law calls fiduciary” (*Norberg v. Wynrib* [1992] 2 SCR 226).

In contrast, Australian courts are hesitant to regard the doctor-patient relationship as fiduciary. Take, for example, the ruling in *Breen v. Williams*.¹⁵ In this case, the appellant was involved in a class action lawsuit, and required a copy of her medical records as part of that litigation. Her doctor refused to provide her with her records in a manner she deemed acceptable (Brebner 1998, 238). The court ruled against her, claiming that, “The relationship between a doctor and patient is not, in this State, “the same relationship as that which exists in equity between the persons in question: it is not ‘a fiduciary for trust relationship’ as those terms are used in the law of this State” (*Breen v. Williams*, above n 61, at 566.). The ruling on *Breen v. Williams* accepted that the doctor-patient relationship

¹⁵ The circumstances of *Breen v. Williams* bear similarity to *McInerney v. MacDonald* insofar as both revolve around patient access to medical records.

exhibited some of the characteristics of a fiduciary relationship (Allan and Blake 2014, 316-317). However, the judges did not alter the existing Australian position, deciding to refrain from placing the doctor-patient relationship squarely into the fiduciary category. English courts too have been resistant to the notion that the doctor-patient relationship is fiduciary. In *Sidaway v. Bethlem*, Lord Scarman pronounced that the appellant's attempt to persuade the court that the relationship between a doctor and patient is fiduciary "fails: there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and *cestui qui trust*¹⁶ or other relationships treated in equity as of a fiduciary character" (*Sidaway v. Bethlem Royal Hospital Governors* [1985] AC 871, qtd. in Bartlett 1997, 193).

Surveying the state of fiduciary law across various jurisdictions regarding the doctor-patient relationship makes it all the more clear that a principled definition of the fiduciary relationship, like the one P. B. Miller provides, is needed. Using either status-based approaches (as do English, Australian, and sometimes Canadian courts) or fact-based approaches (as do Canadian courts at other times) cannot seem to answer the question of whether, at least normatively speaking, the doctor-patient relationship should be understood as fiduciary.¹⁷ However, by adopting P. B. Miller's fiduciary principle, the justification for the fiduciary characterization of the doctor-patient relationship becomes

¹⁶ That is, the beneficiary of the trust.

¹⁷ For a useful summary of how doctors have been considered fiduciaries under law (including, in terms of property law, as advisers, or as agents), see Frances Miller (1983).

clear. Recall that P. B. Miller defines a fiduciary relationship as a relationship in which one person exercises discretionary authority to set or pursue the significant practical interests of another. Given this definition, there are several questions that must be answered about the doctor-patient relationship in order to determine whether or not it is fiduciary: Does a doctor exercise discretionary power? Is that power held relative to a patient's significant practical interests? And finally, is that power understood as the authority to set or pursue those practical interests? I will answer these questions in turn.

First, the doctor-patient relationship does, necessarily, involve a doctor exercising discretionary power. A doctor typically exercises a host of powers, such as the powers to perform tests, diagnose illnesses, provide treatments, and take medical histories (which may involve the disclosure of sensitive personal information). The exercise of these powers is discretionary in nature since patients typically lack the relevant medical knowledge to evaluate or 'check up on' their doctors' decisions and, as I will explain below, since doctors require flexibility to make certain judgment calls in the course of treatment.

A common example of how doctors exercise discretion is found in their decisions about what medical information should be provided to patients so that they can give informed consent to treatment. Informed consent is a cornerstone of ethical medical decision-making and care. However, since patients often have a limited understanding of medicine, doctors must make discretionary judgments in determining what information is needed to effectively inform them. Indeed, doctors may struggle to "strike a balance between too much and too little information" (Murray 2012, 563). Thus, although patients have the final say when it comes to choosing amongst treatment options, doctors

make a multitude of discretionary judgments before they even present patients with those options. While patients can, and often do, get second opinions, they must ultimately rely upon at least one doctor's discretionary judgment if they wish to receive medical treatment.

Moreover, since every human body is different, medical treatments and procedures can have unpredictable results, and doctors must have the freedom to adapt to new circumstances. Imagine, for example, a surgeon who was granted no discretionary power, and therefore had no freedom to deviate whatsoever from an excruciatingly detailed plan to which a patient had consented prior to surgery. She would be unable to change course mid-way through a surgery in light of unforeseeable circumstances. This lack of freedom could have potentially devastating results for the patient's health. Thus, in order for the doctor-patient relationship to be effective, patients must allow their doctors to wield at least some degree of discretionary power.

Second, the discretionary power that doctors wield is clearly power over patients' *significant practical interests*. One's overall welfare is highly dependent upon one's health since illness can make many other valuable goods difficult or impossible to obtain. For instance, if illness seriously impairs one's mobility or cognitive functioning, then it can be challenging for one to pursue one's considered life plans (since those plans may include travelling around the world or attaining an advanced degree). One's health interests may therefore be amongst one's *most* significant practical interests.

Third, this discretionary power is properly understood as authority. Recall that fiduciaries have the authority to exercise legal capacities on their beneficiaries' behalves.

When doctors diagnose illnesses, recommend treatments, and perform medical interventions, they are effectively exercising the legal capacity to make decisions relating to their patients' health and welfare on their patients' behalves. Of course, a doctor's authority to exercise this capacity is not unlimited. As discussed above, doctors do not have the authority to decide on a competent patient's behalf what treatment option should be pursued. That decision resides with the patient herself. However, patients do grant doctors authority over other aspects of their health interests, including the power to decide what medical information they should receive in order to choose a treatment.¹⁸ In addition, once a treatment option has been chosen, a doctor has the authority to carry out the interventions involved in the treatment plan (which can include operating on the patient, providing her with medications, and so on). Finally, since doctors are granted power over their patients' health interest in order to help their patients' get better (or not get sick in the first place), the power that doctors have over their patients' health interests is clearly purposive. In all, I conclude that doctors exercise discretionary authority to pursue their patient's significant practical interests. Therefore, the doctor-patient relationship ought to be recognized as fiduciary.

¹⁸ This is the case with competent patients, at least. In the case of patients who cannot provide consent, the doctor's authority to act on the patient's behalf may come from either a proxy decision-maker or from the state

1.3 Objections to the Doctor-Patient Relationship as Fiduciary

The fiduciary understanding of the doctor-patient relationship is not immune to criticism. In this section, I outline and respond to two of the most pressing concerns. The first is that fiduciary relationships are necessarily paternalistic, and therefore the fiduciary model of the doctor-patient relationship is at odds with the promotion of patient autonomy (the paternalism objection). The second is that the doctor-patient relationship cannot be genuinely fiduciary since doctors cannot act with sufficient loyalty to their patients (the divided loyalties objection). I will address each of these worries in turn.

1.3.1 The Paternalism Objection

Acting paternalistically is often understood as interfering with another's choices or actions in a way that is against their will (or without their knowledge), but for the sake of their own good (or at least, what the person doing the interfering believes is for their own good) (Schramme 2015, 1). In the realm of bioethics, paternalism has long been a subject of derision. Medical paternalism is often perceived as a byword for clinical conduct that ignores patient autonomy. Endorsing a paternalistic view of the doctor-patient relationship seems to place doctors in a dominant position over patients. It licenses doctors to prioritize what they believe to be their patients' needs over their patients' rights, leaving patients acutely at their mercy (Beisecker and Beisecker 1993, 46). As Susan Sherwin (1992) puts it, "Medical tradition has been to grant physicians license to treat as they see fit, and physicians have long considered themselves authorized to

proceed with whatever medical care they judge most appropriate; patient consent has usually been treated as, at most, a formality” (137). Indeed, many view the desire to move away from medical paternalism as one of the main drivers behind the development of bioethics as a field (Schramme 2015, 1). According to Roger Dworkin (2003), “The most ballyhooed achievement of the bioethics movement has been the triumph of patient autonomy over medical paternalism” (235).

This disdain for medical paternalism presents a problem for the fiduciary model of the doctor-patient relationship because the fiduciary relationship is, at least to some degree, thought to be a paternalistic relationship. Daniel Markovits (2014) explains that fiduciary loyalty,

[B]uild[s] a measure of paternalism into every fiduciary relationship.... [E]ven where paternalism is not specifically required or permitted by law, it remains woven into the fabric of the fiduciary relation [because] the beneficiary has sought precisely the fiduciary’s independent and (in commensurate measure) unreviewable judgment, and thus also the paternalism that the exercise of this judgment inevitably involves. (217)

In other words, there is something inherently paternalistic about a fiduciary’s exercise of discretionary power. A fiduciary is obligated to use her own judgment about what course of action is in the best interests of her beneficiary. If we should reject paternalism in the doctor-patient relationship and if fiduciary relationships are inherently paternalistic, then we should reject the view that the doctor-patient relationship is fiduciary.

The literature on the tensions between paternalism and autonomy is vast, and I

won't attempt here to resolve the debate once and for all. However, what I will suggest is that the paternalism that is inherent in fiduciary relationships need not be the strong medical paternalism of the past. Rather, fiduciary paternalism is more accurately understood as a weaker form of paternalism, which may be manifested as 'guided paternalism' (Chin 2002, Lim 2002) and through 'nudging' (Thaler and Sunstein 2008). Guided paternalism is an approach that "sees the physician as [someone] who helps the patient in value clarification and in processing the various potential interventions" (Chin 2002, 154). According to this view, doctors should aim not only to discuss with patients what options they have, but also guide patients in determining what they *should* do based on their own values and goals. This approach acknowledges that patients, who must ultimately live with the consequences of medical treatment, should make the final decisions. Yet, it carves out a role for doctors to exercise their discretion in helping patients make the best choices for themselves. Guided paternalism, according to Chin (2002), acknowledges that doctors' efforts to promote a patient's best interests should include "facilitating and enhancing the latter's capacity for self-determination, in accordance to the patient's own perspectives," rather than acting against a patient's will (154).

A doctor's fiduciary paternalism may manifest in what Richard Thaler and Cass Sunstein (2008) call 'nudges', which are actions that steer someone in a certain direction, but leave open the option for them to choose another course.¹⁹ Thaler and Sunstein claim that nudges are not coercive since the individual being 'nudged' remains free to make her

¹⁹ See Leonard (2008) for a useful summary of their position.

own final decisions. Nudges exploit the fact that the architecture of choice can make a big difference in people's decision-making. Something as simple as the order in which information is disclosed or options are presented can have a large effect on what choices individuals make. For instance, in order to promote healthy eating, a school cafeteria may decide to place a salad bar at eye level and place junk food in harder to reach places (Thaler and Sunstein 2008, 1). While students would not be prevented from eating junk food, the arrangement of food makes it more likely that they will make healthier choices.

In the medical context, Thaler and Sunstein's research on choice architecture implies that it would be difficult for doctors to have no impact on their patients' decision-making. After all, information has to be disclosed in some order. If a doctor wishes to exercise her discretionary power in order to promote her patients' interests, then it would be wise to present choice options in a way that will guide her patients towards making good decisions. The alternative to such 'nudging' would be to intentionally refrain from presenting information in a way that would encourage an optimal outcome, which would hardly be a triumph for patient autonomy.

Accepting that doctors may be justified in engaging in this form of paternalism reflects the fact that patients typically seek out doctors precisely because they want to benefit from doctors' expert medical knowledge and skill. Doctors often do have a better understanding of patients' health interests, narrowly construed, than patients. Of course, patients' health interests are not the only relevant interests when making treatment decisions. Patients will often have to weigh health-related concerns against other concerns, such as religious or moral convictions or the effect that undergoing a particular treatment may have on the pursuit of their life goals. A concert pianist, for instance,

would have a difficult decision to make if faced with a choice between a highly effective treatment for cancer that might cause peripheral neuropathy (which can lead to difficulties in the fine motor skills required for playing the piano at a high level) and a somewhat less effective treatment with side effects that wouldn't inhibit her ability to play the piano. Even though her medical interests would clearly be better served by receiving the most effective treatment, she may still take into account the threat such a treatment may pose to her other interests. Importantly, a paternalistic approach need not seek to override or exclude such non-medical interests. It is unlikely that a doctor's guided paternalism or 'nudge' towards a particular treatment option would be strong enough to hinder a patient from giving great weight to a religious conviction or important life goal in her decision-making process.

It is true that even non-coercive paternalistic measures, like emphasizing the risks of forgoing a treatment, do reduce the sheer number of choices a patient can make. For instance, imagine that a doctor suspects that her patient is refusing to undergo chemotherapy out of fear of the negative side effects (perhaps he seemed fixated on the risk of hair loss and didn't seem to engage with other risks or benefits of treatment). The doctor, as a believer in guided paternalism, does not chide her patient, but rather requests that he take a one-week cooling-off period to thoroughly consider the risks and benefits of refusing treatment before making a final decision. She asks her patient to reflect on how refusing treatment will affect his life, and tells him that she will be available throughout the week to answer questions or to discuss things further. This approach does, in effect, remove one of the patient's options—namely, the option to immediately decline chemotherapy (Aggarwal, Davies, and Sullivan 2014). However, simply having more

options does not necessarily increase one's autonomy. Being able to choose amongst fewer options that have been curated by a medical professional who is obligated to advance your interests can be more conducive to making a good decision for yourself than receiving utterly comprehensive medical information with absolutely no guidance. I therefore claim that fiduciary paternalism, manifested as guided paternalism or nudging, is not a substantial threat to patient autonomy. A doctor can exercise discretion in providing information and recommending treatment options with the goal of helping her patients make the right decisions. Fiduciary powers can be exercised in a manner that supports, rather than competes with, patient autonomy.

On the other hand, one may argue that nudging is not a truly paternalistic intervention at all. Sherzod Abdulkadirov, Scott King, and David Wille (2016), for instance, have argued that although Thaler and Sunstein use the terms 'nudge' and 'libertarian paternalism' interchangeably, not all nudging is actually paternalistic (3). They argue that nonpaternalistic nudges simply "seek to identify the sources of biased behavior and to counter those biases through behavioral design" (Abdukadirov, King and Wille 2016, 16). Such nudges are not paternalistic because "they do not rely on identifying a specific optimal choice," and thus do not attempt to push the 'nudgee' to make the decision the 'nudger' thinks is best (ibid). One could make a similar argument about guided paternalism in general; it may not truly be paternalistic since it does not involve a doctor imposing decisions upon their patients against their will, but rather assisting them in making their own decisions. If this is the case, then Markovits may simply be wrong—there is nothing inherently paternalistic about fiduciary relationships.

Ultimately, whether or not fiduciary relationships are necessarily paternalistic hinges on how one understands paternalism. If paternalism always involves ignoring or overriding a competent individual's choices, then acting as a fiduciary need not—and likely should not—involve paternalism. However, I have argued that paternalism can consist in a fiduciary using the power she has been granted, as a professional with specific expertise, to exercise control over her beneficiary's interests in a way that is sensitive to his considered values and goals, and helps him advance them more effectively than he could on his own.

For instance, in the above example of the doctor who recommends that her patient take a cooling-off period before making a final decision about declining chemotherapy treatment, this doctor can be construed as imposing her judgments about what choice is optimal upon her patient (albeit in a non-coercive way). Yet, she does this precisely because she is justifiably concerned that her patient is basing his decision on a gut reaction of fear, and has not fully thought through the implications of his decision. Her hope is that through reflecting on his own values and life goals, he will realize that the benefits of undergoing chemotherapy outweigh the risks.²⁰ She believes that recommending a cooling-off period, although potentially limiting her patient's liberty in some respects, will actually help him make a decision that is truly in line with his considered life plan. In this sense, the doctor's exercise of fiduciary power is

²⁰ Of course, if after the cooling-off period, her patient still declines chemotherapy, then the doctor would respect his decision.

paternalistic, but it facilitates, rather than undermines, her patient's autonomy.

1.3.2 The Divided Loyalties Objection

The second concern is that doctors may be unable to act as loyal fiduciaries in the contemporary health care system. Marc Rodwin (1995) frames the problem as such:

Physicians have divided loyalties when they perform roles other than patient care or serve two or more patients with diverging interests. In these circumstances, pursuing legitimate roles may cause physicians to act in ways that are not in the best interests of at least some of their patients. In some situations, the law has even required physicians to act for the benefit of parties other than their patients. Although these cases are exceptions, they nonetheless limit the context and manner in which physicians can act as fiduciaries for patients. (251)

For instance, in cases of contagious disease outbreaks, doctors are sometimes charged with protecting public health by disclosing the illness to authorities or quarantining the patient. This can cause doctors to act in ways a fiduciary seemingly ought not to: by breaking confidence or by acting against their patient's desires. Moreover, in a world of finite resources, doctors typically function as gatekeepers to medical resources. They control the flow of services and access to specialists, and they may often make decisions in their gatekeeper capacity that aren't entirely consistent with promoting their patient's best interests, such as refusing to provide a patient with an expensive and only marginally beneficial service in order to serve their hospital's financial interests (Rodwin 1995, 252). In such cases, it seems as though doctors are permitted, or perhaps even required, to serve interests of parties other than their patients. Serving these interests puts strains on the

fiduciary picture of the doctor-patient relationship, leading “us to ask whether doctors can act as fiduciaries while acting on behalf of parties with different interests and whether it is helpful to consider physicians as fiduciaries” (Rodwin 1995, 255).

Does the fact that doctors often have obligations to multiple parties mean they cannot function as fiduciaries to their patients? Rodwin suggests not. He claims that there is precedent for courts and legislatures to balance competing interests within a fiduciary framework. Lawyers, for instance, are expected to act loyally in advocating for their clients, while simultaneously functioning as officers of the court who must protect the integrity of the judicial system (265). Similarly, parents, who are regarded as fiduciaries in Canadian law (see *M (K) v M (H)* [1992] 3 SCR 6), will clearly have multiple loyalties if they have more than one child. Rodwin suggests that it is only when a doctor’s loyalties create “too great a conflict and there are no adequate ways to resolve these conflicts” that a doctor’s multiple roles will present a problem for their ability to act as a loyal fiduciary (256). In general, Rodwin claims that doctors can occupy fiduciary-like roles vis-à-vis their patients, and also be able to take into account the interests of other patients or parties.

Although I agree with Rodwin that the specter of divided loyalties does not undermine the case for viewing the doctor-patient relationship as fiduciary, I do think more needs to be said about what competing obligations are legitimate. Take, for instance, the question of whether or not doctors ought to accept gifts from pharmaceutical companies (Mehlman 2015, 45). How ought we to determine whether accepting such gifts violates doctors’ fiduciary duty of loyalty? As Stephen Toulmin (1986) puts it, what is needed is a way of clarifying when conflicts, or the potential for conflicts, within the

fiduciary relationship “escalate into a larger question of divided loyalties or fiduciary ambiguities” (783).

To answer this question, further examination of fiduciary loyalty is required. Recall that the goal of fiduciary loyalty is primarily to protect the beneficiary from abuses of discretionary power. There are two requirements of this duty: a positive obligation to act in a beneficiary’s relevant interests, coupled with a prophylactic requirement that fiduciaries avoid situations where they might be tempted to act otherwise (Smith 2003, 3). According to Lionel Smith (2003), these two elements are fundamentally connected to the fiduciary’s motives. Smith argues that in the fiduciary context, “Disloyalty is a matter of motive” (21). Smith explains that “the heart of the fiduciary obligation is the surveillance and the justiciability of motive. Whatever powers a fiduciary has, he must exercise them (or not exercise them) with a particular motive. He must act (or not act) in what he *perceives to be* the best interests of the beneficiary” (14). Smith’s arguments have a great deal of intuitive appeal. After all, if a fiduciary used her discretionary power in a self-interested way, which by chance also happened to bring about an outcome that was in her beneficiary’s interest, most would agree that the fiduciary was still abusing her power. The fact that the action turned out to be in the beneficiary’s interests is not, therefore, sufficient to conclude that the fiduciary acted loyally. Understanding fiduciary loyalty as a matter of motive also deepens our understanding of the aforementioned prophylactic requirement. Preventing fiduciaries from entering into situations where they may have conflicts of interest can be viewed as a means of protecting their *motives* from being compromised. Of course, fiduciaries’ actions can still be evaluated on the basis of outcomes (for instance, outcomes are relevant when considering whether a fiduciary

exercised due diligence). However, if a fiduciary fails to perform her role competently, this is not in and of itself a violation of loyalty. A lawyer can be a terrible lawyer without ever being disloyal.

The question then becomes: how do we evaluate a fiduciary's motives? In general, the (dis)loyalty of motives can be evaluated with reference to the reasons for which the fiduciary powers in question were granted. When determining whether or not a fiduciary acted loyally, one must look to whether or not she was attempting, in good faith, to use her discretionary power to achieve the ends for which she was empowered in the first place. This type of evaluation has some clear implications, such as the exclusion of self-interested motives. If a fiduciary uses the powers she has been granted over another's interests with the goal of promoting her own interests, she is obviously failing to act loyally. She wasn't granted such powers so that she could profit. However, this approach also has some more subtle implications that have to do with the complex questions of loyalty that Rodwin discusses.

I argue that evaluating a doctor's motives, when they stem not from self-interest but rather an interest in protecting public health or effectively distributing limited medical resources, for instance, requires that we understand the doctor's professional role. In terms of the doctor-patient relationship, it is often acknowledged that doctors have professional obligations that go beyond their relationships with individual patients. The medical profession is defined and justified not only by the relationship between doctors and their patients, but also in terms of the importance of the profession's societal function (Kolars 2014). Regardless of whether one wholly endorses a 'social contract' view of the relationship between the medical profession and society, it is difficult to deny that society

has certain legitimate expectations of the profession vis-à-vis the public good. As Richard Cruess and Sylvia Cruess (2004) put it, “Inasmuch as the profession is given a monopoly over the practice of medicine, it is expected that its members will address the problems faced by individual patients and also concern itself with issues of importance to society” (2). For instance, it is widely agreed that the medical profession as a whole is obligated to provide treatment to patients with communicable diseases, even if doing so places doctors’ own health at risk (Daniels 1991, Hui 2005b).²¹ Treating such patients is a matter of public good, not just a concern for individual patients.

Given doctors’ social and professional role, I argue that it is legitimate for their uses of discretionary power to sometimes be motivated, in part, by the larger obligations they have to society *qua* medical professionals. This ought not to be viewed as disloyalty, I claim, because patients do not just grant doctors’ power over their interests with the goal of promoting their health. Patients also empower doctors to act in their interests insofar as they are members of a society that has a collective interest in the public good. In that sense, a highly contagious patient also has an interest in being quarantined, even if, in the moment, she believes she has a greater interest in being allowed to travel internationally. A similar argument could be made for other fiduciaries, such as lawyers who, as aforementioned, function both as advocates for their clients and also as officers of the court who uphold the principles of justice. This view coheres well with Frankel’s (2011) claim that fiduciaries who provide professional services can have not only

²¹ There is debate, however, regarding to what degree individual doctors must discharge this duty (Freedman 1988).

individuals or groups as beneficiaries, but also the public at large. Members of the professions, she claims, can be rightfully expected to use their fiduciary powers to meet society's needs in addition to the needs of particular beneficiaries (Frankel 2011, 36). While obligations to individual beneficiaries and the public may sometimes clash, I claim that the duty of loyalty is not designed to rule out such conflicts. In public health crises, doctors can grapple with the competing interests of their patients and society without necessarily violating their fiduciary obligation of loyalty.

What fiduciary loyalty ought to rule out, however, is the consideration of interests that do not stem from doctors' professional roles *qua* doctors. These are not limited to self-interested motivations. Doctors can have all sorts of altruistic motivations that do not stem from their professional role, such as motivations to do with religious or political beliefs. It would be just as inappropriate for a doctor to fail to inform a patient of promising treatment options due to a religious belief as it would be for a doctor to fail to inform a patient of promising treatment options since they would be very costly for the doctor's clinic. Indeed, understanding the goals and requirements of loyalty as such can also provide doctors with a tool to resist forces that seek to undermine their ability to act loyally to their patients (Mehlman 2015, 48). As Mehlman points out, entities such as managed care plans and hospitals that place doctors in positions that require them to act out of inappropriate motivations could be held liable for interfering with doctors' fiduciary duties (2015, 63).

1.4 Conclusion

In this chapter, I have defended the view that doctors' obligations to their patients are best understood as stemming from the fiduciary nature of the doctor-patient relationship. Following P. B. Miller, I claimed that a fiduciary relationship is a relationship in which one person exercises discretionary authority to set or pursue the significant practical interests of another. I then argued that the doctor-patient relationship satisfies this definition since doctors wield considerable discretionary power over the health interests of patients. Finally, I addressed two concerns with the fiduciary characterization of the doctor-patient relationship—the paternalism objection and the divided loyalties objection. I argued that the fiduciary model, although perhaps paternalistic to a degree, need not involve the problematic paternalism of old medicine. Finally, I claimed that doctors are able to act loyally to their patients, so long as their exercise of discretionary power is not motivated by concerns with self-interest or interests that do not stem from their role as doctors.

Chapter 2

2 The Doctor-Surrogate Relationship as Fiduciary

Although the ethics of surrogacy have been discussed for decades, the growth of the global commercial surrogacy industry, coupled with high-profile scandals,²² has given rise to heated public and academic debate in recent years. The ethical and legal analyses of surrogacy have been rich and varied. Some have focused on criticizing the practice, arguing that transnational surrogacy arrangements lead to the exploitation of impoverished women in the global south (Panitch 2013a), or with the impermissible commodification of women's reproductive capacities (Anderson 2000). Others have examined the motivations of contracting couples (Parks 2014), or have looked at the negative effects that surrogacy has on children (Overall 2015). Some feminists have rejected the practice entirely, viewing it as 'baby-selling' or as inherently demeaning to women (Anderson 1990), while others have praised the potential for economic empowerment and control over one's body that surrogacy may accord to women (Teman

²² For instance, the case of baby Gammy, an infant with Down Syndrome born to a Thai surrogate who was left behind by his Australian intended parents, garnered a great deal of international attention (Saul 2014). I will discuss this case in greater detail in Chapter 4.

2001). However, throughout these explorations of the ethics of surrogacy, comparatively little attention has been paid to the moral status of a crucial actor: the fertility doctor.²³

Without doctors willing to provide prenatal and postnatal care to surrogates and make use of assisted reproductive technologies (ARTs) for the purposes of surrogacy, commercial surrogacy would cease to take place. However, participation in this industry presents many ethical dilemmas for doctors. Typically, fertility doctors involved in commercial surrogacy arrangements provide medical care for surrogates, but they are hired by commissioning couples. The interests of the couple may not always align with the interests of the surrogate, especially when it comes to decisions about multiple pregnancy, birth defects, and selective reductions. Thus, the potential for conflicts is

²³ As aforementioned, there have been a few bioethicists who have considered this issue (Rothenberg 1988, 1990; Ber 2000; Daar 2014; Rafique and DeCherney 2014). I explore Rothenberg, Ber, and Daar's views on doctors' participation in surrogacy in Chapter 3. I do not discuss Rafique and DeCherney's article separately because they come to roughly the same conclusion as Daar on the issue of non-consensual disclosure of information to commissioning couples (although Rafique and Decherney's case involves a doctor entering information into the surrogate's medical records rather than directly informing the commissioning couple).

great.²⁴ How are doctors involved in surrogacy to navigate these situations?

In order to answer this question, it is important to understand what duties doctors have when they participate in commercial surrogacy arrangements and why they have them. In this chapter, I aim to provide a framework for conceptualizing these duties: the framework of fiduciary obligation.²⁵ First, I will provide an account of the doctor-surrogate relationship in practice, and give an initial explanation as to why the relationship between fertility doctors and surrogates should be viewed as a doctor-patient relationship. Given my arguments in Chapter 1 about the fiduciary nature of the doctor-patient relationship, I suggest that the doctor-surrogate relationship should therefore also be viewed as normatively fiduciary. Then, I consider an objection to this view, the *difference position* objection, which takes inspiration from the literature on medical research ethics. The difference position objection states that since the aims and nature of commercial surrogacy are distinct from the aims and nature of therapeutic medical practice, the two realms ought to be governed by their own distinct ethical norms. The fiduciary duties doctors have towards their patients, according to the objection, do not

²⁴ As I will discuss below, Chapter 3 is devoted to considering whether or not it is actually possible for doctors involved in commercial surrogacy arrangements to avoid conflicts of interest.

²⁵ I provide a rough version of the argument for why the doctor-surrogate relationship is fiduciary in Ryman and Fulfer (2017). However, the argument I provide here is much more refined, and includes an explicit discussion of the duty of loyalty.

necessarily apply to their relationship with commercial surrogates. To respond to this objection, I argue that regardless of whether commercial surrogacy is sufficiently analogous to therapeutic medical practice, the relationship between surrogates and the doctors who treat them is nonetheless fiduciary. Given the discretionary authority that doctors wield over surrogates' significant practical interests, the doctor-surrogate relationship satisfies the fiduciary principle I defended in Chapter 1, and doctors involved in treating surrogates therefore owe them the duty of loyalty.

2.1 The Doctor-Surrogate Relationship

In this section, I explore the relationship between fertility doctors and commercial gestational surrogates in practice, and explain why it is intuitive to view the doctor-surrogate relationship as a form of doctor-patient relationship. The roles fertility doctors play in surrogacy vary depending on the circumstances in which surrogacy arrangements take place. A country's laws, health care regimes, and societal attitudes towards surrogacy can shape the degree of involvement fertility doctors have in surrogacy arrangements, and what legal and professional responsibilities they have. For instance, a doctor who is employed at a surrogacy clinic in India will often be involved with regulating and monitoring the diet, exercise, and general day-to-day activities of a surrogate living in a surrogacy hostel (Pande 2014a). Such living arrangements grant doctors a considerable level of access to and control over surrogates' lives, which is rare if not entirely absent in other surrogacy destinations like California (where surrogates typically live in their own homes for the duration of their pregnancies).

Nonetheless, despite variations in the particulars of surrogacy arrangements, I argue that surrogacy inevitably involves the development of a doctor-patient relationship between fertility doctors and the surrogates they treat. If it is true that the doctor-surrogate relationship is simply a type of doctor-patient relationship, then, like the doctor-patient relationship, it should be understood as being fiduciary. It is widely acknowledged that a doctor-patient relationship is formed “when a physician affirmatively acts in a patient’s case by examining, diagnosing, treating, or agreeing to do so” (Blake 2012, 404; see also Bush 2010). Although a woman serving as a surrogate often does not require medical diagnosis, she clearly undergoes examination and treatment.

The gestational surrogacy process is highly medicalized, and involves considerable clinical interaction between doctors and surrogates. According to the website for the organization “Surrogacy in Canada,” the gestational surrogacy process can involve a range of treatments and interventions, including taking birth control pills or hormone injections to coordinate cycles with the oocyte provider, undergoing embryo transfer (which involves a reproductive endocrinologist inserting a speculum into the vagina, inserting a catheter through the cervix and into the uterus, and then transferring the embryos through the catheter into the uterus under ultrasound guidance), taking a blood test to check for pregnancy, and having to take various fertility medications for 10-14 weeks post-conception (“FAQ”, *Surrogacy in Canada Online*). Additional medical procedures involved in the surrogacy process can include amniocentesis or chorionic villi sampling to test for chromosomal abnormalities or fetal infections, selective fetal reductions in cases of multiple pregnancy, or caesarian sections. Given that the doctor-surrogate relationship involves such examination and medical treatment, it seems to meet

the conditions for the establishment of a doctor-patient relationship. Since, as I argued in the previous chapter, the doctor-patient relationship is fiduciary, the doctor-surrogate relationship should also be regarded as such. This means that doctors involved in treating surrogates owe them the duty of loyalty, which includes the obligation to act in surrogates' best interests and to avoid conflicts of interest.

2.2 The Difference Position Objection

However, one may object that simply being examined and treated by a doctor is not actually sufficient to make an individual a 'patient.' For instance, doctors examine clinical trial participants and administer medical interventions in the context of research. Yet, Howard Brody and Franklin G. Miller (2003) have argued that research subjects are not patients, nor do they stand in traditional doctor-patient relationships with researchers. Brody and F. G. Miller refer to this view as the *difference position*.²⁶ The difference position holds that clinical research and therapeutic medical practice should each be governed by their own set of ethical rules and principles. As Brody and F. G. Miller (2003) put it, the difference position maintains:

[R]esearch and clinical practice are distinct activities with very different goals—the former is intended to produce general medical knowledge to benefit future patients, while the latter is aimed at producing a therapeutic benefit for the

²⁶ I also discuss Brody and F. G. Miller's difference position in Ryman and Fulfer (2017), but I do not apply it to the surrogacy context there.

individual patient. Both research subjects and patients in the therapeutic setting have basic rights that have to be respected, but one should not expect that the same ethical principles necessarily would apply in both of these distinct settings.

(330)

Brody and F. G. Miller developed this view in response to what they call the *similarity position*, which views medical research as normatively continuous with therapeutic practice. The similarity position is mistaken, they claim, because it fails to recognize the different underlying justifications for research and treatment, respectively. In the therapeutic context, a doctor's goal is to benefit her patients, who have typically sought her help due to illness. When she makes medical judgments or provides treatments, she does so primarily on behalf of individual patients. On the other hand, when it comes to medical research, the doctor-researchers involved are not primarily acting on behalf of their research subjects. Rather, researchers perform medical interventions upon subjects primarily for the benefit of future patient populations. The good they hope to achieve is a future good for society, not necessarily a good for one individual patient. According to Brody and F. G. Miller, this distinction does not mean that researchers have no obligations to subjects, but rather that the content and justification of their duties is context dependent. For instance, they claim that in both research and treatment, doctors have a duty to avoid causing harm. In the case of medical treatment, the doctors' obligation to do no harm is derived from the duty of therapeutic beneficence they have towards their patients. In the case of medical research, Brody and F. G. Miller argue that

the obligation is derived from a duty of non-exploitation.²⁷

This distinction, according to Brody and F. G. Miller, means that in the context of research, doctors' conduct need not be guided by duties they typically have towards individuals whom they examine and treat, such as their fiduciary obligations. As they put it,

One important ethical consequence of the difference position is that the investigator, in contrast to the treating physician, *cannot be seen as having a fiduciary relationship with research subjects*, including those who have a prior physician-patient relationship with the investigator. In research, the investigator cannot in good faith promise fidelity to doing what is best medically for the patient-subject. It follows that to a greater or lesser extent the therapeutic obligation of the treating physician must be suspended in the course of research. (336, my emphasis)

In sum, even though research and treatment both involve doctors examining, diagnosing,

²⁷ Brody and F. G. Miller (2003) claim, “the harm-avoidance duty that the investigator owes the subject is best understood as one of a number of duties that can be viewed collectively as non-exploitation” (336). They argue that the duty of non-exploitation requires investigators to ensure that the risks of trial participation are “minimized, consistent with conducting scientifically valid research, and justified both by the potential benefits to subjects (which may be lacking entirely) and by the potential value of the knowledge to be gained from the research” (*ibid*).

or treating individuals, the fact that doctors do so with ‘very different’ goals in mind means, according to Brody and F. G. Miller, that they owe those who are being treated or examined different obligations.

It is easy to see how this type of argument could be extended to the realm of commercial surrogacy. Brody and F. G. Miller’s view is based in the principle that “the clearest ethical thinking on an activity is obtained when one understands best the nature and goals of that activity” (334). Applied to surrogacy, this would require that we consider the nature and goals of commercial surrogacy when deliberating about the ethical norms that should guide it. Just as Brody and F. G. Miller contrast the aims of medical treatment with the aims of medical research, so too can we contrast the aims of typical fertility treatment with the aims of commercial surrogacy.

When it comes to treatment for infertility, patients generally receive medical interventions with the goal of overcoming infertility and enabling them to conceive and birth healthy children. There is some debate as to whether or not infertility is a disease (McTernan 2015; McLeod 2017). Moreover, even if infertility is a disease, IVF treatment does not actually ‘cure’ infertility (Shannon 1987, 156-157). Nonetheless, most patients seeking fertility treatment are suffering from a condition they hope to alleviate through medical intervention. This may create a particular type of vulnerability and dependence upon doctors, akin to the vulnerability caused by the “fact of illness” (Pellegrino 1979). As Virginia Sharpe (1997) explains, illness is,

characterized by a sense of disruption, by anxiety, uncertainty and often fear and pain that together force us to place ourselves under the power of another person—

the health professional. The vulnerability that we experience as a result of illness is thus compounded by the fact that the possibility of benefit depends on our willingness to reveal our bodies, our personal lives and personal histories to another. We must entrust to the health professional those things about which we care most deeply. (202)

Regardless of whether infertility is truly an illness, it can lead to the type of vulnerability that Sharpe describes. Anxiety, fear, and uncertainty about one's ability to conceive children is often what leads individuals to seek out fertility treatment, and thereby make themselves dependent upon health care professionals (Cousineau and Domar 2007). Thus, the relationship between doctors and patients in fertility medicine results from a fundamentally therapeutic motivation: to alleviate the distress associated with infertility.

On the other hand, in the context of commercial surrogacy, women usually receive medical interventions with the goals of obtaining financial compensation and helping infertile individuals or couples form families. Unlike typical fertility patients, surrogates do not seek out the help of fertility doctors in the hopes of 'getting well.' While surrogates are often vulnerable, due to poverty or lack of education for instance, they may lack the particular kind of vulnerability Pellegrino and Sharpe regard as being central to understanding the ethics of the doctor-patient relationship: that is, the vulnerability caused by the 'fact of illness.' The relationship between surrogates and fertility doctors is not initiated out of illness-related vulnerability, but rather out of a

desire for financial gain.²⁸ Indeed, there is a great deal of work on surrogacy that advocates for viewing it more explicitly as a form of wage-earning labour, and for granting surrogates various worker's rights.²⁹ The doctor-surrogate relationship may therefore be understood as a commercial relationship that bears few morally relevant similarities to the relationship that exists between doctors and patients in the context of medical treatment.

Thus, a proponent of the difference position may conclude that commercial surrogacy and fertility treatment should be treated as distinct realms of activity. The doctor-surrogate relationship should be regulated by its own set of ethics and norms that are independent of the ethics that govern doctor-patient relationships in fertility medicine. It is beyond the scope of this chapter to fully flesh out what such a set of distinct norms might include (especially since I will ultimately reject the difference position). Perhaps a contractual approach, which treats doctors and surrogates as being bound only by the terms of a mutually beneficial agreement, could be adopted. In any case, the logic of the difference position implies that fertility doctors should suspend their typical therapeutic obligations when treating commercial surrogates. They should perhaps function more as technical specialists helping surrogates earn money for their reproductive labor, rather

²⁸ Altruism also often plays a motivational role in commercial surrogacy.

²⁹ See, for example, Cooper and Waldby 2014 or Pande 2014b. Katy Fulfer and I argue that viewing surrogates as workers is not incompatible with also viewing them as standing in fiduciary relationships with doctors (Ryman and Fulfer 2017).

than as doctors providing care for patients.

One potential response to the difference position is that commercial surrogacy and fertility treatment do share a crucial common goal, namely producing children for infertile individuals or couples. Rather than being viewed as a distinct enterprise, surrogacy should be understood as a form of medical intervention that is continuous with *in vitro* fertilization (IVF)—the ‘next’ step in fertility treatment. This view would imply that there is, in fact, a genuine doctor-patient fiduciary relationship that arises in the context of commercial surrogacy: the relationship between the infertile individual or couple and their fertility doctor. When she performs medical interventions on a surrogate, the fertility doctor should therefore be seen as acting on behalf of the commissioning couple (who are her true patients).³⁰ According to this view, the nature and aims of commercial surrogacy are not distinct from the nature and aims of fertility medicine, at least when it comes to the relationship between fertility doctors and infertile individuals or couples. Therefore, the two realms of practice should be governed by the same norms.

However, this response does not refute the logic of the difference position when applied to the doctor-surrogate relationship. Although the goals of surrogacy and other forms of infertility treatment may be the same from the perspective of the infertile individual or couple, the nature of the relationships that arise between doctors and surrogates may, according to the difference position, be much more like researcher-

³⁰ This view about doctors acting on behalf of commissioning couples while treating surrogates is, as I will explain in Chapter 3, deeply problematic.

subject relationships than doctor-patient relationships. In both cases, the doctors may be seen as acting not on behalf of the individual they are ‘treating,’ but rather on behalf of a third party (future patient populations or infertile couples, respectively). The difference position objection could therefore retain its force when considering the norms that should govern doctors’ obligations to surrogates.

2.3 The Fiduciary Relationship Between Fertility Doctors and Surrogates

In this section, I respond to the difference position objection by arguing that the fiduciary nature of the doctor-surrogate relationship does not depend on it being sufficiently similar to the traditional doctor-patient relationship. Rather, the doctor-surrogate relationship is normatively fiduciary due to the structure of the relationship, which involves fertility doctors wielding discretionary power over surrogates’ significant practical interests. In other words, I will argue that it does not matter if commercial surrogacy and fertility medicine are distinct activities with different goals; the norms of fiduciary obligation still apply in both areas of practice.

However, before I make this argument, I want to acknowledge that for some, applying the difference position to the realm of surrogacy may read like a *reductio*. For those who have the intuition that surrogates are clearly patients, a convincing analogy between surrogates and human research subjects may constitute a reason to outright reject the difference position (as it applies to both surrogacy *and* medical research). On the other hand, those who find the difference position appealing in the realm of research but

disagree with it in surrogacy may be able to argue that the two don't stand and fall together, and that there are morally relevant differences that render the analogy inappropriate. I don't intend to engage in such a debate here. My discussion of the difference position is merely intended to give an account of why some might be skeptical about viewing surrogates as patients.

To explain why the relationship between fertility doctors and surrogates is fiduciary, I return to the analysis of the doctor-patient relationship I provided in Chapter 1. In that chapter, I defended Paul B. Miller's definition of the fiduciary relationship as a relationship wherein one party exercises discretionary authority to set or pursue the significant practical interests of another. I then argued that the doctor-patient relationship is fiduciary because doctors exercise discretionary authority to pursue the health interests of their patients. To establish that the doctor-surrogate relationship is fiduciary, I adopt the same approach. That is, I examine the doctor-surrogate relationship and determine whether it involves doctors exercising discretionary authority over surrogates' significant practical interests.

This approach takes inspiration from P. B. Miller and Charles Weijer's (2006a) response to the difference position in the realm of medical research. P. B. Miller and Weijer do not attempt to refute Brody and F. G. Miller's claim that the goals and nature of medical research differ from medical practice. Rather, they argue that researchers wield considerable discretionary authority over the significant practical interests of subjects, and that the researcher-subject relationship therefore satisfies the fiduciary principle (P. B. Miller and Weijer 2006a, 430-431). P. B. Miller and Weijer do not hinge the fiduciary status of the researcher-subject relationship upon it being sufficiently

analogous to the doctor-patient relationship per se. They argue that it is fiduciary based on the nature of the power wielded by researchers. I take up this tactic when responding to the difference position view of the doctor-surrogate relationship. That is, instead of attempting to argue away the differences between the goals and nature of fertility medicine and those of surrogacy, I argue that the doctor-surrogate relationship independently satisfies the fiduciary principle. This means that doctors cannot simply suspend their fiduciary obligations to surrogates in the context of commercial arrangements.

First, I will show how surrogates' significant practical interests are at stake in surrogacy arrangements. Then, I will illustrate how fertility doctors have discretionary power over those interests. Finally, I will argue that the power that these doctors wield is properly understood as the authority to act on surrogates' behalves, relative to their significant practical interests. In doing so, I will establish that even if commercial surrogacy is importantly different from therapeutic medical practice, the relationships that arise within it between doctors and surrogates are nonetheless fiduciary.

When engaged in commercial surrogacy, women's significant practical interests are clearly at stake. Like typical fertility patients, surrogates receive medical treatments and tests that carry with them varying physical, psychological, and emotional risks. As aforementioned, these procedures may include the injection of fertility hormones, the transfer of embryos, abortion, or caesarian sections. Moreover, while pregnancy and childbirth already pose risks—including eclampsia, gestational diabetes, and death—the use of ARTs creates additional hazards. Fertility doctors often implant multiple embryos

in surrogates to increase the success rate of pregnancy. Such practices can lead to either multiple births, or to surrogates having to undergo selective fetal reductions, both of which pose serious health risks (Tanderup et al. 2015a). There have even been reports of surrogates dying as a result of birth complications (Carney 2010, ref. in Pande 2014, 15; “Surrogate Mother Dies of Complications” 2012, ref. in Pande 2014, 15). Given these serious risks, it would be difficult to deny that surrogates put their significant health interests in the hands of their doctors.

Of course, the fact that surrogates’ significant practical interests are at stake does not in and of itself mean that the doctors who treat them owe them fiduciary obligations. Doctors must exercise discretionary authority over those interests in order for their relationship to be considered fiduciary. I claim that when surrogates consent to participate in surrogacy, they grant doctors discretionary power over their health interests. Some of these powers are the same as those that exist in a traditional doctor-patient relationship, such as the power to diagnose illness and to gather medical histories. However, some of these powers are more specific to the circumstances of surrogacy and assisted reproduction. For instance, fertility doctors are often granted an enormous amount of discretion in decisions surrounding the number of embryos to implant in a surrogate, and whether or not to proceed with selective fetal reductions. Malene Tanderup and colleagues’ study of Indian surrogacy clinics (2015a) revealed that decisions made about the number of embryos to implant were almost always made by doctors alone. Twelve of the clinics she studied had doctors who unilaterally made all of the decisions about the number of embryos transferred, four clinics involved commissioning couples in the decision-making, and only one clinic involved the doctor, commissioning couple, and

surrogate (Tanderup et al. 2015a, 469). When it came to decisions about selective reductions, only three clinics viewed fetal reduction as being a joint decision between the doctor, commissioning couple, and surrogate, with other clinics treating it as a decision to be made by doctors alone, or by doctors in conjunction with the commissioning couple. Tanderup et al. also noted that surrogates were not always told the number of fetuses they were carrying before undergoing fetal reduction (ibid).

Moreover, even in cases where surrogates are involved in the medical decision-making process, as they rightfully should be, they still must rely upon their doctors to provide competent medical advice and treatment. This reliance is due to the fact that surrogates typically lack the relevant medical expertise to evaluate their doctors' recommendations and overall competency. Surrogates may, for instance, genuinely not know whether they have the physical capacity to safely carry twins or triplets, and must therefore rely on their doctors' expert medical opinion. Surrogates' reliance on doctors may be particularly pronounced in situations where they are obligated to receive preconception and/or early pregnancy care from doctors who are chosen by commissioning couples since it may be difficult for them to seek out second opinions in such cases.

Yet, is this discretionary power that fertility doctors wield properly understood as authority? Recall P. B. Miller's claim about what it means to have fiduciary power. Fiduciary power does not consist in simply having the capacity to affect or influence another's interests. Rather, having fiduciary power means having the authority to act relative to the significant practical interests of another in a substitutive exercise of a legal capacity. For instance, returning to the personal trainer example from Chapter 1, although

my trainer may have the power to affect my health interests (insofar as she can help me exercise effectively or, conversely, cause me to injure myself), she does not have the authority to act on my behalf when it comes to my health interests.

Do fertility doctors have this type of authority over surrogates' interests? I claim that they do. Recall that legal capacities include not only explicitly legalistic abilities, like the ability to enter into a legally binding relationship, but also the capacity to make decisions about one's welfare. When women consent to serve as gestational surrogates, they effectively empower the fertility doctors who treat them with the authority to exercise on their behalf the capacity to make decisions about their health and well-being. While surrogates can still consent to or refuse specific treatments (or at least, they ought to be able to), doctors often exercise discretionary authority before treatment options are even presented. Doctors make discretionary judgments in determining what tests or treatment options are warranted, and what information should be supplied to surrogates in the course of obtaining their consent.

A striking example of how doctors' authority can operate comes from Elly Teman's work on surrogacy in Israel.³¹ She notes that in standard contracts in Israel, surrogates are bound to comply with the medical recommendations of their doctors. Although Israel's patients' rights laws technically protect surrogates (so that they cannot

³¹ Surrogates in Israel can be paid for their services; however, there is not the same type of commercial surrogacy industry in Israel as there is in the United States, for instance, since surrogacy in Israel is run by the state. I thank Christine Overall for this point.

be literally forced to obey their doctor's recommendations), refusals are treated as breaches of the surrogacy contract. As Teman (2010) explains, surrogates are therefore "implicitly forced to comply because they would otherwise have to reimburse a couple for all payments made until that point and to pay them an additional fine amounting to thousands of shekels" (87-88). In circumstances like this, where it is difficult for surrogates to refuse treatment recommendations, doctors' authority over their interests is especially pronounced.³² Yet, as discussed above, even in cases where surrogates are not contractually committed to abiding by doctors' judgments, they have still delegated the powers to diagnose and recommend treatments to their doctors. While the scope of doctors' discretionary powers varies across different surrogacy contexts, in all cases doctors clearly wield some degree of authority over surrogates' significant practical interests. Therefore, although surrogates typically do not experience the so-called 'illness-related' vulnerability that may result from experiencing infertility, they are

³² Although there is no comprehensive data on how commonly this type of situation occurs, the surrogacy contracts I've come across thus far have all included language about surrogates being obligated to abide by the medical recommendations of the treating doctor (who may be selected by the commissioning couple or a surrogacy agency hired by the commissioning couple). I would venture that most commercial surrogacy arrangements involve doctors having this type of pronounced power over surrogates' interests.

nonetheless highly vulnerable to doctors' exercises of discretionary power.³³

Finally, as with all fiduciary relationships, the power that doctors wield over surrogates' interests is clearly purposive. The aim of a surrogacy arrangement is to produce a healthy child for a commissioning couple. Thus, surrogates give fertility doctors power over their health interests in order to achieve this end. Indeed, a fertility doctor would be misusing her fiduciary power if she did not act with this goal in mind. However, the purpose of granting fertility doctors such power is also to protect the health interests of the surrogate. Doctors are granted power over surrogates' health interests precisely because doctors have the knowledge and ability to safely perform the procedures involved in surrogacy. In that sense, the relationship between surrogates and their doctors is not all that different (or at least, it ought not to be that different) from the relationship between a patient struggling with fertility and her reproductive

³³ P. B. Miller and Weijer make a similar point in their defense of the fiduciary characterization of the doctor-subject relationship. They argue that although research subjects are often vulnerable by virtue of being ill, this type of 'circumstantial' vulnerability is not relevant for determining whether they are owed fiduciary duties. They argue that although vulnerability is a key characteristic of fiduciary relationships, it is the structural vulnerability that arises from subjecting one's significant practical interests to another's exercise of discretionary power that matters (P. B. Miller and Weijer 2006a, 430). Illness-related vulnerability may be a relevant consideration for justifying other obligations doctors have to their patients (for instance, perhaps they have duties pertaining to good bedside manner), but these obligations are not fiduciary.

endocrinologist. In both cases, there is a desire to bring a healthy infant into the world and the need for medical intervention. In the latter case, a doctor would be acting unethically if she allowed the goal of bringing a child into the world to override her concern for protecting the health and well-being of the woman being treated. The same should be true in the former case involving the surrogate. The goal of bringing a child into the world should not trump the need for due concern about the health of the woman doing the gestating, regardless of who will ultimately parent the child.

One interesting feature to note is that, on my account, the goals of commercial surrogacy are important for considering what constitutes ethical conduct within the doctor-surrogate relationship. In that sense, I agree with Brody and F. G. Miller; goals do matter. However, we part ways when it comes to what goals matter for (that is, whether the goals of a relationship can determine whether it is fiduciary). Recall that according to a difference position view of surrogacy, the goals of commercial surrogacy are so different from the goals of fertility medicine that doctors' fiduciary duties can be suspended in commercial surrogacy. However, I claim that the features of the relationship itself (i.e. whether there is a delegation of power, whether one party is acting on behalf of another, whether a party's significant practical interests are in the hands of another, and so on) are what matter for evaluating whether a relationship is normatively fiduciary. Understanding the goals of the relationship is most important for determining what constitutes appropriate exercise of fiduciary power. To evaluate a fiduciary's use of power, one must understand *why* she was granted those powers. In short, an examination of the goals of a relationship matter more for evaluating a fiduciary's conduct than they do for determining whether a fiduciary relationship has been established in the first

place.³⁴

In all, regardless of whether commercial surrogacy is morally continuous with therapeutic medical practice, the doctor-surrogate relationship (like the doctor-patient relationship) is normatively fiduciary. It involves one party (the fertility doctor) exercising discretionary authority over the significant practical interests of another (the surrogate). Therefore, doctors who treat surrogates owe them fiduciary obligations, as discussed in Chapter 1. In particular, fertility doctors are obligated to uphold the fiduciary duty of loyalty, which includes the duty to avoid conflicts of interest and the duty to wield their discretionary power solely in pursuit of surrogates' interests.

One may wonder, however, if it is actually possible for doctors to act loyally to surrogates. At the end of section 2.2, I raised the possibility that the relationship between a doctor and a commissioning couple may also be a fiduciary relationship. If a doctor were in a fiduciary relationship with both a commissioning couple and also their surrogate simultaneously, then this would likely generate a conflict of interest. In the following chapter, I turn to this question of whether doctors can actually uphold their

³⁴ In general, when considering what obligations a particular relationship should involve, it may be useful to draw a distinction between the goals of the relationship and its normative structure. The goals of different types of fiduciary relationships are diverse, but they fall under the category 'fiduciary' due to their shared normative structure. Interpersonal trust relationships, for instance, may also function in this way. I thank Dennis Klimchuk for this point.

fiduciary duty of loyalty when involved in surrogacy arrangements. To put it in Brody and F. G. Miller's terms, I explore whether doctors can "in good faith promise fidelity to doing what is best medically" for surrogates (2003, 336).

2.4 Conclusion

In this chapter, I argued that the relationship between surrogates and fertility doctors ought to be regarded as fiduciary, regardless of whether or not one accepts the view that all of the norms of the doctor-patient relationship should automatically apply to the doctor-surrogate relationship. I began by outlining some features of the doctor-surrogate relationship, and by suggesting that it is a form of a doctor-patient fiduciary relationship. Then, I addressed an objection to this view, the *difference position* objection, which claims that the doctor-surrogate relationship is morally distinct from the doctor-patient relationship, and should therefore be governed by its own set of norms. I responded to this objection by returning to the fiduciary framework I defended in Chapter 1, which views relationships as fiduciary when one party exercises discretionary authority to set or pursue the significant practical interests of another. I explained why the relationship between doctors and surrogates satisfies this view of the fiduciary relationship. I concluded that even if commercial surrogacy is distinct from therapeutic medical practice, the relationship between doctors and surrogates (like the typical relationship between doctors and their patients) is nonetheless fiduciary.

Chapter 3

3 Conflicts of Interest, Divided Loyalties, and Commercial Surrogacy

In the previous chapter, I argued that the doctor-surrogate relationship ought to be viewed as a fiduciary relationship. Therefore, doctors owe surrogates the fiduciary duty of loyalty, which comprises two aspects: the duty to use one's discretionary power for the sole benefit of one's beneficiary, and the duty to avoid conflicts of interest. At the end of Chapter 2, I raised the concern that doctors who treat surrogates may end up standing in fiduciary relationships with surrogates and commissioning couples simultaneously. This creates, I argue, a clear conflict of interest for doctors. In this chapter, I will address this issue, as well as explicate other conflicts of interest that arise in commercial surrogacy. Given that, as I will demonstrate, conflicts of interest abound in surrogacy, I question whether it is possible for doctors to actually act loyally to surrogates. In other words, I will address whether it is permissible for doctors to become involved in commercial surrogacy arrangements.

I will begin by examining conflicts of interest in commercial surrogacy. As previously discussed, the surrogacy industry is not monolithic; surrogacy practices vary based on the laws and health care systems of the countries in which they take place. While paid surrogacy is illegal in many places, such as Canada and Germany, it is a profitable transnational industry in countries such as the United States (at least in some states) and Ukraine. Up until recently, India, Thailand, Mexico, Nepal, and Cambodia

were all attractive surrogacy destinations; however, these countries have restricted or outright banned commercial surrogacy in the past few years (Srivastava 2017). In this chapter, I will primarily draw from literature on surrogacy in India, Israel, and the United States, including bioethical and ethnographic work and professional guidelines.

As I will explain, this literature reveals that there are many concerns with divided loyalties in surrogacy practices. First, there are concerns that stem from conflicting fiduciary obligations. For instance, in cases of ‘dual treatment’ (Daar 2014), a doctor is put in a position where a commissioning woman and the surrogate she has hired are both her patients, and acting in the best interests of one may mean failing to act in the best interests of the other. Such cases typically occur when the commissioning woman is contributing her own ova to the pregnancy. However, even in the absence of dual treatment, conflicts of interest may still arise. A doctor who answers to, but is not treating, a contracting couple may still find herself in a position where she feels obligated to act in accordance with the couple’s wishes. Underlying these concerns are financial conflicts of interest. Some feminists, like Karen Rothenberg (1990), have argued that these pervasive conflicts of interest create seemingly insoluble moral dilemmas for health care professionals. Thus, there is good reason to think that doctors should altogether refrain from participating in surrogacy, lest they be put in a position where they will be unable to uphold their duty of loyalty.

However, I will argue that these conflicts of interest are not intrinsic to surrogacy, but rather a product of how commercial surrogacy arrangements tend to be undertaken. I will propose some solutions to this problem of divided loyalties, drawing from the literature on other ‘dual obligation’ contexts, including live organ donation and sports

medicine. I will argue that doctors can ethically participate in surrogacy arrangements only if these arrangements are structured to mitigate conflicting fiduciary duties and financial conflicts of interest. First, in cases where commissioning couples bear the costs associated with surrogates' medical treatment, I argue that payments should be mediated through surrogates rather than coming directly from commissioning couples. Second, I claim that single embryo transfer should be made standard, so that there is no temptation to bolster pregnancy success rates by implanting multiple embryos. Third, I argue that surrogates must receive medical treatment from doctors who are independent from the commissioning couple. I suggest that commissioning couples and surrogates should therefore each have access to their own health care professional(s) who can assist them throughout the process. This should be the case regardless of whether the commissioning couple receives any medical treatment (i.e. whether or not they contribute their own gametes). I recognize that adopting these recommendations may make commercial surrogacy more uncertain for commissioning couples since their ability to control many aspects of the surrogacy process will be restricted. However, I argue that such changes are necessary so that doctors participating in commercial surrogacy arrangements can honour their role as fiduciaries.

3.1 Conflicts of Interest in Commercial Surrogacy

In this section, I will explore in detail some conflicts that commonly arise in commercial surrogacy arrangements, drawing from the bioethics literature, ethnographic work on surrogacy, and professional guidelines. In medicine, a conflict of interest is sometimes defined as a “set of circumstances that creates a risk that professional judgment or actions

regarding a primary interest will be unduly influenced by a secondary interest” (Lo and Field 2009, 46; ref. in Blake, McGowan and Levine 2015, 411). Conflicts of interest, in other words, arise when a doctors’ professional judgment about a patient may be swayed inappropriately by concerns external to their doctor-patient relationship. As discussed in Chapter 1, not all influence of secondary interests rises to the level of a ‘conflict of interest’ as defined by Lo and Field.³⁵ Some consideration of secondary interests may be unavoidable and may not end up posing a threat to doctors’ fiduciary loyalty. For instance, if two procedures are equally effective, but one is less expensive, then a doctor may legitimately perform the cheaper procedure for the sake of conserving medical resources. In some sense, the secondary interest of limiting expenses influences the doctor’s actions, but in a way that is still entirely consistent with prioritizing the best interests of the patient. The interest in conserving resources is allowed to sway decision-making because both options available are equally favorable for the patient.³⁶ Such a circumstance does not, therefore, involve a conflict of interest. What is problematic is when secondary interests unduly alter (or have the potential to unduly alter) a doctor’s medical judgment such that her professional decisions are no longer motivated by a good

³⁵ In Chapter 1, I distinguished between ‘conflicts of interest’ and ‘divided loyalties;’ however, Lo and Field define conflicts of interest in a way that necessarily implies a division of loyalty.

³⁶ As I discussed in Chapter 1, Mehlman (2015) argues that taking seriously doctors’ fiduciary obligations can provide a tool for doctors to resist the commercialization of medical practice if and when it undermines their ability to act loyally to their patients.

faith desire to act in her patients' best interests. This type of conflict, which involves an inappropriate division of loyalty, will be the focus of this section.

The first conflict of interest I will discuss arises in the context of dual treatment. Dual or simultaneous treatment occurs when the doctor who treats the commissioning mother or couple is also the doctor involved in the medical treatment of the surrogate. In her study of surrogacy in Israel, Elly Teman notes that dual treatment is common. She explains that in most surrogacy contracts she examined, only one doctor was involved, who accompanied "both the surrogate and the couple through the process and... represent[ed] both parties' interests" (Teman 2010, 89). Such arrangements create a clear conflict of interest because the doctor has fiduciary obligations to two parties whose interests may directly clash.

Consider the situation where a commissioning woman, Anna, is contributing her own ova to the IVF process and is being treated by Dr. Brown. Dr. Brown is also the doctor who ultimately performs the surrogate's (Connie's) embryo transfer, and treats Connie throughout the IVF process. In this case, it is uncontroversial to claim that Anna is Dr. Brown's patient, and there is a fiduciary relationship between them. Anna is receiving medical advice and treatment from Dr. Brown, who thereby wields discretionary power over her health interests. Yet, as I argued in Chapter 2, the relationship between Dr. Brown and Connie is also fiduciary.

The problem with such an arrangement is that often what is in Connie's best interests will not be in Anna's best interests, and vice versa. For instance, imagine that Anna had gone through multiple cycles of ovarian stimulation and egg retrieval that did

not produce any viable eggs. However, her latest cycle was unexpectedly good, producing three viable eggs that Dr. Brown was able to fertilize. Given the available evidence, Dr. Brown is convinced that using multiple, rather than single, embryo transfer in this case would increase the overall chances for a successful pregnancy.³⁷ However, as mentioned in Chapter 2, having more than one embryo transferred at a time makes multiple pregnancies more likely. As I will discuss in detail below, multiple pregnancies pose considerable health risks to pregnant women, including preeclampsia and postpartum hemorrhaging (Committee on Ethics 2007). In light of these risks, Dr. Brown judges that it would not be in Connie's health interests to undergo multiple embryo transfer. In this case, it is unclear to whom Dr. Brown owes her allegiance. The best decision for Anna is not the best decision for Connie. Yet, Dr. Brown appears to have a fiduciary obligation to act in the best interests of both of them.

Due to the conflicts of interests that arise in dual treatment, the American College of Obstetricians and Gynecologists (ACOG) strongly advises against such arrangements.

³⁷ Transferring multiple embryos at a time likely increases the odds of a successful pregnancy per round; however, the clinical data on whether multiple embryo transfer actually increases the overall rate of successful pregnancy is somewhat mixed (Martikainen et al. 2001; Gerris 2009; Lee et al. 2016). The efficacy of transferring more than one embryo at a time may also depend on the age of the woman receiving the transfer (Lawlor and Nelson 2012). For the sake of this example, however, imagine that Dr. Brown has done her due diligence in reviewing the available evidence, and is convinced that multiple embryo transfer is the best option for Anna.

ACOG's Committee on Ethics' "Opinion on Family Building Through Gestational Surrogacy" states that:

Pertinent medical risks, benefits, and alternatives [to surrogacy] should be discussed by the physicians treating the gestational carrier [sic] and intended parent(s), and these physicians should be separate and independent, whenever possible, to optimize patient advocacy and avoid conflicts of interest. (Committee on Ethics 2016)

However, the ACOG guidelines only suggest that dual treatment should be avoided, and ACOG has no authority to enforce a prohibition on dual treatment. Moreover, the ACOG committee opinion also notes:

One generally unavoidable exception to this guideline [about having independent fertility doctors] is the management of the preconception and early pregnancy care of a gestational carrier [sic] by the same reproductive endocrinology and infertility subspecialist who is treating the infertile intended parent(s).³⁸
(Committee on Ethics 2016)

³⁸ This is a significant departure from ACOG's 2008 Opinion on "Surrogate Motherhood," which was replaced by the 2016 Opinion. It stated:

A physician who performs artificial insemination or *in vitro* fertilization as a part of surrogacy services *necessarily* will be involved with both the intended parents and the surrogate mother. However the intended parents and the surrogate mother

ACOG does not elaborate upon why this exception is generally unavoidable. One possible explanation for this “unavoidability” is that, if fresh embryos are being used, it might be necessary for the same doctor to treat both the commissioning woman (who is contributing her own eggs) and the surrogate to facilitate embryo transfer. In fresh embryo transfer, the surrogate and the commissioning woman’s menstrual cycles are synced, which is typically achieved through the use of hormones. However, even if it is easier to have one doctor overseeing this syncing process, it seems possible that it could be done with two doctors in communication with each other. Another possible explanation for the exception to the independence guideline is that some fertility specialists may operate in regions where there are no other fertility specialists nearby, which could make coordination challenging. In such cases, however, it would likely be possible (though more expensive) for the commissioning woman to travel to another clinic and have her eggs frozen for IVF use.³⁹

should have independent counseling and independent legal representation, and the surrogate mother should obtain obstetric care from a physician who is not involved with the intended parents. (Committee on Ethics 2008, my emphasis)

The language of necessity has been removed in the 2016 Opinion, which suggests a willingness to view dual treatment as less inevitable.

³⁹ There is some evidence that the transfer of thawed frozen embryos produces a live birth rate similar to that of fresh transfers (Wong et al. 2017).

Despite ACOG's determinations, there appears to be disagreement amongst bioethicists as to whether doctors have an ethical imperative to avoid dual treatment. Some, like Rosalie Ber (2000), support the sentiment expressed in ACOG's guidelines. She states,

[I]n order to avoid the issue of dual loyalty, it may be preferable that separate physicians perform these roles/obligations [involved in surrogacy]. Thus, it is possible to avoid coercing the surrogate mother to perform tests, or change her style of living, continue with the pregnancy should she desire to terminate it, or have the child delivered by Caesarian section to comply with the wishes of the genetic parents of this "precious baby." (157)

Ber is keenly aware that dual treatment leads to serious concerns about divided loyalties. However, other bioethicists seem less troubled by dual treatment. For instance, although Judith Daar (2014) acknowledges that professional organizations discourage dual treatment arrangements, she seems to treat such arrangements as permissible when she considers how doctors ought to navigate a surrogate's hypothetical breach of contract. Daar states that "dual treatment may be preferred when an intended mother undergoes oocyte retrieval to contribute to the embryos transferred into the surrogate" (45).⁴⁰ She considers doctors' obligations in the context of dual treatment when they are faced with a surrogate's breach of contract. The scenario she imagines is one in which a reproductive medicine specialist continues to treat both the commissioning couple and the surrogate

⁴⁰ Daar does not elaborate upon why dual treatment is preferred in such cases.

until a pregnancy is well established, and this specialist discovers behavior that violates the surrogacy contract.

Daar claims that doctors involved in surrogacy arrangements should familiarize themselves with the conditions of the surrogacy contract so that they are aware of what behaviours constitute a breach. She argues that if a contract calls for a surrogate to avoid drinking alcohol or to only eat organic food for the duration of her pregnancy, the doctor should assume that knowledge about behaviour that violates these provisions is material to the commissioning couples' decision-making about whether to proceed with the surrogacy arrangement. As a result, Daar claims that a good contract will include an agreement to waive confidentiality about any material information discovered by the doctor in the course of treatment. Such waivers represent, according to Daar, "an exception to a physician's duty to maintain patient confidentiality" (2014, 46). If the contract includes such a waiver, she recommends that doctors consider a two-part approach, wherein they first encourage the surrogate to disclose the breach, and if the surrogate refuses, the doctor can then discuss the breach with the commissioning couple since it is "material to their ongoing informed consent" (*ibid*). In cases where the surrogate has not expressly waived confidentiality in the contract, Daar recommends that doctors should consider the pros and cons of nonconsensual disclosure. She ultimately concludes that because a breach of the surrogacy contract could lead to the revocation of the agreement, "the potential balance of harms seems to weigh in favor of disclosure" (*ibid*). She grounds this recommendation in the duty to respect patient autonomy since it includes, according to Daar, "the duty to provide information material to a patient's decision making" (*ibid*). Thus, in this type of conflict between her patients' interests,

Daar suggests that the doctor's loyalty should ultimately lie with the commissioning couple.⁴¹

From the standpoint of fiduciary obligation, it should be clear that dual treatment is a threat to a doctor's duty of loyalty. If a doctor agrees to treat a commissioning woman or couple, then she should refrain from initiating a doctor-patient relationship with the surrogate they hire (except, perhaps, in a case where a surrogate requires emergency medical treatment and no other doctor is available). Similarly, if a doctor agrees to treat a woman acting as a surrogate, she should refrain from initiating a doctor-patient relationship with a commissioning couple (again, barring emergency scenarios). *Contra* Daar, dual treatment is therefore never preferable, even if it is significantly more convenient for the couple or doctors involved.⁴² The type of scenario Daar attempts to address ought, from the fiduciary standpoint, never come about. The thought that the conflict of interest in question can be resolved with a careful weighing of the potential

⁴¹ Daar's argument also applies to dual treatment scenarios that involve a commissioning couple disclosing a breach of contract to their doctor. (Imagine that a couple discloses to their doctor that they are planning to divorce, which would violate a condition of their surrogacy contract.) In such cases, the doctor could be justified in informing the surrogate of the breach without the couple's consent.

⁴² As I will discuss in section 3.2, alternative arrangements involving additional parties who can facilitate the syncing of menstrual cycles are preferable in cases where the commissioning woman is contributing her own gametes.

harms and benefits of nonconsensual disclosure is wrongheaded. In this case, there is no way to act in the best interests of both patients, and the conflict is therefore insoluble.

However, even if dual treatment is avoided, there are still other types of conflicts of interest that arise in surrogacy. One may be concerned that even if the doctor treating a surrogate is not also simultaneously treating the commissioning woman, she may nonetheless be motivated by a consideration of the commissioning couple's interests. Rothenberg (1990) suggests this point in her critique of surrogacy. She states that, "By its very definition, IVF and embryo transfer with a gestational surrogate is a case of potential conflict of interest" (1990, 347); presumably, this is because there is always the risk that the interests of the couple and the surrogate will clash. As aforementioned, Rothenberg criticizes surrogacy arrangements in which the doctor treating the surrogate plays any role in helping to enforce the terms of the surrogacy contract by disclosing whether a surrogate smokes or drinks alcohol. Rothenberg claims that in their capacity as 'monitor' of the surrogate, doctors "take on the role of spy, rather than the *fiduciary* role to the patient" (1990, 350, my emphasis).⁴³ She also cautions that even if the surrogate is treated as the sole decision-maker for her own medical care, in the event of multiple pregnancy or birth defects, the commissioning couple and health care provider may still exert pressure on her to make a decision in line with the couple's desires, given that they

⁴³ As I discussed in the introduction, this is the only time Rothenberg mentions the term 'fiduciary,' so it is unclear what precise understanding of the fiduciary relationship she is employing.

will be parenting the future child. Rothenberg concludes that health care providers should reject surrogacy as a solution to infertility, claiming that the “medical, ethical and legal risks of using another woman to serve the interests of the infertile couple cannot be minimized” (1990, 350).

Such concerns are supported by the study by Tanderup and colleagues on decision-making in Indian surrogacy, which I discussed in Chapter 2. Tanderup et al. (2015b) found that commissioning couples had a great deal of influence on doctors’ decisions, and were often treated as the ‘primary stakeholders’ in surrogacy arrangements (493). This appears to be the case both when the commissioning couples were directly consulted, and also when they were not consulted, but the doctor still considered what they *would* want. Take, for instance, medical decision-making about birth method. In three of the clinics Tanderup et al. studied, commissioning couples were reported as exerting pressure on doctors to perform C-sections on surrogates rather than allow for vaginal births. In one clinic, that pressure came in the form of direct consultation; the commissioning couple could “reportedly directly decide the mode and then pay the surrogate extra for the C-section” (2015b, 498). In the other two clinics, the pressure was indirect as it resulted from what the doctors believed was in the couple’s interests. One doctor claimed, “No one wants to risk a vaginal delivery when it is such a wanted child... [and] These parents have been through so much, so we don’t want to risk a stillbirth or other complications” (*ibid*).

Pande’s study also revealed that surrogates are often pressured into undergoing medically unnecessary caesarian sections to satisfy the interests of commissioning couples and to protect the ‘precious’ fetuses being gestated. Only two of the forty-two

surrogates she interviewed had vaginal deliveries (Pande 2014b, 117).⁴⁴ Pande attributes the high prevalence of caesarian section births in part to the clinic staff's desire to accommodate their own scheduling needs and the scheduling needs of the commissioning couple (particularly when the couple were international clients). She also suggests two other possible causes: the staff's belief that surrogates who give birth through caesarian sections will be less attached to the babies than those who give birth vaginally, and the desire to do everything possible to protect the 'precious' fetuses. One surrogate who was interviewed about having to undergo a medically unnecessary caesarian section (referred to by surrogates at the clinic as a 'scissor' operation) made this statement about the surrogacy process:

It's very painful—the medicines, the injections and now this scissor. It's not like there can't be normal [vaginal] deliveries in this process but they [doctor and intended parents] don't want to take any risk. *The child is most important, not our bodies* [emphasis added by Pande]. (Pande 2014b, 117)

Pande notes that the surrogate is “well aware of the doctor's priority” since she recognizes that the baby she is carrying for the commissioning couple is more 'precious'

⁴⁴ According to the WHO, the ideal rate for caesarean section deliveries is between 10% and 15% (WHO 2015). The caesarian section rate in general has been rising in India, especially in private hospitals, with some regions reporting rates of 41-58% of deliveries (Rao 2015). Yet, even when compared to the already high rates of caesarian section deliveries in India, the 95% rate at the clinic Pande studied is striking.

to the doctor than her own health (Pande 2014b, 118). It is worth noting that the doctor's desire to promote the health of the children being produced through surrogacy may also give rise to a potential conflict of interest. I will address such considerations about surrogates' interests and children's interests in Chapter 4.

Teman noted that in the cases she followed, the doctor was usually the primary mediator of conflicts that occurred between the couple and the surrogate. One type of conflict that arose in several cases surrounded what freedom surrogates had to travel during pregnancy (on long bus or train trips, for instance). Teman explains,

In numerous cases, this issue was debated so heatedly by surrogate and couple that it was only resolved by their doctor's intervention. In two cases, the doctor acceded to the intended mother's pleas to recommend that the surrogate forfeit her plans, and in two other cases, doctors acceded to the surrogate's wishes and reassured the intended mother that the surrogate would not endanger the pregnancy by traveling. (2010, 89)

In these cases, the doctors clearly felt as though they had obligations to both the surrogate and the commissioning couple, and their medical recommendations about what would or would not endanger the pregnancy may have been shaped by where their loyalties lay. Thus, even when there is no dual treatment, there is still considerable potential for doctors' medical judgment regarding their primary interest (the health interests of the surrogate) to be unduly swayed by a secondary interest (the interests of the commissioning couple).

Underlying this potential conflict of interest is, I argue, a considerable financial

conflict of interest. Returning to the example of Anna, Dr. Brown and Connie, imagine that Anna and her partner do not have access to public funding for fertility treatment, and must therefore pay for all the medical expenses associated with the surrogacy arrangement. In this case, there is a sense in which Dr. Brown is ‘working for’ Anna and her partner. Dr. Brown may stand to benefit financially from making medical decisions about Connie’s pregnancy that are in line with Anna and her partner’s interests, such as scheduling a caesarian section on a date that is convenient for them or ordering invasive tests such as amniocentesis to test for chromosomal abnormalities (when a C-section or amnio would otherwise not be medically indicated).

Financial conflicts of interest arise most starkly in circumstances where the fertility doctors involved in the care of surrogates are also fertility clinic owners. For instance, Pande interviewed a doctor who served as both the chief doctor and proprietor of a surrogacy clinic. Under such an arrangement, the doctor in question has significant financial motive to prioritize the interests of the parties who are paying her (the commissioning couples) over the parties she is treating (the surrogates). However, even when doctors are not the owners of surrogacy businesses, financial conflicts can still arise if they profit from making medical decisions that are not in surrogates’ best medical interests. As mentioned in the introduction, there is an active transnational market for surrogacy services, and pregnancy success rates can be used as a key marketing tool for clinics to attract clients. According to Vanessa Gruben (2013), “High pregnancy rates... translate into more business for the clinic, which is in the pecuniary interest of the

physician” (270).⁴⁵ Although Gruben is discussing the competitive market in ova, her point is equally applicable to commercial surrogacy. In the case of oocyte provision, fertility doctors can be financially motivated to over-stimulate egg providers to maximize the number of embryos that can be created. Similarly, surrogacy doctors can be financially motivated to transfer multiple embryos at a time into surrogates to maximize pregnancy rates. This is not just because they wish to expedite the process for commissioning couples, but also because it can help attract future business to the clinic.⁴⁶ For instance, Pande references promotional material from the Indian surrogacy agency *Rotunda Center for Human Reproduction*, which claims, “Our pregnancy rates are very high, because we can transfer more embryos in difficult patients (unlike clinics in UK and Australia, where the number of embryos which can be transferred is limited by law)” (“The Rotunda Overseas IVF Patient (ROIP) Program,” *Rotunda Center for Human Reproduction*, ref. in Pande 2014b, 11). In the surrogacy clinics that Tanderup et al.

⁴⁵ Similarly, Jennifer Rosato (2004) argues that given the business structure of the fertility industry in general, “there is intense pressure on doctors to maximize their success rates” (73).

⁴⁶ Increasing business is clearly beneficial for clinic-owners, but it is also valuable to individual doctors since they still profit from increased business to the clinic. Moreover, if a doctor develops a reputation for successfully facilitating surrogate pregnancies, this may lead to her particular services being in high demand. Thus, such considerations can still present financial conflicts of interest for doctors even if they do not own clinics themselves.

(2015a) studied, the maximum number of embryos doctors would transfer at a time ranged from two to seven (469).

As aforementioned, in addition to improving pregnancy success rates, implanting multiple embryos in surrogates often leads to multiple pregnancies. Multiple pregnancies pose serious health risks to surrogates since surrogates must either undergo selective fetal reductions or else carry multiple fetuses to term. The fetal reduction procedure itself poses some risk of maternal complications, and can result in the loss of the entire pregnancy (Brambati et al. 2004). Moreover, undergoing fetal reductions can be stressful and emotionally painful, and can leave women with feelings of guilt and sadness (Garel et al. 1997). On the other hand, as I previously discussed, carrying multiple fetuses to term poses many health risks. According to the ACOG Committee on Ethics' "Opinion on Multifetal Pregnancy Reduction," the maternal risks of multifetal pregnancies "include hypertension, preeclampsia, gestational diabetes, and postpartum hemorrhage" (Committee on Ethics 2007). It is questionable, then, whether implanting multiple embryos is ever in the surrogate's best medical interests. Yet, doctors are incentivized to do just that since high pregnancy rates both satisfy their clients, and can also bolster the clinic's reputation and translate into more business in the future. Moreover, concern for the financial interests of the clinic can also influence doctors in their decisions about selective reductions. One doctor Tanderup et al. (2015a) interviewed explained, "We do fetal reduction down to twins. It doesn't look good for the clinic if we have too many multiple pregnancies" (469). In general, the fact that doctors involved in commercial surrogacy often profit from engaging in medical practices that are inconsistent with surrogates' best medical interests raises serious concern about their fiduciary loyalty.

Even when doctors are, in practice, successful in prioritizing surrogates' health interests over their own profits, the specter of financial conflicts of interest may still loom.

3.2 Conflicts of Interest and Divided Loyalties: Meeting the Challenge

Given the conflicts of interest that appear to permeate commercial surrogacy arrangements, it may be tempting to conclude, as Rothenberg does, that doctors simply should not participate in them. Even in the absence of dual treatment, there seems to be the continual risk that doctors' exercise of discretionary power within surrogacy arrangements will be motivated by a commitment to promoting the interests of commissioning couples and/or their own financial interests. Since fiduciaries are obligated to avoid conflicts of interest, doctors should therefore avoid commercial surrogacy arrangements.

However, I argue in this section that this conclusion is too hasty. I claim that, *contra* Rothenberg, it is possible for doctors to uphold their duty of loyalty within surrogacy arrangements.⁴⁷ I argue that the conflicts of interest that abound in surrogacy

⁴⁷ In the next chapter, I will consider a final potential conflict of interest for fertility doctors, namely between a surrogates' interests and the interests of the child she gestates. Rafique and DeCherney (2014), for instance, claim that "[a]long with her obligation to [the surrogate], [the fertility doctor] has a responsibility to the unborn child" (12). I

are not inherent to the enterprise, but are rather a result of poorly constructed and regulated practices. Surrogacy arrangements must, I claim, undergo significant revisions in order to render doctors' participation in them permissible. To make this argument, I first examine how conflicts of interest have been addressed in two other 'dual obligation' clinical contexts: sports medicine and live organ donation. Drawing upon insights from those contexts, I then make several recommendations that, if put into effect, would help mitigate conflicts of interest and ultimately enable doctors to act as loyal fiduciaries to surrogates.

As discussed in Chapter 1, divided loyalties are a perennial concern in many areas of medicine. It is helpful to examine these areas to understand what strategies can be taken to mitigate the undue influence of secondary interests. One area of medical practice where conflicts of interest give rise to ethical concern is sports medicine. In professional sports, teams often hire their own doctors to care for and treat their injured athletes. Brad Partridge (2014) points out that this state of affairs creates the potential for divided loyalties. He frames the problem as such:

Team doctors clearly have an obligation to the welfare of their patient (the injured athlete) but they also have an obligation to their employer (the team), whose primary interest is typically success through winning. At times, a team's interest

devote a separate chapter to this issue because it is a potential problem for all forms of assisted reproduction, and therefore transcends the surrogacy context.

in winning may not accord with the welfare of an injured player, particularly when it comes to decisions about returning to play after injury. (65)

In other words, when doctors work for a sports team, there is the constant risk that their medical judgments about players' health will be clouded by a concern for the team's success. Moreover, they may be concerned that their very jobs rest on performing their duties in a way that satisfies their employer's interest in winning. In response to this conflict of interest, Arthur Caplan (2014) argues that sports teams should not be permitted to hire their own doctors. Rather, leagues should hire doctors for a professional franchise, and those doctors should report to a head medical official or regulatory body. In this way, doctors would be primarily accountable to the athletes they treat, and their decision-making would be evaluated only by other medical professionals, rather than by the owners or coaches of particular teams. Since doctors' jobs would not be in peril if they made decisions that were not satisfactory to the team, they can focus on making decisions that are in the best interests of the athletes they treat.

Doctors working for sports teams are analogous to doctors involved in commercial surrogacy arrangements insofar as they may be unduly influenced by both financial interests and also third party interests (the team and the commissioning couple, respectively) to make decisions that are not in their patients' best medical interests. Part of Caplan's solution to this conflict in sports medicine is to create financial distance between the team and the doctor. Such a strategy can also be applied to commercial surrogacy arrangements. Surrogacy arrangements could be structured such that doctors who treat surrogates would never be paid directly by commissioning couples. When surrogacy arrangements take place within health care systems that require commissioning

couples to bear the costs associated with surrogates' medical treatment, payments for these costs should not be made directly by the couple. Rather, payment should be mediated through the surrogate. The commissioning couple could set up an account for the surrogate, for instance, so that she could directly select her own doctor and pay for medical treatments herself. That way, the doctors treating surrogates would genuinely be 'working for' the surrogates themselves, reducing the financial conflict that would otherwise exist.

As I mentioned in the previous section, financial conflicts can also arise out of doctors' concern with their clinics' reputation for high success rates. Having payments come directly from surrogates would not necessarily help mitigate such a conflict. A tactic for addressing this type of financial conflict of interest would be to impose uniform standards of care across all surrogacy clinics. For instance, if single embryo transfer were the enforced standard of care,⁴⁸ then there would be no room for competition between clinics surrounding boosting success rates by transferring multiple embryos. In turn, this would limit the number of multiple pregnancies, and therefore limit the need for selective reductions. This standard could be incorporated into surrogacy contracts, imposed by legislation, or perhaps enforced by professional organizations (such as regulatory colleges).⁴⁹ Such considerations about financial conflicts of interest also suggest that

⁴⁸ Any departure from that standard should be permitted only in circumstances when it is clearly medically indicated.

⁴⁹ I will address concerns with the enforceability of these limitations below.

medical professionals who own surrogacy clinics should perhaps not be directly involved in medical decision-making, so that no doctor-patient fiduciary relationship is formed between clinic owners and surrogates. The potential for the undue influence of financial motives may simply be too great.

Moving on from the insights gleaned from the ethics of sports medicine, another area of medical practice where there are serious concerns with divided loyalty is live organ donation. Since live organ donation involves doctors subjecting otherwise healthy individuals to serious medical risks for the benefit of another, there is a great deal of worry about potential conflicts of interest. The primary juncture in which conflicts of interest arise in live organ transplantation is during the screening process that determines if a prospective donor is an appropriate candidate. As Gruben explains, the concern in live organ donation “is that the physician will be committed to the recipient’s transplant and, as a result, may under-evaluate the prospective donor’s fear of donation or may ‘gloss over’ the risks associated with the donation” (Gruben 2013, 268). For instance, in 2010, a live liver lobe donor named Paul Hawks died during transplantation surgery (Kowalczyk 2014). His widow, Lorraine, later discovered that he was approved to be a donor despite doctors having found extra blood vessels in his liver (which can make surgery more challenging), abnormalities in his electrocardiogram, and that he was near the upper age limit for live donors. Moreover, the donor advocate working with him was a part of the recipient’s (her brother-in-law’s) transplant team. Lorraine later sued the hospital for malpractice, although it had been cleared of wrongdoing by a government investigation. In a newspaper article chronicling the incident, a reporter noted that Lorraine wondered “whether the transplant team, intent on saving her brother-in-law,

Timothy Wilson, failed to focus enough on her husband's safety" (Kowalczyk 2014).

In response to concerns about conflicts of interest, various guidelines have been developed to ensure that the well-being of organ donors is protected. The American Medical Association's (AMA) Code of Medical Ethics' "Opinion on Organ Transplantation," for instance, recommends that every donor be assigned an advocate team that is as independent as possible from the team responsible for the recipient's care. The Opinion states:

Because donors are initially healthy and then are exposed to potential harms, they require special safeguards. Accordingly, every donor should be assigned an advocate team that includes a physician. This team is primarily concerned with the well-being of the donor. Though some individuals on the donor advocate team may participate in the care of the recipient, this team ideally should be as independent as possible from those caring for the recipient. This can help avoid actual or perceived conflicts of interest between donors and recipients. (AMA Code of Medical Ethics' Opinion on Organ Transplantation 2013, 205.)

The Multi-Organ Transplant Program of the University Health Network (UHN) in Toronto has also developed ethical guidelines for live organ donation. When it comes to donor evaluation, the UHN recommends that "separate health care teams assess potential living donors and recipients," and that each party should have their own doctor to advocate for their interests (Wright et al. 2004, 410). They also recommend the use of "separate coordinators, social workers and psychiatry staff whenever possible" in order to "avoid conflicts of interest and permit advocacy for the potential donor while suitability

is being determined” (*ibid*).

These guidelines suggest that in order for live organ donation to proceed in an ethically sound manner, there must be as much separation as possible between the health care professionals who evaluate and treat live donors and the health care professionals who treat recipients. Moreover, an independent advocate whose sole role is to protect the welfare of the donor must be involved. In these guidelines, there is less explicit discussion about potential conflicts during transplantation surgery than there is about potential conflicts during screening. However, the need for as much independence as possible between the two health care teams is presumably relevant not just during screening, but also during any medical interventions.

Live organ transplantation offers a useful comparison to surrogacy since both involve health care professionals performing medical procedures that pose serious health risks to otherwise healthy individuals for the benefit of a third party (although the risks of live organ donation are greater).⁵⁰ In both surrogacy and live organ donation, there is a pressing need to ensure that surrogates and donors are agreeing to take such risks freely, and that they are physically and psychologically appropriate candidates. Of course, there are many relevant differences. Live organ donations are intended to save lives, which is why doctors are willing to put healthy donors at risk. Surrogacy does not save, but rather creates, lives. There also appears to be a greater concern regarding conflicts of interest after candidate approval in surrogacy than in organ donation. For one thing, surrogacy is

⁵⁰ Ber also considers the analogy between surrogacy and organ donation (2000, 162-163).

a much lengthier process than organ donation, leaving surrogates under medical care for longer than typical organ donors and giving rise to more opportunities for conflicts (about genetic tests, birth method, fetal reduction, and so on).⁵¹ Nonetheless, despite these differences, the ethics of live organ donation present a useful touchstone when tackling conflicts of interest in surrogacy.

In section 3.1, I discussed the current ACOG guidelines on surrogacy, which recommend that the doctors treating the surrogate and the commissioning couple should be separate and independent, except in cases where the surrogate's preconception and early pregnancy care is done by the same doctor who is treating the commissioning couple. Although this guideline is partially correct insofar as it recognizes the desirability of separate treatment, it does not go far enough. As I argued above, it is not sufficient to simply avoid situations where the same doctor treats both the commissioning couple and the surrogate (and the ACOG guideline doesn't even wholly proscribe such arrangements). This is because there remains the potential for the doctor treating the surrogate to nonetheless feel obligated to the commissioning couple or be otherwise

⁵¹ After an organ donor has been approved, she typically undergoes surgery and a recovery period, spending roughly two days in hospital and four to six weeks recovering at home ("What to Expect as a Living Donor," *Johns Hopkins Comprehensive Transplant Center*, 2016). On the other hand, surrogacy can occupy over a year of a woman's life, factoring in the time it takes to receive hormone treatments, gestate, give birth, and recover.

influenced by their desires. The ACOG guidelines fail to address the conflicts of interest that may arise even in the absence of dual treatment.

Drawing inspiration from live organ donation guidelines, I argue that separate advocate teams should attend to surrogates and commissioning couples, respectively. These teams may include psychologists, social workers, fertility doctors, and obstetricians who are able to guide their respective client/patients through the process and advocate for their interests. If coordination needs to occur in the preconception or early pregnancy stage (for example, if menstrual cycle syncing needs to occur for the transfer of fresh embryos), this can be achieved by using a coordinator, rather than by simply having one doctor treat both parties. In cases where neither member of the commissioning couple is contributing their own gametes, it may be unnecessary to assign a full team to them. Nonetheless, the commissioning couple should never interact directly with the professionals caring for the surrogate since this presents the opportunity for the couple's interest to unduly influence the doctors' actions. As the Tanderup study revealed, even if couples are not explicitly consulted about their preferences for the surrogate's treatment, a concern for what they *would* want can still influence doctors' judgments if there is insufficient separation from the couple. It is therefore still advisable to have an independent doctor or coordinator who can update the couple and provide them with whatever medically relevant information the surrogate has consented to share.

An implication of this recommendation is that commissioning couples would have no direct say in the medical decisions being made throughout the course of the surrogate's pregnancy. In particular, this means that couples would not be able to make medical decisions regarding genetic testing, abortion, or selective fetal reductions

(although, as per my earlier recommendation, multiple pregnancies would be much less common if a standard of single embryo transfer is adopted). To some, this may seem like an objectionable state of affairs since the commissioning couple has a strong interest in determining whether the child they will parent will suffer from a genetic disease or how many of ‘their’ children will be born.⁵²

My response to this concern comes in two parts. The first part of my response is that commissioning couples would still have *some* degree of input through their agreements with surrogates. A surrogacy contract can still specify that a surrogate will agree to request certain tests, disclose their results, and ultimately abort the pregnancy if certain genetic defects are found. There is nothing in my recommendations that prevents the surrogate and commissioning couple from discussing the pregnancy with their legal representatives and making decisions amongst themselves. However, any agreement made between a surrogate and a commissioning couple should not bind doctors’ clinical judgments or practice. For instance, returning to my previous example of Anna and Connie, imagine that their arrangement has been constructed according to my guidelines, and that Dr. Brown is the primary doctor treating Connie. Anna and Connie have agreed that Connie will request amniocentesis. Yet, when Connie requests the procedure, Dr. Brown informs her that there is no clinical indication that amniocentesis is warranted. Dr.

⁵² This also poses a risk that more children will be born than the commissioning couple are willing to parent, which may put the future children’s interests at risk. As aforementioned, I will discuss doctors’ obligations to children in more detail in Chapter 4.

Brown, as a diligent practitioner, also informs her thoroughly about the risks and benefits of the test. If Connie, after being fully informed about amniocentesis, still wishes to have it done, then Dr. Brown can certainly perform the test. However, if after being informed about the risks of the procedure, she no longer wishes to undergo it, then that should be the end of the discussion. Dr. Brown would be under no obligation to perform amniocentesis just because Anna and her partner want certain information. *Contra* Daar, I argue that Dr. Brown should not even be aware of the details of what Connie has agreed to unless Connie herself informs Dr. Brown of these details. In general, a doctor should never be in the business of enforcing the terms of a surrogacy contract. This means that contracts wherein surrogates waive their right to doctor-patient confidentiality in advance are unacceptable, and a doctor should not agree to be party to such an arrangement.

Although my recommendation doesn't preclude the commissioning couple from having any input, it still does leave considerable uncertainty for the commissioning couple. This leads to the second part of my response: family formation is often complicated and there are many aspects of the process that cannot be controlled. This is true in adoptions, and also to some extent in unassisted reproduction. It is therefore not unreasonable to expect commissioning couples to be willing to tolerate a degree of uncertainty. Just because surrogacy presents commissioning couples with the possibility to assert control over certain outcomes does not mean that they should. While commissioning couples' interest in determining how many children they will be expected to parent or whether a pregnancy should continue at all is certainly important, it is not overriding. Surrogacy arrangements should be undertaken with the express acknowledgement that medical decisions will ultimately reside with the surrogate, and

that couples' input into such decisions will occur at the surrogate's discretion. Only under these circumstances can doctors truly act loyally to surrogates.

These recommendations—that doctors not be paid directly by commissioning couples, that single embryo transfer be adopted as the standard, and that commissioning couples and surrogates be attended to by their own independent health care professionals or teams—may make commercial surrogacy function much more like an adoption that is arranged before birth than it currently does, at least from the perspective of the doctors involved in the surrogate's care.⁵³ Although there is an understanding that the woman who gestates the baby will not be the individual who parents him/her, this fact should have no impact on the medical treatment of the woman doing the gestating. From the doctor's point of view, the primary difference between an adoption arrangement and a surrogacy arrangement would simply be the use of IVF in conception.

The notion that surrogacy arrangements could function as a type of adoption is not new; it has been around at least since Bonnie Steinbock's 1988 paper, "Surrogate Motherhood as Prenatal Adoption." Steinbock suggests that surrogacies could proceed much like adoption arrangements made before a child's birth ('prenatal' adoptions). To the best of my knowledge, prenatal adoption does not legally exist in any jurisdiction since adoption papers cannot be signed before the child in question is born. However, adoption arrangements can indeed be worked out in advance of birth, such that the adoptive couple and the birth mother have a mutual understanding that the adoptive

⁵³ I thank Amalia Amaya for this point.

couple will parent the baby. (The birth mother is free, however, to opt out of this agreement if she decides she wants to parent the infant.) In such arrangements, the prospective parents may be involved in the pregnancy to some degree. As Steinbock notes, the prospective adoptive parents may even be present for the child's birth (1988, 43). Moreover, prospective adoptive parents may pay for the birth mother's medical expenses, or even for things like food, rent, or maternity clothes when doing so is consistent with adoption laws (Thalken 2013). However, since in these arrangements, the adoption does not legally take place until after birth, the birth mother should still be treated as the decision-making party. For instance, the birth mother is the one who ultimately makes decisions about birth method, genetic testing, or abortion in the event of birth defects. Although the birth mother may certainly consult the adoptive parents if the decisions may impact their decision to adopt, it would be entirely inappropriate for her doctor to engage in such consultation.

As far as the doctors who treat the surrogate are concerned, surrogacy arrangements could function much like these so-called 'prenatal' adoption arrangements, with the additional presence of IVF use in conception. Some jurisdictions have begun moving towards a more adoption-like model for surrogacy regulation. Ontario, for instance, passed legislation in November 2016 called the *All Families are Equal Act*, whose surrogacy regulations are "based on a model more akin to adoption than third party reproduction" (Cohen 2016). I should note that I am not arguing that this Act gets surrogacy regulation right, all things considered. It grants, for instance, that "a surrogate (gestational and traditional) has at least seven days [after birth] to change her mind about parentage, and requires joint medical decision-making between the parents and the

surrogate in the interim...” (Cohen 2016).⁵⁴ It is beyond the scope of this chapter to comment on whether provisions like a seven-day waiting period before parentage is assigned are appropriate. In general, it is not my intention to make claims about which party is truly the ‘parent’ or ‘parents’ of the children created through surrogacy. Rather, I merely argue that when it comes to the doctor-surrogate relationship, the fact that the surrogate won’t parent the child she gestates should not influence the doctor’s medical judgments any more than it would in adoption cases.

I will address two final objections to my recommendations. The first is that requiring separate advocate teams and alternative payment arrangements may make surrogacy even more expensive than it already is. This may significantly reduce the number of surrogacies taking place in general. Moreover, it may also effectively limit access to surrogacy to only the very wealthy. Reducing the number of surrogacy arrangements taking place is not a genuine worry, however. If the cost of ensuring that doctors prioritize the health interests of surrogates is an overall reduction in the number of surrogacy arrangements taking place, then that is a reasonable price to pay. Doctors are under no moral obligation to provide infertile couples with access to surrogacy, while they *are* under an obligation to avoid situations where they face serious conflicts of interest.

The concern with limiting access to surrogacy to only the very wealthy is more

⁵⁴ These regulations only apply to altruistic surrogacy arrangements since commercial surrogacy is illegal in Canada.

troubling from the standpoint of fairness. Some may argue that if only affluent infertile individuals are able to access surrogacy services, this may be unfair to less affluent prospective parents. Moreover, if surrogacy is only accessible to the very wealthy, this may further exacerbate the power imbalance that often exists between commissioning couples and surrogates. A criticism that feminists often level against the commercial surrogacy industry is that it creates a system of stratified reproduction, where privileged individuals make use of the reproductive capacities of less privileged women to further their family formation goals (Twine 2011, 16).⁵⁵ Making surrogacy even more expensive may serve to further the economic gap between those accessing and those providing surrogacy services.

These concerns with fairness are difficult to overcome, and it is beyond the scope of this chapter to thoroughly address them.⁵⁶ Most responses go far past the question of doctors' conduct within surrogacy. Dominique Martin and Stefan Kane (2014), for example, have proposed a model of national self-sufficiency in reproductive resources, where countries aim to meet their citizens' reproductive assistance needs domestically. This model would "require a complete overhaul of policies and practices concerning procurement, use, and distribution of gametes and surrogacy services" (Martin and Kane

⁵⁵ For further discussion of stratified reproduction, see Whittaker and Speier (2010); Mohaptra (2012); Deomampo (2016).

⁵⁶ A discussion of the issue of unequal access to reproductive treatment also takes place in the debate surrounding the public funding of IVF (Panitch 2014; McLeod 2017).

2014, 31). Such a model would reduce the stratification of reproduction by promoting greater reciprocity in the giving and receiving of reproductive services. A self-sufficiency model could also include increased public funding for surrogacy services, and also for infertility prevention. This would alleviate the financial burden of accessing surrogacy and also reduce the potential for financial conflicts of interest. However, the notion of publically funding surrogacy services brings up additional ethical concerns. For instance, publically funding surrogacy may end up imposing disproportionate burdens on women since they would be the ones called upon to provide gestational labour.⁵⁷ The overall demand for surrogates may also increase if surrogacy is publically funded, potentially putting additional pressure on women to become surrogacy providers.

Although I am unable to thoroughly explore remedies to the problem of fairness here, it is worth emphasizing that inequalities already plague surrogacy. At worst, through increasing the costs associated with surrogacy, my recommendations would only potentially exacerbate them. However, my proposed changes can also work to reduce unfairness. For example, as discussed above, commissioning couples often have the power to influence the medical decisions made by surrogates' doctors. If the doctor-surrogate relationship is better insulated from commissioning couples' influence, then this may reduce the power they have over surrogates. While the economic gap between commissioning couples and surrogates may not necessarily be lessened, the problematic

⁵⁷ The burden may, of course, also fall upon those who have the capacity to gestate children but do not identify as women.

power imbalances that can flow from that gap would indeed be reduced.

The second objection to my recommendations is to do with enforceability. As discussed above, commercial surrogacy often takes place transnationally, standards of care are variable, and doctors' roles within surrogacy are diverse. It would therefore be a difficult task to ensure that surrogacy arrangements adequately safeguard the doctor-surrogate fiduciary relationship in practise. To respond to this worry, I will simply reiterate that I am concerned primarily with making a normative argument about doctors' participation in commercial surrogacy. Doctors must be able to act loyally while facilitating surrogacy arrangements in order for their actions to be permissible. This requires considerable departure from the practises of commercial surrogacy as they commonly occur. Ensuring that doctors do, in fact, live up to these standards of fiduciary loyalty may require a paradigm shift on the part of both the countries that allow for commercial surrogacy and also the countries that grant citizenship to children born to surrogates abroad. It is my hope that recognizing both doctors' fiduciary obligations to surrogates, and also the ways in which commercial surrogacy arrangements can undermine those duties, will help spur change in that direction.

3.3 Conclusion

In this chapter, I have explored how recognizing the doctor-surrogate relationship as fiduciary can provide guidance regarding fertility doctors' participation in commercial surrogacy. First, I argued that commercial surrogacy arrangements, as they commonly take place, often undermine doctors' ability to uphold their fiduciary duties. Then, taking inspiration from other 'dual loyalty' contexts (sports medicine and live organ donation), I

argued that surrogacy arrangements could be structured so that the doctor-surrogate relationship is better insulated from the undue influence of secondary interests. I argued that (1) payments to surrogates' doctors should not come directly from commissioning couples, (2) single embryo transfer should be adopted as the standard of care, and (3) there must be clear separation between the commissioning couple and the doctor(s) who treat the surrogate in all cases. Although commissioning couples can reach agreements with surrogates about certain aspects of her pregnancy, doctors should be under no obligation to uphold or enforce the terms of their contracts. I concluded that adopting these recommendations would help ensure that doctors can wield the discretionary power they have over surrogates' health interests in a manner consistent with their fiduciary duty of loyalty.

Chapter 4

4 Fertility Doctors' Duties to Future Children

In the previous two chapters, I primarily discussed the fiduciary relationships that arise between doctors and surrogates, and how commissioning couples' interests may influence those relationships. However, as I alluded to in Chapter 3, surrogates and commissioning couples are not the only parties whose interests are at stake in surrogacy arrangements. The primary goal of surrogacy is to bring a child into the world. Thus, it stands to reason that a consideration of children's interests may come into play when exploring doctors' obligations. Indeed, there is some indication in the surrogacy literature that in practice, doctors prioritize not only the interests of the commissioning parents, but also the interests of the children produced through surrogacy arrangements.⁵⁸ Recall, for

⁵⁸ I should note that since the commissioning couple has a strong interest in the live birth of a healthy infant, their interests are often intertwined with the well-being of the child. For instance, interventions like medically unnecessary cesarean sections are framed both as being for the benefit of the commissioning couple and also for the benefit of the child. As aforementioned, Tanderup et al. (2015b) reported doctors defending the routine use of C-sections by claiming, "No one wants to risk a vaginal delivery when it is such a wanted child," and, "These parents have been through so much, so we don't want to risk a stillbirth or other complications... So, for them even that 1 per cent or 0.1 per cent chance of having, say a catastrophe during labour ... is a risk no one would like to take" (498).

instance, the testimony of the Indian surrogate interviewed by Pande regarding her doctors' apparent priorities when it came to delivery method: "It's not like there can't be normal [vaginal] deliveries in this process but they don't want to take any risk. *The child is most important, not our bodies* [emphasis added by Pande]" (Pande 2014, 117). Such an attitude raises questions about how doctors ought to view their responsibilities towards the children they help create through surrogacy.

To answer these questions, I first explore both how children's interests are at stake in surrogacy arrangements, and also how various regulations impose obligations on fertility doctors vis-à-vis those interests. Then, I consider what potential grounds there are for imposing such obligations. I begin by considering a causal account of doctors' moral obligations. The causal account suggests that since doctors are, in part, causally responsible for the creation of these children, they are also morally responsible for their creation. However, I argue that the causal account of doctors' responsibility ends up implying that doctors have parental-like obligations to the children they help create, which is highly counterintuitive.

Rather than adopt a causal view of responsibility, I argue that what generates fertility doctors' obligations is that their role in the creation of children involves them wielding discretionary power over those future children's interests. I argue that doctors wield this power as part of a fiduciary mandate created by the state to protect the vulnerable interests of the children produced through surrogacy and other forms of assisted reproductive technology. Thus, I conclude that they have a fiduciary obligation to these children. In making this argument, I distinguish what I call *pre-conception* obligations from *post-conception* obligations, and argue that doctors' post-conception

obligations to future children are contingent upon doctors' receiving authorization from the pregnant woman to act in her future child's interests.

Finally, I address two objections to the fiduciary account of doctors' obligations to the children they help create through assisted reproduction. The first objection is that if a doctor has fiduciary obligations to future children, this may generate a conflict of interest for doctors between the pregnant woman (either a surrogate or an infertile patient in other forms of ART) and the future child. Since the duty of loyalty requires that fiduciaries avoid conflicts of interest, this suggests that doctors ought to avoid becoming involved with the provision of assisted reproductive services. I address this objection by arguing that a concern with the welfare of future children is a legitimate part of doctors' larger mandate to act in the public good. Therefore, conflicts that arise between the interests of prospective surrogates/fertility patients and future children do not give rise to divided loyalties. The second objection is that the 'non-identity' problem poses a challenge to my view, given that my view implies that a doctor could be acting in the best interests of a future child by refusing to bring him or her into existence (Cohen 2011). I address this concern by appealing to the notion that doctors' duties to future children are more structural than interpersonal. That is to say, their duties attach to whoever occupies the position of 'future child' rather than to specific, identifiable future persons.

4.1 Surrogacy, ART, and Children's Interests

Many philosophers, legal theorists, and policymakers have written on the impact surrogacy may have on the children created through it. These analyses often consider how surrogacy practices relate to children's rights (Hanna 2010; Ergas 2013; Gerber and

O’Byrne 2016), whether surrogacy involves baby-selling or otherwise commodifies children (Anderson 2000; Allan 2014; Watson 2016), or whether surrogacy is inherently harmful to children (Agnafors 2014; Baylis 2014; Overall 2015). It is beyond the scope of this chapter to fully engage with this literature. For the sake of argument, I proceed under the assumption that surrogacy, at least in principle, need not be harmful to children. That is, I assume that surrogacy does not inherently violate children’s human rights, and that there is no intrinsic reason why doctors who are concerned for children’s welfare must refuse to provide surrogacy services outright.

However, even proceeding under the assumption that surrogacy is not intrinsically harmful to children, there are still aspects of the commercial surrogacy industry that raise concerns about children’s interests. Take, for instance, the case of baby Gammy, whose birth to a Thai surrogate provoked widespread anger about transnational surrogacy and ultimately contributed to Thailand banning foreign nationals from hiring Thai surrogates. In December 2013, a Thai surrogate named Pattaramon Chanbua gave birth to twins who had been commissioned by an Australian couple, David and Wendy Farnell. According to some reports, ultrasound results had indicated that Pattaramon Chanbua was carrying twins and that the male twin had Down syndrome (Murdoch 2014). The couple reportedly requested that she undergo a selective reduction seven months into the pregnancy and only carry the healthy female fetus to term. However, she refused and decided to carry both fetuses to term (*ibid*). After the twins were born, the Australian couple returned home with only the female infant, Pipah. The male infant, Gammy, was left in Thailand under the care of Pattaramon Chanbua. When this story was reported in the news, it sparked public outrage, especially since it was revealed that David Farnell

had spent three years in prison in the late nineties for sexually assaulting two young girls. After learning this information, Pattaramon Chanbua petitioned Australian courts for custody of Pipah. Although the suit was unsuccessful, the conditions of the Farnells' retaining custody over Pipah included regular home visits from the Department of Child Protections, and the requirement that they must comply with a safety plan that prohibits Pipah from being left alone with Mr. Farnell so that he cannot "groom her" (McNeill 2016).

The case of baby Gammy raised concern about whether children's interests were being paid due regard in surrogacy arrangements. Many had the intuition that given David Farnell's history of child abuse, he should not have been allowed access to surrogacy services since he would not be a minimally decent parent. The thought that his history of abuse portended severe inadequacies in parenting seemed validated by the fact that he and his wife apparently abandoned their disabled child in Thailand.⁵⁹ Yet, it is unclear how their access to surrogacy services could or should have been prevented. Although Thailand's current regulations now prohibit international couples from traveling to Thailand to hire surrogates, they do not prevent Thai couples from doing so (as long as they are married).

⁵⁹ There are conflicting accounts as to whether the Farnells truly wanted to leave Gammy behind (McNeill 2016). However, regardless of their intentions, the fact remains that they were willing to leave their disabled son behind in a foreign country to be raised by Pattaramon Chanbua while returning home with their healthy daughter.

Some regulatory frameworks do attempt to limit access to assisted reproduction based on the interests of children. According to Guido de Wert (1998), “Suitability for parenthood has been widely established as a valid consideration in determining who may receive infertility treatment” (230-231).⁶⁰ Canada’s Assisted Human Reproduction Act (AHRA) requires that “the health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use.” In the Australian state of Victoria, which prohibits commercial surrogacy but allows altruistic surrogacy, any individual accessing surrogacy services or other forms of assisted reproduction (other than self-insemination) must undergo a criminal record check and a child protection order check.⁶¹ If an individual fails any of these checks (i.e. if it is discovered that he or she had been convicted of a sexual offense or violent crime, or previously had a child removed from his or her custody), then a ‘presumption against treatment’ applies. According to the Victoria Assisted Reproductive Treatment Authority (VARTA), “treatment may also be denied because a registered ART provider or doctor is concerned that there is a risk of abuse or neglect of a child who may be born as a result of treatment....” (VARTA, “Refusal of treatment”). In such cases, the individual(s) may apply to a Patient Review Panel, which considers whether there is sufficient evidence to deny the individual access to assisted reproductive treatments. The Panel is guided by the principles of Victoria’s 2008 Assisted Reproductive Treatment Act

⁶⁰ There is no universally accepted standard, however, for determining what constitutes suitability for parenthood.

⁶¹ Surrogacy laws vary state-by-state in Australia.

(ARTA), which state that “the welfare and interests of persons born or to be born as a result of treatment procedures are paramount” (ARTA, 5.a). The Panel is tasked with determining, among other things, whether granting an individual or couple access to ART is “consistent with the best interests of a child who would be born as a result of the treatment procedure” (ARTA, 15.3.b).

The United Kingdom’s Human Fertilization and Embryology Act (HFEA) and its accompanying Code of Practice guidance notes provide an in-depth account of how the welfare of children born through ART ought to be protected. Section 13(5) of the HFEA states, “A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting)...” HFEA guidance note “8. Welfare of the Child,” which explains how the mandatory requirements listed in Section 13(5) of the Act should be implemented, states that health care professionals working in fertility centers must consider “factors that are likely to cause a risk of significant harm or neglect to any child who may be born...” According to part 8.10:

These factors include any aspects of the patient’s or (if they have one) their partner’s: a) past or current circumstances that may lead to any child mentioned above experiencing serious physical or psychological harm or neglect, for example: i) previous convictions relating to harming children ii) child protection measures taken regarding existing children, or iii) violence or serious discord in the family environment b) past or current circumstances that are likely to lead to an inability to care throughout childhood for any child who may be born, or that are already seriously impairing the care of any existing child of the family, for

example: i) mental or physical conditions ii) drug or alcohol abuse iii) medical history, where the medical history indicates that any child who may be born is likely to suffer from a serious medical condition, or iv) circumstances that the centre considers likely to cause serious harm to any child mentioned above.

In addition, part 8.11 states:

When considering a child's need for supportive parenting, centres should consider the following definition: 'Supportive parenting is a commitment to the health, well-being and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect.'⁶²

In the UK, the health care professionals working in fertility centres are therefore held responsible for protecting the welfare of children created through assisted reproduction prior to and during conception, insofar as they must consider whether those children will have access to 'supportive parenting' or will be at risk of significant harm or neglect, before helping to bring them into existence. These regulations raise the question: should

⁶² Specifically with regards to surrogacy, guidance note 8.12 also includes the provision, "If the child will not be raised by the carrying mother, the centre should take into account the possibility of a breakdown in the surrogacy arrangement and whether this is likely to cause a risk of significant harm or neglect to any child who may be born or any existing children in the surrogate's family."

we hold health care professionals responsible for protecting the welfare of the children they help produce through assisted reproduction? What might justify the imposition of such responsibility?

4.2 The Causal Account

The most obvious explanation one might give for why fertility doctors have obligations to the children they help create through surrogacy and other forms of assisted reproduction is a causal one: doctors are causally responsible for the creation of these children, and this causal responsibility carries with it moral responsibility. De Wert endorses such a view when he explains why it is justifiable for doctors to impose a standard of suitability upon prospective parents who wish to access assisted reproduction, but not upon prospective parents who conceive naturally. He argues that in natural conception, the prospective parents bear sole responsibility and decision-making authority for reproduction. However, in the context of assisted reproduction, “a third party is involved, namely the doctor” (1998, 231). De Wert explains, the doctor “has his own responsibility for the consequences of his acts. A doctor assisting in reproduction shares the responsibility for creating a new human being. Assisting in reproduction is as little morally neutral as is reproducing” (ibid).

De Wert seems to suggest that doctors’ causal responsibility for the creation of children grounds a pre-conception duty to consider whether prospective fertility patients will be minimally decent parents before providing them with access to assisted reproductive treatment. Yet, this same type of causal argument about moral responsibility towards children has also been used to ground duties much more robust than the duty to

ensure that prospective parents are minimally suitable. Indeed, the same type of causal argument has been used to ground parental obligations. Jamie Lindemann Nelson (1991), for example, argues that “parental obligation primarily stems from the parents’ role in causing the existence of their children...” (50). She goes on to explain,

[I]n the absence of special considerations, such as force or fraud, those causally responsible for the child’s existence—and hence, her existence as a morally considerable being at serious risk of death, suffering and other harms—have a particular obligation to attempt to preserve their children from such risks. This is as much as to say, barring rape or other kinds of coercive intercourse, if you’ve been involved in making a baby, you’re responsible for it, whether you consent to such responsibility or not. (*ibid*)

In other words, parental responsibility is grounded in the act of voluntarily contributing to the existence of “specific valuable and vulnerable beings” who have needs and who will suffer greatly if those needs are not met (Nelson 2014, 190).

Nelson argues, further, that not all actors implicated in the causal chain of events leading up to the creation of a child acquire parental obligations. A banker who provides a couple with a loan to finance their fertility treatment would not, for instance, acquire parental obligations to the subsequently produced child. To determine which causal agents acquire parental obligations, Nelson appeals to the roles played by sufficiency and proximity in causation. She claims that in the absence of special mitigating factors, actions that are proximate to and jointly sufficient for a particular event are typically regarded as being that event’s cause. When it comes to parental obligation, Nelson argues

that “the making available of one’s gametes is an act highly proximate to conception, and, in concert with the other parent’s actions, is jointly sufficient for it” (1991, 54). This implies, according to Nelson, that any person who has contributed their gametes to conception (not only individuals actively attempting to conceive, but also sperm and egg providers, one-night stands, and sexual partners who have no interest in being parents), have parental obligations to the subsequently created children.

Yet, the limiting criteria of proximity and joint sufficiency do not seem to rule out fertility doctors as potential bearers of parental responsibility. In the context of assisted reproduction, the actions of the doctors involved are proximate to conception, arguably more so than a sperm or egg provider who may have contributed gametes months or years prior to conception. Furthermore, the actions of the fertility doctor, when done in concert with the actions of the intended parents, are jointly sufficient for the creation of the child.⁶³ Should we therefore conclude that doctors have parental responsibility to the children they help create through ART? Such a view would strike many as implausible. For one thing, it would imply that doctors have a duty to ensure that children’s needs are met throughout their lives, and to step in if those needs are not being met. This would be highly burdensome for fertility doctors, who likely help create hundreds if not thousands of children over the course of their careers.

⁶³ Moreover, in such cases, the actions of the prospective parents alone would not be jointly sufficient for the creation of a child. I thank Charles Weijer for this point.

Nelson addresses this worry by introducing a further criterion: irreplaceability. She argues that gamete providers are “irreplaceably involved in the production of the child in a way that other causal agents (apart from the mother) are not” (59). The thought seems to be that other causal agents, including the doctors involved in assisted reproduction, are more fungible than gamete providers, and are therefore less implicated in the causal chain that leads to moral responsibility. A causal agent is understood as irreplaceable if he or she plays, as Tim Bayne (2003) puts it, “a crucial role in fixing the identity of the child” (81). Fertility doctors, according to Nelson, are interchangeable in a way that gamete providers are not when it comes to the setting of a child’s identity.

However, as Bayne points out, fertility doctors do engage in certain medical interventions that would qualify as ‘identity-determining’ (2003, 81). For instance, some forms of mitochondrial replacement therapy (such as Maternal Spindle Transfer, which involves removing the maternal spindle from the egg of a woman suffering from a mitochondrial disorder and placing it in a healthy enucleated donor egg prior to fertilization) alter the genetic makeup, and therefore arguably the identity, of the resulting child (Wrigley, Wilkinson, and Appleby 2015).⁶⁴ Nelson could respond by arguing that the doctor who performs the Maternal Spindle Transfer is still more fungible than the gamete provider. A different doctor could have performed the same identity-determining procedure. However, this response ultimately ends up collapsing the causal account into a mere genetic account (that is, an account that views parental responsibility as a product of

⁶⁴ More generally, fertility doctors select which eggs to fertilize and which embryos to transfer, which can also be understood as identity-determining acts.

genetic connection) (Bayne 2003, 78, 81). As Bayne explains, “What’s doing the work here isn’t the role of the gamete donor as an efficient cause of the child, but the structuring role of ‘their’ gametes” (2003, 81). If a causal account is to avoid this collapse into geneticism, it seems as though it must accept that fertility doctors too have parental responsibility. Such an implausible conclusion constitutes a good reason to reject a causal account of parental responsibility altogether.

To return to De Wert, when he suggests that doctors have moral responsibility towards the children they help create through assisted reproduction, he is presumably not suggesting that doctors should have parental obligations to these children. The responsibility he has in mind is clearly a pre-conception obligation to use assisted reproductive technologies in a manner consistent with the interests of the children potentially created through them, rather than an on-going parental responsibility to ensure that those children’s needs are being met. If not causal responsibility, then what might ground this type of obligation? Is there a justification for doctors’ refusing, for example, to provide demonstrably unfit individuals with access to ART that does not rely on giving special moral significance to their causal role in the creation of children?

4.3 The Fiduciary Account

In this section, I argue that fertility doctors have fiduciary obligations to the children they help create through ART. I argue that fertility doctors’ obligations arise not because they are causally responsible for the creation of these children, but rather because doctors

make discretionary judgments about those potential children's interests.⁶⁵ In providing an individual or couple with access to ART, a doctor actively makes discretionary judgments that will greatly impact the interests of a potential future child. If a doctor provides a couple who are demonstrably unfit for meeting a future child's needs with access to ART, this will likely have a significant negative effect on that child's welfare. The same could be said were a doctor to use ART to create a child with a painful, debilitating condition or otherwise make use of these technologies in a negligent manner. What is relevant for grounding doctors' duties, I claim, is not that doctors are causally responsible for the creation of vulnerable individuals with needs that must be met, but rather that potential future children's significant practical interests are highly vulnerable to doctors' use or misuse of discretionary power.

As discussed extensively in the preceding chapters, fiduciary relationships arise when one party exercises discretionary authority over the significant practical interests of another. If it's true that fertility doctors make discretionary judgments regarding the welfare of the children they help create, then doctors' obligations to these potential future children could indeed be viewed as fiduciary. Taking a fiduciary approach to understanding fertility doctors' obligations to future children is attractive because, unlike the causal approach, it can offer an account of responsibility that is sufficiently narrow in scope. If obligations to future children arise from exercises of discretionary power, this

⁶⁵ Importantly, I am not arguing that doctors have anything akin to parental obligations. Although both doctors and parents may act as fiduciaries, the scope of their fiduciary authority over children is very different.

helps explain why many causal actors (such as lab technicians, clinic support staff, or bankers who finance fertility treatments) do not have these obligations. Of course, many individuals who play important causal roles in the creation of children through assisted reproduction take actions that will affect the future interests of those children. However, those actions do not involve wielding any authority to act relative to future children's significant practical interests. As I will explain, the actions taken by fertility doctors during and prior to conception do involve the exercise of this type of power, and thus fertility doctors can be understood as fiduciaries to the future children they help create.

However, before I can argue for this position, I must establish that fiduciary duties are the sorts of things that can actually attach to *future persons*. Certainly, most fiduciary relationships arise between entities or individuals who currently exist. These relationships typically involve an identifiable beneficiary authorizing a fiduciary to act on her behalf, as is commonly the case in doctor-patient relationships. Yet, not all fiduciary relationships involve a clearly identifiable beneficiary. P. B. Miller and Andrew Gold (2015) argue that there are two types of fiduciary mandate: service-type mandates and governance-type mandates. Service-type fiduciary mandates, which are the most common type of fiduciary mandate, exist to serve the interests of determinate persons. The fiduciary mandate of a lawyer is to represent the interests of her client, for instance. The service-type mandate is the type of fiduciary mandate I have been discussing when considering the doctor-surrogate relationship. On the other hand, governance-type fiduciary mandates arise in order to determine or advance certain abstract purposes, such as in the administration of a charitable trust to promote literacy. In governance-type fiduciary relationships, “[t]he powers of the fiduciary, and the objects for which he acts,

are specifiable entirely with reference to one or more abstract purposes without it being necessary to identify a beneficiary, much less the particular interests or preferences of that beneficiary,” (P. B. Miller and Gold 2015, 4). According to P. B. Miller and Gold, fiduciary mandates can therefore exist without identifiable beneficiaries whose “personal practical interests in the mandate are ascertainable *ex ante* and whose interests are protected through personal enjoyment of rights or powers relative to the mandate” (2015, 8). Governance-type fiduciary mandates are held relative to collectives whose membership may be more determinate (such as particular communities) or less determinate (such as members of a socio-economic class). These types of fiduciary relationships are institutional, rather than interpersonal, and are maintained through legal offices that may be occupied by various individuals over the course of many years.

Fiduciary authority in governance-type relationships is derived from a benefactor empowering a fiduciary office to act in order to pursue an abstract purpose. Individuals other than the beneficiaries themselves can thus grant fiduciary authority.⁶⁶ Moreover, since the mandate of a fiduciary institution can be specified without having to identify particular beneficiaries, it can theoretically be constructed so that the beneficiaries are persons who do not yet exist. For example, one could imagine a charitable trust initiated to aid individuals displaced as a result of climate change, which had been set up such that all of its beneficiaries are people who will be born years from now. P. B. Miller and

⁶⁶ Individuals other than beneficiaries can also grant fiduciary authority in service-type relationships. For instance, as I mention below, parents can grant doctors fiduciary authority over their children’s interests.

Gold's work therefore offers an account of how it is possible to have fiduciary duties to future persons. Such a view supports claims made by some in the realm of environmental law about fiduciary obligation and the interests of future persons. Ken Coghill, Charles Sampford, and Tim Smith (2012), for example, have suggested that the principles of fiduciary duty may help guide how governments protect the interests of future generations from the harms of anthropogenic climate change.

Given that it is possible for individuals who do not yet exist to be beneficiaries in fiduciary relationships, I can now return to my analysis of the doctor-future child relationship. Potential future children are indeterminate beneficiaries insofar as their specific interests and identities are unknowable *ex ante*. In that sense, they are different from the type of beneficiary typically involved in service-type fiduciary relationships. Yet, future children are more determinate than the highly abstract beneficiaries that governance-type mandates seem to involve (for example, "the public"). When a doctor is considering a particular request for ART, she must consider not how her decisions would affect future children in general, but rather how they would affect a particular future child, who would be born to particular parents or have certain features (such as a genetic condition). Thus, whatever the relationship between fertility doctors and the children they help create through assisted reproduction is, it does not fall neatly under the category of either type of fiduciary mandate.

Is there a middle ground between these two types of mandate? Is it possible to have a relationship that involves features of both service-type and governance-type fiduciary relationships? P. B. Miller and Gold actually describe some relationships that involve "a hybrid mandate involving service and governance elements" (580). One

example of a hybrid fiduciary mandate is the mandate that governs public benefit corporations. Public benefit corporations have two types of beneficiaries: the company's shareholders and the public. As a for-profit company, the corporation's board has fiduciary duties to its shareholders. As a corporation that exists for the public benefit, the pursuit of shareholder's pecuniary interests is tempered by corporate commitments to certain public goods.⁶⁷ However, in this case, the hybrid character of the mandate is the result of there being two classes of beneficiary. What I have in mind when it comes to doctor-future child relationships is a class of beneficiary that is itself 'hybrid,' which comprises neither concrete individuals nor abstract purposes, but rather particular future persons.

To the best of my knowledge, there has yet to be a discussion in the literature on fiduciary relationships that considers this type of 'hybrid' beneficiary. However, I argue that if fiduciary obligations can attach to both individuals and also future generations, there is no principled reason to exclude future individuals. What remains to be established is whether or not there can actually be any fiduciary *authority* in such cases. In order for the relationship between doctors and the future children they help create through assisted reproduction to be fiduciary, doctors must wield discretionary authority over those future children's significant practical interests. When fertility doctors make decisions about whether or not to grant couples access to ARTs, they are certainly

⁶⁷ One could potentially make the argument that doctors in general also have, in some sense, a hybrid fiduciary mandate since they have duties both to their patients and also to the public.

exercising power over the significant practical interests of any future child that is created. This power is discretionary in nature since the doctor is ultimately the one who makes a decision about whether to provide access to ARTs and how these technologies will be administered based on her own professional judgment.⁶⁸ But is this power truly authority? A potential future child is clearly unable to authorize a doctor to make decisions on her behalf. So where would the authority to act on the potential future child's behalf come from?

In general, when doctors treat children, they do so on the basis of the authority granted to them by the child's parent(s). One could argue that in seeking out assisted reproduction, an individual grants a doctor a similar type of authority, namely the authority to act on behalf of their future children. However, in the standard doctor-child relationship, the parent usually retains final decision-making authority, and is allowed to refuse a doctor's medical recommendations for her child. It would seem that if a doctor wishes to refuse to grant an individual access to ART out of concern for a potential future child's interests, the prospective parent should similarly be entitled to refuse to take the doctor's recommendation. Why should the parent retain decision-making authority in the former case, but not in the latter?

To answer this question, I note that there are instances when parental authority over a child's medical treatment can be overridden. For instance, according to a 2004

⁶⁸ As I will discuss below, doctors do not necessarily have expertise in evaluating parental suitability.

position statement by the Canadian Pediatric Society:

When the physician and health care team believe that parental decisions are clearly inconsistent with the child or adolescent's best interests, the assistance of an institutional ethics committee or ethics consultant is recommended. If this is not available or the conflict is not resolved at this level, then the involvement of local child protection authorities and the legal system may be unavoidable.

Although such a course of action is often uncomfortable for the health care team and should only be used as a last result, its ethical basis rests soundly on the health care professional's duty to ensure that the best interests of the child or adolescent are given primacy. ("Treatment Decisions Regarding Infants, Children and Adolescents," 102-103)

Thus, medical professionals can seek to override parental decision-making authority if the child's interests are not being adequately protected. Such considerations therefore point towards the state as an additional source of fiduciary authority over children's interests.

I suggest that, at least in countries where the state licenses fertility doctors to provide ARTs and requires that they consider the welfare of the children they help create through their use of such technologies, the state effectively creates a fiduciary mandate for fertility doctors to protect the interests of potential future children. Although the specific interests of these potential children cannot be known *ex ante*, all future children have basic significant practical interests, such as an interest in having access to minimally decent parenting and an interest in not being born with preventable, highly debilitating

conditions.⁶⁹ Fertility doctors have discretionary power over these interests insofar as they are both the gatekeepers to accessing ART, and also the providers of these treatments (who play a large role in determining which technologies will be used and how they will be administered). I therefore claim that fertility doctors can have obligations to the children they help create through assisted reproduction as part of a fiduciary mandate created by the state.

In making this argument, it is useful to note the interplay between recognizing that a given relationship involves the kind of structural vulnerability inherent in fiduciary relationships and creating fiduciary mandates. Recall that in Chapter 1, I defended Evan Fox-Decent's (2005) view that in some circumstances, it is sufficient for the establishment of a fiduciary relationship "that the fiduciary has discretionary control over the vulnerable interests of another party which themselves are capable of forming the subject matter of a fiduciary obligation" (294). In such cases, fiduciary mandates are created out of the recognition that one party has discretionary control over the vulnerable interests of another. I argue that when legislation requires that doctors consider the welfare of potential future children, it does so out of recognition that those children's significant practical interests are highly vulnerable to the decisions made by fertility doctors. It is this legislation that grants doctors the authority to act on behalf of these potential future children since they cannot authorize doctors themselves. Thus, there is both an element of recognition and of creation when it comes to the fiduciary obligations

⁶⁹ The conditions I have in mind are not ones like deafness, which is arguably not debilitating, but rather painful, life-shortening conditions like Tay-Sachs disease.

fertility doctors have to potential future children. In the absence of such legislation, doctors may not actually have the authority to make decisions on behalf of potential future children (such authority resides with the pregnant woman, unless she grants it to her doctor). However, recognizing potential future children's vulnerability to doctors' decisions could provide a compelling reason for the state to create a fiduciary mandate.

Finally, when discussing the fiduciary obligations of fertility doctors, it is helpful to clarify at what juncture(s) doctors actually have discretionary authority over the interests of potential future children. I have thus far been discussing doctors' discretionary powers in pre-conception decision-making—that is, in making decisions about whether to provide access to ART, what particular technologies to make use of, and how to provide them. These decisions concern future children who may or may not be conceived. However, one may also wonder whether doctors have post-conception discretionary authority over the future children they help create. That is, one may wonder whether doctors also have fiduciary duties to future children once they are instantiated as fetuses.

Before addressing this question, I want to emphasize that there is, in general, an important moral distinction between fetuses and future children. Bonnie Steinbock (2011) makes this distinction when she argues that the moral obligations that pregnant women have change if and when they decide to carry their fetus to term. She states, "Once this decision [to carry a fetus to term] is made, the fetus is not simply a potential child. It *will* be a child who, once born, has interests, including an interest in a healthy life" (Steinbock 2011, 31, my emphasis). On this account, we should view fetuses as being future children only when a pregnant woman decides to bring that child to term. The fetus is morally

considerable at that juncture not because it has interests *qua* fetus, but rather because it will one day have interests *qua* person. Anne Lyerly, Margaret Little, and Ruth Faden (2008) make a similar distinction when they argue that medical professionals acquire duties to fetuses that are not simply derivative of their duties to their pregnant patients only when those patients decide to continue with their pregnancies (42). In short, fetuses should be thought of as future children only so long as the pregnant woman intends to carry them to term.⁷⁰ This distinction means that one can accept the view that doctors can have fiduciary duties to future children without having to accept that doctors necessarily have duties to all fetuses. Therefore, my view about doctors' duties to future children does not provide any justification for limiting access to abortion.

Bearing this distinction in mind, I argue that doctors can have fiduciary duties to fetuses, but only in cases where they genuinely have discretionary authority over that fetus's (*qua* future child's) significant practical interests. Fertility doctors may continue to have post-conception power over the interests of the future children they help create, insofar as they have the ability to intervene in a woman's pregnancy in ways that can affect the resulting child's future welfare. However, this does not mean that they have the authority to do so. Once that future child resides in the body of a woman, she is the one who now has authority over its interests. This is because, as Rosamund Scott (2002)

⁷⁰ My view implies that if a pregnant woman who previously had wanted to carry her fetus to term changes her mind, then her doctor should no longer view her fetus as a future child. For the sake of brevity, I put aside debates about the moral status of viable fetuses.

argues, her body is implicated in any decision made about the fetus. Her right to bodily integrity and self-determination are therefore inextricably at stake (Scott 2002, 24-25). Doctors simply do not have the authority to override competent adults' decision-making about their own bodies. They do not, therefore, have authority over the interests of future children post-conception. That said, it is possible for pregnant women to grant authority over the interests of their future children to doctors. Imagine a case where a doctor discovers that a fetus, which a pregnant woman intends to bring to term, suffers from myelomeningocele (a defect wherein the spinal cord does not form or close normally), and that fetal surgery is a viable option for treatment. In this case, the pregnant woman may consent to surgery and authorize the doctor to wield discretionary power not only over her interests, but also over the interests of the fetus.⁷¹ In this case, I claim that the doctor would have fiduciary obligations to the fetus *qua* future child.

4.4 Objections

In this section, I address two objections to the notion that fertility doctors have a fiduciary mandate to act in the interests of the children they help create through assisted reproduction. The first is the *divided loyalties* objection, which argues that if doctors have fiduciary duties to future children, this may create a conflict of interest between the future

⁷¹ Again, I am understanding the interests of the fetus as the interests of a future person, not as the interests of a fetus *qua* fetus. It should also be noted that the interests of the pregnant woman and the fetus are deeply intertwined, and it is difficult to conceptually separate them.

child's interests and the pregnant woman's interests. Since fiduciaries must avoid conflicts of interest, they should therefore avoid any situation where their loyalties to their pregnant patients clash with their loyalty to the future children they help create. That is, they should refrain from providing ART services. The second objection is the *non-identity problem* objection. This objection implies that, on my view, a doctor can discharge her fiduciary obligation to a potential future child by refusing to bring that child into existence. This implication strikes some as implausible since they claim that even if a particular child would have unsuitable parents or suffer from a debilitating genetic condition, it would still be in her best interest to be brought into existence.

4.4.1 The Divided Loyalties Objection (A Reprise)

In section 4.3, I claimed doctors do not wield fiduciary authority over the interests of future children when there is an established pregnancy (beyond whatever authority is granted to them by the pregnant woman). Thus, no conflict of interest arises. However, one may question whether, prior to conception, there is a genuine conflict between the interests of future children and the interests of surrogates or prospective fertility patients. Recall that fiduciaries have an obligation to act loyally to their beneficiaries, which includes the obligation to avoid conflicts of interest. That is, fiduciaries must avoid situations where their professional judgment or actions will be unduly influenced by a secondary interest. If there is a case in which a doctor has a fiduciary obligation to both a potential future child and also to a prospective parent or surrogate, then this may give rise to a conflict of interest since the interests of the respective parties may clash. For example, returning to the hypothetical case of Anna and Dr. Brown from the previous

chapter, imagine a situation where Anna is an individual struggling with fertility who goes to Dr. Brown, a fertility specialist, for tests. The tests determine that Anna is unable to carry a child to term. So, Anna decides to pursue surrogacy as an option, and finds a woman, Connie, willing to serve as her gestational surrogate. Anna returns to Dr. Brown and requests assisted reproductive treatments as part of the surrogacy process. In this case, a clear doctor-patient fiduciary relationship has been established between Anna and Dr. Brown since Dr. Brown had been performing medical tests on Anna and providing her with diagnoses. However, imagine further that while discussing the treatments with Dr. Brown, Anna discloses that she chose to pursue surrogacy because she knows she would be unable to adopt due to prior convictions regarding child abuse. At this point Dr. Brown feels conflicted. If, as I argued in the previous sections, Dr. Brown has a duty to protect the interests of the children she helps create through assisted reproduction, she ought to refuse to provide Anna with ART treatment. Yet, as her doctor, Dr. Brown also has a fiduciary relationship with Anna, which means Dr. Brown must loyally act in Anna's interests when it comes to her medical treatment.⁷² In general, if doctors have a fiduciary duty to act in the interests of potential future children, and also a fiduciary obligation to act in the interests of individuals seeking access to ART, this appears to routinely generate conflicts of interests for fertility doctors. Should doctors therefore

⁷² There might be some disagreement as to whether a desire to have a child through assisted reproduction rises to the level of a significant practical interest. If it does not qualify as a significant practical interest, the divided loyalties objection would not arise. I thank Dennis Klimchuk for this point.

refuse to become involved in the provision of assisted reproductive services to avoid such conflicts and uphold their fiduciary duties? This would certainly be an undesirable situation.

This is a challenging objection. Is it possible to maintain that doctors have duties to potential future children without placing them in situations of divided loyalties? To answer this question, I return to an argument from Chapter 1 regarding the nature of fiduciary loyalty. In that chapter, I claimed that not all instances of multiple loyalties rise to the level of divided loyalties. I defended the view that loyalty is a matter of motive: a fiduciary can be understood as acting loyally when her actions are motivated by a good faith desire to use her discretionary power in order to achieve the ends for which she was empowered in the first place. For instance, if I am the CEO of a company, I am acting loyally when I use my power over that company's resources in order to produce optimal returns for my shareholders (rather than using my power to personally profit or sabotage the company). Further, I claimed that the social role of doctors involves the expectation that the profession will address certain issues pertaining to the public good, even if this means sometimes prioritizing the public good over the wants of a particular patient (such as in disease outbreak crises). Given that social role, I argued that if doctors use their discretionary power over patients partly in service of the larger obligations they have to society *qua* medical professionals, this ought not to be viewed as disloyalty. This is because patients grant doctors power over their interests not only with the goal of promoting their health as individuals, but also insofar as they are members of a society that has a collective interest in the public good.

Returning to the case of assisted reproduction, I argue that the medical profession is entrusted with the responsible use of ARTs as part of society's broader interest in protecting vulnerable persons from harm. Thus, if a doctor refuses to provide access to ART services out of concern for the interests of potential future children, this can be a legitimate use of her discretionary power, even if it means she ultimately does not fulfill the immediate wants of the prospective parents or surrogate. This is, I argue, a case where a doctor has multiple loyalties, not divided loyalties. After all, doctors do not have a fiduciary obligation to provide patients with access to any medical treatment they desire. Rather, doctors should act in the best interests of their patients in a way that is consistent with fulfilling their social role as doctors. It would be unethical for a doctor to single-mindedly pursue the interests of her patients with no regard for how any of her actions may affect other parties (for example, by helping her patient unfairly circumvent a waiting list to receive an organ transplant).

In addition, when it comes to infertile prospective parents, I argue that these patients have a strong interest in having children who are emotionally and physically healthy.⁷³ If individuals seeking out assisted reproduction have demonstrated a clear inability to provide minimally decent parenting (for instance, by having a prior conviction for abusing children), then it may truly not be in their interests, broadly construed, to have access to assisted reproduction. Returning to the case of a doctor

⁷³ It is not obvious that the same could be said about surrogates. Although, one could potentially argue that surrogates do have an interest in producing healthy children who will be adequately cared for since doing so is in the public good.

quarantining a contagious patient, it is true that being quarantined may frustrate a patient insofar as it restricts her freedom of movement. However, as a member of society, she ultimately has an interest in not spreading a disease amongst the population. Given such considerations, I argue that a doctor who refuses to provide access to assisted reproduction in order to protect the interests of potential future children does not act disloyally to her patients. Doctors' multiple loyalties in assisted reproduction therefore do not present a genuine conflict of interest.

4.4.2 The Non-Identity Problem Objection

A final objection to the fiduciary duties to future children view is that it faces issues of 'non-identity.' The non-identity problem is best understood by way of an example: suppose an individual decides to use *in vitro* fertilization coupled with the genetic testing of embryos to specifically select for a gene that causes significant health problems. The child who is born as a result of this procedure has serious health issues, although she still leads a life that is worth living. Some have the intuition that this action is morally wrong.⁷⁴ Nonetheless, it was this very action (selecting an embryo with a genetic defect) that brought this specific child into being. Selecting a healthy embryo would have produced a child *non-identical* to the child who was born. In such a case, "we find it difficult to explain why an individual appears to be wronged by an action that is the condition of his or her own worthwhile existence" (Gardner 2015, 429).

Problems of non-identity present an explanatory difficulty for my account of

⁷⁴ Some disability rights activists may object to this line of argument.

fiduciary duties to future persons. If a doctor has a pre-conception obligation to act in the best interests of a potential future child, can she ever refuse to provide prospective parents with access to assisted reproduction, so long as the child would still lead a minimally worthwhile existence? Even if the child would be born with serious ailments or to abusive parents, is it really in that child's best interest to not be created?

The literature on non-identity and reproductive ethics is vast, and it is beyond the scope of this chapter to adequately address all the issues it brings up regarding what it means to act in the interests of future children. However, I will provide a provisional sketch as to how my view can avoid such concerns. I mentioned earlier that governance-type fiduciary mandates are held relative to collectives whose membership may be more or less determinate, and that the fiduciary relationships that exist under such mandates are institutional, rather than interpersonal. That is, they are maintained through offices that may be occupied by various individuals over time, and thus there may be no particular fixed beneficiaries (or fiduciaries, for that matter).

This framework is applicable to understanding the fiduciary duties doctors have to future children. I suggest that when making decisions about whether or not to provide an individual or couple with assisted reproduction services, there is no future child with a fixed psycho-physical identity to whom a doctor's duties attach. Rather, the individual towards whom a doctor has duties occupies something akin to the 'office' of future child. That is, doctors' duties attach to whoever will occupy the structural position of future child instead of a future person with a fixed identity. This framing of fertility doctors' duties avoids the non-identity problem since it implies that they do not have obligations to act in the interests of future people with identities that would be altered through

medical interventions (or lack thereof). A doctor can therefore act in the best interests of a future child by refusing to grant demonstrably unfit parents access to assisted reproduction since the future child who would be produced is not a beneficiary with a fixed identity (but rather a more abstract future child). This account makes it clear that doctors are not obligated to bring any specific person into existence. Instead, they must simply act in the interests of whoever will occupy the structural position of ‘future child.’⁷⁵

⁷⁵ It is interesting to note that my response echoes an approach to the non-identity problem taken by Rahul Kumar (2003). Kumar considers the case of a child born with “severe restrictions on the quality of her life,” which could have been prevented had her parents taken appropriate precautions prior to conception, such as undergoing certain genetic tests (2003, 99). Kumar argues that the child has been wronged, despite the fact that had her parents undergone such tests, the child they conceived would have been non-identical to her. To respond to this non-identity problem (i.e. how could the child have been wronged by the very act that brought her into existence?), Kumar claims that it is useful to distinguish between the *type* ‘person’ and individuals who are *tokens* of that basic *type*. As he puts it,

A ‘type’ of person is not, of course, a substantive individual.... Rather, the ‘types’ in question are simply normatively significant sets of characteristics, whose instantiation together may be found in actual, substantial, individuals.... An individual, for instance, is a token of the basic type ‘person’ insofar as those facts that are picked out by the type description ‘person’ are true of her. (2003, 111)

4.5 Conclusion

In this chapter, I have argued that health care professionals have a fiduciary mandate to protect the interests of the future children they help create through assisted reproduction. First, I argued that the interests of future children are at stake in decisions about who is

Kumar argues that the type/token distinction is relevant because what matters for understanding the prospective parents' moral duties is that they may create an individual who is the *type* 'child' who suffers from a serious, preventable condition. This *type* child will stand in a morally considerable relationship of dependency with them, regardless of its eventual *token* identity. As Kumar puts it, the fact that the "particular psycho-physical identity of the person in question, at the point in time when compliance with the duty is required, may still be an indeterminate matter turns out to be of no consequence," precisely because "the other retains her standing as a certain type to whom certain duties are owed regardless of what her token identity turns out to be" (2003, 113). Kumar's type/token argument is similar to my claim that doctors' duties attach to whoever ends up occupying the 'office' of future child insofar as in both approaches, the actual identity of the 'office-holder' of future child (on my account) or the *token* instantiation of the child (on Kumar's account) is not a relevant consideration. The duties in question do not flow from a doctor or prospective parent, respectively, to a particular future child, but rather are the product of the structural relationship between the doctor/prospective parent and whoever that future child happens to be.

granted access to surrogacy and other forms of assisted reproduction. Then, I explored a causal account of why doctors might be responsible to protect future children's interests, and claimed that this view was not satisfactory. I argued that it is not the causal role that doctors play in the creation of children, but rather the discretionary power doctors wield over potential future children's interests that is relevant. Finally, I defended the fiduciary account from two objections: the divided loyalties objection and the non-identity problem objection.

I want to conclude by addressing a final concern, which is that although doctors may have the power to make decisions about who will receive assisted reproductive services (which will greatly impact the future welfare of children created through these technologies), doctors may not necessarily be well qualified for assessing whether a given individual will be a suitable parent. I concede this point. Rather than having doctors make judgments about parental suitability, it may well be preferable for the state to introduce screening requirements for access to ART similar to those used in adoption (such as having a social worker conduct a home study before the individual or couple is cleared to access fertility services).⁷⁶ This way, by the time infertile individuals approached fertility doctors to request treatment, doctors could be assured that these individuals had fulfilled certain criteria for parental suitability. Doctors would retain certain types of discretionary authority over the interests of potential future children, for example, when it comes to decisions about what ARTs to use and how they should be

⁷⁶ For a discussion of surrogacy, adoption, and 'parental licensing,' see McLeod and Botterell 2014; Overall 2015; Botterell and McLeod 2016.

administered. However, doctors would not have to consider whether infertile individuals would be minimally decent parents. Such a system may better enable doctors to make responsible use of assisted reproductive technologies and to protect the vulnerable interests of future children.

Conclusion

In my thesis, I have argued that the framework of fiduciary relationships serves as a promising foundation upon which to ground and explicate fertility doctors' duties in commercial surrogacy, and also in the fertility industry more broadly. I began by defending the view that fiduciary relationships are relationships that arise when one party exercises discretionary authority to set or pursue the significant practical interests of another. Given this understanding of fiduciary relationships, I argued that the doctor-patient relationship is a fiduciary relationship, and that doctors owe their patients the duty of loyalty. Further, I claimed that despite the differences between the typical doctor-patient relationship and the doctor-surrogate relationship, the relationship between doctors and the surrogates they treat is normatively fiduciary.

Having established that the doctor-surrogate relationship is fiduciary in nature, I demonstrated how surrogacy arrangements give rise to serious conflicts of interest for fertility doctors. These conflicts of interest, including conflicts of fiduciary duty and financial conflicts, threaten doctors' ability to act loyally to surrogates. Importantly, although I did not claim that doctors' involvement in surrogacy is inherently problematic, I argued that understanding fertility doctors' fiduciary obligations reveals that many of the practices currently taking place in commercial surrogacy are objectionable. In response to the concerns I raised, I made several recommendations for ameliorating surrogacy arrangements. Taking inspiration from ethical debates surrounding divided loyalties in sports medicine and organ donation, I argued that there needs to be greater clinical and financial distance between commissioning couples and the doctors treating

surrogates. To achieve this separation, I suggested that surrogates' doctors should not be paid directly by commissioning couples, and that fertility clinic owners should perhaps refrain from entering into doctor-patient relationships with surrogates so as to avoid financial conflicts of interest. Moreover, I argued that single embryo transfer should be adopted as the standard of care to eliminate the risk that doctors could be unduly influenced by commissioning couples' interests or their own financial interests to attempt to increase pregnancy success rates in a way that poses unnecessary risks to surrogates (i.e. through multiple embryo transfer). Finally, if commissioning couples require fertility treatment or medical information in the course of the surrogacy arrangement, I argued that this treatment or consultation should be provided by a health care professional who is independent from the doctor or team providing the surrogate's care. In my future research, I aim to consider how these recommendations can be operationalized in the Canadian health care context, given that surrogacy is on the rise in Canada and that the Canadian government is currently revisiting the Assisted Human Reproduction Act.

Lastly, I explored fertility doctors' obligations to the children they help create through surrogacy and other forms of assisted reproduction. The future interests of children created through assisted reproduction are, I claimed, highly vulnerable to doctors' discretionary judgments about what types of technologies are used, how they are used, and who is granted access to them. I argued that this vulnerability to exercises of discretionary power can give rise to a fiduciary obligation on behalf of the doctor, specifically under regimes where the state requires that health care professionals consider the interests of future children when providing access to assisted reproduction. In such cases, I argued that a fiduciary mandate is created that empowers ART providers to act in

the interests of potential future children. However, I also conceded that doctors may not be well equipped to make certain judgments pertaining to the welfare of future children, such as whether a given individual requesting assisted reproductive services will be a minimally decent parent. It may therefore be preferable for other groups, perhaps social workers, to evaluate prospective parents to ensure that they meet certain standards for parental suitability. Of course, there is much debate as to what constitutes parental suitability. Yet, imposing minimal standards, such as not having criminal convictions for child abuse or other violent crimes, may be less controversial. In the future, I hope to develop a more thorough account of the consequences and limits of my view about doctors' fiduciary duties to future children. In addition, I aim to further explore what implications my view on fiduciary duties to future persons may have for other types of relationships, including the relationship between prospective parents and their future children and the relationship between governments and their future citizens.

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