

A surrogate's secrets are(n't) safe with me: patient confidentiality in the care of a gestational surrogate

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ABSTRACT

Gestational surrogacy relies on a legal agreement between the surrogate and the intended parents to define the roles and responsibilities of the parties, including explicit consent by the surrogate to allow the physician to release all pregnancy-related medical information to the intended parents. In the event of surrogate misconduct, however, physicians may feel conflicted if the surrogate asks the physician to withhold information about potentially dangerous behaviour in pregnancy from the intended parents. While the American Society for Reproductive Medicine guidelines may support disclosure over the objections of the surrogate, the authors argue that such disclosure is a violation of the surrogate's rights and the physician's ethical and professional duties. A surrogate's confidentiality must be maintained as it is an essential element of the physician–patient relationship.

INTRODUCTION

Gestational surrogacy raises multiple ethical and legal issues, and is inconsistently regulated across the USA. The practice of gestational surrogacy relies on the existence of a contract between the intended parents (IPs) and the surrogate, and separates the genetic, social and gestational roles of parenthood among the participating parties. This arrangement can lead to conflicts between the parties themselves, and for the treating physician who may feel she or he has conflicting duties in the care of the patient. This paper addresses the potential conflict that may arise in the event of surrogate misconduct, and analyses the relevant rights of the surrogate and duties of the physician in the course of treatment of gestational surrogates. Specifically, the authors address two questions: (1) whether a surrogate's waiver of confidentiality and subsequent revocation affects a physician's duty to maintain confidentiality, and (2) whether third-party interests are compelling enough to justify a physician's disclosure of information over the objections of the surrogate.

CONFLICT

Suppose a woman enters into a contract with a couple to carry their genetic child and relinquish custody to these intended parents after birth. The contract explains in detail the rights and responsibilities of each party, and includes specific provisions regarding the activities the surrogate can and cannot engage in while pregnant. These provisions include a total prohibition on caffeine, nicotine and alcohol, as well as an agreement that the surrogate will avoid deli meats and fish high in mercury content. The surrogate also agrees to adhere to a

daily vitamin regimen and eat a high-protein, low-sugar diet. Finally, in the contract, the surrogate expressly agrees to waive her right to confidentiality with regard to pregnancy-related medical care, allowing her treating physician to disclose pregnancy-related information to the intended parents.

This arrangement works well until the 16th week of pregnancy, when the surrogate admits to her physician, in private, that she has been drinking wine during the second trimester and has occasionally forgotten to take her prenatal vitamins. She tells the physician not to disclose this to the intended parents, and promises she will not drink anymore. How should the physician address this instance of surrogate misconduct? Does the physician owe a duty to the intended parents to inform them of this behaviour, or does the physician owe a greater duty to the surrogate to maintain patient confidentiality?

POLICY POSITIONS

The American Society for Reproductive Medicine (ASRM) has addressed the issue of gestational carrier (GC) misconduct and the relevant duties of the treating physician. According to their 2013 published opinion, 'Misconduct in third-party assisted reproduction: a committee opinion', disclosure by the physician may be appropriate in limited cases:

[W]hen a GC engages in conduct that is potentially harmful to the resulting child and would have excluded the patient from being considered as a gestational carrier at the outset, the physician should take steps to inform the intended parent(s) of the GC's behavior. Initially, the physician should encourage the GC to self-disclose and *after a brief period can discuss the GC's actions with the intended parent(s)*.¹ (emphasis added)

The American College of Obstetricians and Gynecologists (ACOG), on the other hand, seems to offer a different, although unclear view. In their 2016 Committee Opinion on gestational surrogacy, they state that obstetricians/gynaecologists 'should communicate clearly to the patient the primacy of her right to autonomous decision making related to her health and her pregnancy, which includes the right to choose what information she does and does not wish to receive or share'.² However, the Opinion goes on to state:

There must be a clear understanding of how appropriate medical details related to the health of the fetus will be communicated to the intended parent(s) during the pregnancy, keeping in mind



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that such communications must take place only with the express consent of the pregnant patient. In most instances, the gestational carrier's consent to disclose medical details about her pregnancy-related health status and the health of the fetus will be contained in the preconception agreement. *In the absence of such a provision*, the treating physician must obtain the pregnant patient's informed consent before any disclosure regarding the health of the patient or fetus is made to the intended parent(s).² (emphasis added)

While this wording emphasises the surrogate's right to confidentiality, it is unclear whether the presence of explicit consent in the surrogacy contract overcomes a surrogate's revocation of this consent during the pregnancy, particularly in the scenario presented above, as the statement only seems to require contemporaneous informed consent to disclosure where no such provision exists. ACOG punctuates its discussion of the issue with the point that '[g]uidance from professional organizations may be helpful in such situations', and inserts a reference to the ASRM statement referenced above.² This seems to indicate that, despite what appears to be an internally contradictory position, ACOG ultimately yields to the recommendation of the ASRM that disclosure without the surrogate's consent may be appropriate.

LEGAL CONSIDERATIONS

An easy response to this issue is that the surrogate has already made a careful and informed decision to disclose all pregnancy-related information to the IPs, even information that is against her own interests, and this decision was memorialised in a legal contract and therefore is enforceable. However, this assumes that a patient's right of confidentiality is irrevocably waivable, an assumption that is not without controversy. While seemingly straightforward, this question is further divided into two considerations: the legal waivability of rights and whether such waiver extends to the clinical encounter. A surrogate's agreement to waive confidentiality may be legally irrevocable, but it does not follow that a physician is required or permitted to disregard the surrogate's contemporaneous revocation of the contractual waiver in the clinical setting.

Legal obligations under the surrogacy contract

The surrogacy contract is enforced judicially, with legal remedies available through the court process if a party commits a breach. In this legal context, whether or not a court will enforce certain provisions in the contract depends on the content of the specific provision and the jurisdiction, as some states have determined that surrogacy contracts are unenforceable.³ Generally, if a contract is enforceable, legal remedies available may include money damages to compensate the aggrieved party, or specific performance which compels the breaching party to perform what they agreed to perform under the contract. Importantly, a breach of contract claim for failure to disclose would be brought against the surrogate, since she is the one who entered into the agreement. Whether or not the confidentiality provision in the contract is legally enforceable is an important question that raises significant issues¹, but ultimately is outside the scope of this paper.

¹ It is an open question as to whether a voluntary and knowing waiver of a Constitutional right, such as the right to privacy, is legally enforceable. Can an individual waive a Constitutional right? More importantly, if waiver of a Constitutional right is possible, is that waiver irrevocable, or can the individual revoke that waiver at a later time? This latter question is an important question in any legal analysis of enforceability in court, but outside the scope of this paper as we focus primarily on whether

For purposes of our argument, we can assume that it is enforceable against a surrogate in court. The IPs could sue the surrogate for breach of contract, for the misconduct (drinking wine) and for revoking her waiver of confidentiality. The IPs would have a viable cause of action against the surrogate, as it is the surrogate who promised to abide by the contract.

While the surrogate may face financial penalties for her breach of the contract, a physician's professional and ethical obligation to maintain patient confidentiality is not affected by the legal contract between the IPs and the surrogate. The contract is an agreement between the surrogate and the IPs, and the physician is not—nor should be—a party to the contract. Because of this, the physician is not legally bound to abide by the terms of the surrogacy contract, including terms related to clinical care of the surrogate such as disclosure and confidentiality.

Legal obligations in the release of information document

The surrogacy contract does not support a legal duty to disclose, but at the initiation of medical care of the surrogate by the obstetrician, the surrogate signs a release of information as part of her contractual obligations, authorising the physician to disclose information to the named individuals (the IPs). Despite the fact that the release was signed because it is a condition of the contract, there is nothing unique about this release compared with the release of information that any other patient may sign during the course of medical care. Patients with capacity are free to designate anyone—or no one—to receive information about their medical care, and they always retain the right, while capacitated, to revoke this consent to release information. Without this release, information generally cannot be disclosed to third parties for non-treatment-related reasons without the patient's consent, with few legal exceptions.⁴

If the surrogacy contract provided any force of law to compel or allow the physician to disclose, the clinical release of information would not be necessary. In this case, the surrogate has signed the release of information under the same circumstances as any other patient, and, as any other patient, retains the same right to revoke. The release of information, which is a clinical waiver of confidentiality, is therefore revocable and does not provide legal justification for disclosure over the objections of the surrogate.

COMPELLING ETHICAL INTERESTS

Without a legal obligation to disclose confidential information, the interests of the gestational surrogate and additional third parties must be considered to analyse whether such ethical considerations could justify disclosure.

Surrogate's privacy interest

Compelled disclosure ignores the surrogate's legal and ethical right to privacy, which includes bodily autonomy and confidentiality. It is widely accepted that a pregnant patient with capacity cannot be compelled to undergo a procedure, such as an amniocentesis.⁵ While some have argued in favour of specific performance when surrogates have contractually agreed to consent to such procedures in the surrogacy contract, the general consensus is that such compulsion would not be upheld for Constitutional rights reasons.⁶ She may be liable to the IPs for breach of

the waiver is irrevocable from an ethical perspective requiring physician participation in enforcement.

contract for refusing a procedure, but no physician can compel her to undergo that procedure based on any contract or other interest that a third party may have in the pregnancy. Likewise, as argued above, the same patient who refuses to allow disclosure despite signing a contract to the contrary retains this same right to privacy, and her physician cannot disregard her right to refuse disclosure.

Confidentiality is a foundational component of the physician–patient relationship. This relationship relies on mutual trust: the patient trusts the physician to act in the patient’s best interest, and the physician trusts the patient to be honest and forthcoming with information necessary to ensure the physician can provide appropriate medical care. A patient’s right to confidentiality may only be abridged for legitimate reasons, such as a patient’s loss of capacity that requires disclosure of certain medical information to allow a healthcare surrogate to make medical decisions for the patient. Physicians disagree with the choices made by their patients regularly, including what information they choose to disclose or withhold from loved ones and family members. This disagreement, even when the physician believes the patient is behaving unethically, does not empower the physician to violate patient confidentiality.

A physician’s breach of confidentiality breaks trust between the patient and the physician, demonstrating to the patient that the physician is not acting solely in the best interest of the patient.⁷ This may in turn affect the quality of care, as the surrogate may no longer be forthcoming with material information necessary to care for her during pregnancy. While it is the case that the surrogate presumably waived her right to confidentiality knowingly and voluntarily, understanding that her privacy would not be protected, the physician’s professional and ethical obligations as a medical provider do not change based on the parental arrangement over the future child.

Finally, there is a harm that occurs even prior to the establishment of the physician–patient relationship based on the contractual waiver of confidentiality itself. Because a surrogate must provide advanced consent to disclosure, the mere possibility of this violation of confidentiality erodes trust and undermines the physician–patient relationship before any misconduct or disclosure even occurs. From the outset, the surrogate may already fear being open and honest with her physician, even regarding accidents or mistakes, because she knows that what she tells her physician may be told to the IPs, and she may be open to legal liability for breach of contract.

Third-party interests

Generally, the autonomous wishes of a capacitated patient cannot be over-ridden without compelling justification. While public health concerns may be compelling enough to restrict autonomy by quarantine of a patient with ebola, the interests of other individuals outside of a public health context do not typically justify infringement of autonomy. In gestational surrogacy, however, the interests of the fetus and the intended parents are contractually made superior to the interests of the surrogate. Each of these interests is examined in turn to determine whether these third parties can impact the physician’s clinical obligations in practice.

Interests of the fetus

Obstetricians provide medical treatment for patients who are pregnant. Various ethical dilemmas that may arise in the course of treatment of a pregnant woman involve confusion about who is the patient: the pregnant woman, the fetus or both. The answer to this question shapes the ethical and professional

obligations of the physician, as well as the rights of both the pregnant woman and the fetus. In general, patients’ rights of privacy and self-determination are largely unaffected by pregnancy, with the exception of certain legal constraints regarding access to abortion.ⁱⁱ ⁸ In a non-surrogate pregnancy, the pregnant woman is unambiguously the primary patient, and it is a point of contention within bioethics debates whether the fetus should ever be considered to be a patient prior to birth.⁹ One position, that of Frank Chervenak and Laurence McCullough,¹⁰ is that the fetus, prior to viability, can be treated as a patient when the pregnant woman confers this status to the fetus by way of her autonomous choice. That is, the fetus becomes a patient at viability or by designation by the pregnant woman at any point prior to viability. Given that this position could be understood as containing a potential counterargument to our position, we will first accept its reasoning and show that our position is still valid within its logic and conclusions.

Pregnancy presents a unique situation in which there may be an additional third party with an interest in the resulting child, such as the biological father of the child, the pregnant woman’s partner, the anticipated adoptive parent(s), or, in this case, the intended parents in a surrogacy arrangement. Historically, this interest does not translate into a right to over-ride patient confidentiality, and it is unclear why gestational surrogacy should be treated any differently.

But if the fetus is also a patient by virtue of the gestational surrogate’s conferral, does the fetus as a patient potentially allow a physician to violate patient confidentiality in order to protect their other patient? One simple response that seems unsatisfactory, although supported by the original logic of fetus as a patient, is that the gestational surrogate can, and presumably would, revoke the status of the fetus as a patient in a circumstance where her right to privacy came into conflict with a fetal right (presumably a right to health or life). This raises more questions than it solves, such as whether it makes sense for the fetal status as a patient to wax and wane based solely on circumstances entirely extrinsic to it, and it also does not address a circumstance where the fetus would remain a patient because it is beyond the point of viability. But it is fair to ask whether the intended parents should be the ones who have the greater interest in the fetus, and therefore should be the ones to determine whether the fetus is a patient.

By this logic, a physician could perhaps justify a violation of confidentiality because the duty to fetal beneficence is a weightier concern than patient confidentiality. For example, if a gestational surrogate confided to using intravenous drugs during her pregnancy, the physician could disclose to the intended parents on the grounds that the fetal harm was more ethically pressing than the surrogate’s privacy. It seems relevant here to invoke the Tarasoff case where it was decided that patient confidentiality could be over-ridden if there was a ‘foreseeable harm’ that could be avoided by violating patient confidentiality.¹¹ The comparison of a pregnant surrogate using intravenous drugs and the Tarasoff case, where the patient revealed a well-developed plan to harm his ex-girlfriend, is far from perfect, but in both cases it could be argued that the duty to violate patient confidentiality now exists because there is a plausible risk of significant and

ⁱⁱ While access to abortion services is Constitutionally protected, the Supreme Court has upheld various restrictions such as waiting periods and parental consent laws in certain contexts.⁸ Generally, states may enact restrictions on abortion access if such restrictions do not impose an ‘undue burden’ on the woman seeking the abortion.⁸

preventable harm to another. However, if this logic is admitted, there seems to be no good reason to prevent this argument from being extended to any pregnant woman engaging in any risky behaviour. As such, any instance of potential fetal harm from maternal behaviour may be disclosed to the patient's partner, who is, in addition to the patient, another 'intended parent'. This scenario is contrary to well-established rights of privacy and confidentiality, as no physician may ethically breach a pregnant patient's confidentiality without consent, even if such disclosure is to the genetic and/or intended parent of the fetus.

There are at least two other problems with this argument and by extension with the ASRM guidelines. The first is that in the field of obstetrics there is a firmly established right of the pregnant woman to make all decisions regarding her health and the pregnancy even though there are other individuals with an interest in the life or health of the fetus.⁵ This is not grounded in a genetic connection to the fetus because a woman pregnant with donor eggs and her husband's sperm would still maintain complete decisional autonomy over her husband in all medical decisions regarding the pregnancy. Instead, it is her right to control her own body, and by extension the fetus within her, that makes her the sole decision maker, and in this circumstance the analogy to gestational surrogacy is complete. The fetus can only be accessed through the pregnant woman's body, and the decisions regarding her body remain hers alone. Similarly, if a contract cannot over-ride a patient's bodily autonomy, it also cannot over-ride confidentiality in part because patient confidentiality is required to respect patient autonomy.¹² In fact, Beauchamp and Childress¹² consider patient confidentiality as a specification of patient autonomy because choosing who to share medical information with is a decision that resides with and respects the patient's personhood and privacy, and only in extreme circumstances should this right be abrogated.

The second problem is that recognising the fetus as a patient is not the same as conferring the rights of personhood on it. No analogy to the Tarasoff case is valid since legally there is no *person* in immediate danger when a gestational surrogate violates the terms of her contract. 'Personhood' confers legal rights¹³ and would give the fetus the same protections as the pregnant woman. While it is beyond the scope of this paper, one obvious consequence of conferring personhood to the fetus would be to allow the state to potentially limit any harmful habit or activity of a pregnant woman using the same logic as laws that restrict secondhand smoke in public places. In Lyerly *et al*'s⁹ critique of the fetus as a patient they point out that patients are paradigmatically 'separate' and 'fully individuated'. This argument applies even more forcefully against any claims of fetal personhood given its completely dependent status.

Furthermore, when Frank Chervenak and Laurence McCullough first proposed this designation of the fetus as a patient, it was to make the very modest claim that physicians could be directive in their counselling regarding fetal beneficence when the fetus had attained patient status.¹⁰ As Lyerly *et al* argue, it would be a dangerous medical precedent to claim that a fetus must be understood as having coequal rights to the mother. The potential consequences of this logic include maternal deaths from failing to intervene when the fetus poses a serious threat to maternal health.⁹ Although Lyerly *et al* agree with Chervenak and McCullough that the fetus deserves to be included in beneficence-based reasoning, it would be unprecedented in bioethics to over-rule an autonomous patient's confidentiality solely for the benefit of another patient. The only exception to this that we can conceive is infectious disease reporting which allows violations of patient confidentiality in some cases but

which also has public health justifications that go far beyond beneficence-based concerns to a single patient.

Interests of the intended parents

In addition to relying on the surrogacy contract provisions, ethical arguments in favour of disclosure place value on the position of the intended parents, claiming that they have a right to know of a material breach of the agreement by the surrogate, because such information would have excluded the surrogate from being considered as a carrier in the first place.¹⁴ In other words, had the intended parents known that the surrogate would engage in misconduct while pregnant, they would never have commissioned the pregnancy and allowed the surrogate to gestate their embryo.

In this argument, Judith Daar¹⁴ frames the physician's professional conflict as one between 'the duty to obtain informed consent and the duty to maintain patient confidentiality'. She argues that if provisions regarding surrogate behaviour are memorialised in the contract, 'a physician can assume these behaviors are material to the parties' decision making'. She goes on to state, 'Respect for patient autonomy includes the duty to provide information material to a patient's decision making. Since the breach of an agreement could provoke rescission of the contract, the potential balance of harms seems to weigh in favor of disclosure' (sic).¹⁴

While this argument attempts to balance the interests of the surrogate and the intended parents by framing it as an issue of informed consent, this is an inappropriate conflation of informed consent with contract law. In contract law, two parties have agreed to cooperate with one another, and the validity and enforceability of the contract are contingent on being provided 'material information' that is relevant to the decision to enter into and uphold the contract. Informed consent, however, is a process within the physician-patient relationship that requires disclosure of relevant information to allow the patient to make an informed decision regarding treatment. The informed consent process, which also requires information to be provided to patients throughout their medical treatment, is not related to principles of contract law.

Prior to undergoing in vitro fertilisation (IVF) and transfer of the embryo to the surrogate, information about surrogate misconduct discovered during or subsequent to the screening process that would exclude her from being a candidate for surrogacy can and should be disclosed to the intended parents, because at that point, it is the intended parents who are seeking medical care, and the surrogate is not yet a patient. During this screening process, the physician responsible for evaluating whether the woman is an appropriate candidate for surrogacy is employed by the IPs and should clearly communicate her responsibilities to the prospective surrogate. Much like an industry-employed physician or independent medical examiner, the physician is not entering into a traditional physician-patient relationship in which the physician's sole obligation is to act for the benefit of the patient, as there are competing interests.^{15 16} She is not treating the surrogate's own medical conditions; rather, she is evaluating her fitness to serve as a surrogate, keeping in mind the interests of the IPs in having a healthy child. It is at this point that the information the surrogate is providing to the physician is material to the parties' decision whether or not to enter into a contract, and such information can be shared with the IPs with the consent of the surrogate. The surrogate may still refuse to allow the physician to share information with the IPs, but failure to share information will likely exclude her as a candidate for participation without further penalty.¹⁷ Once the surrogate

becomes pregnant, however, the medical decision requiring *medical informed consent* of the intended parents is complete, as any necessary gamete retrieval and IVF has already occurred.

During the pregnancy, information about surrogate misconduct is material to the parties' ongoing participation in the surrogacy contract, but *not* in terms of informed consent. The intended parents are not patients, and have no right to be involved in decisions requiring informed consent in the clinical setting unless the surrogate chooses to continue to include them in medical decision making. Rather, material information in this context refers to a legal standard that applies to whether or not the contract has been breached. This materiality is not an issue for the physician to consider, but is properly decided by a judge in the legal adjudication and enforcement of a contract. It follows that not only is the physician not bound by the terms of the surrogacy contract, but also not responsible for enforcement of the contract by disclosing information about the medical care of the pregnant patient over the objections of the surrogate.

Refusing to disclose this information to the intended parents is not, however, without its own harms. The surrogate's actions affect the fetus in whom the IPs have a sincere interest, harming not only the fetus but those who intend to parent the child after birth. Such actions may lead to pregnancy complications or disability after birth, the burdens of which will be borne by the child and the IPs. Furthermore, if the IPs knew about the surrogate's actions, it is possible that they might change their reproductive decision making, including asking for more comprehensive testing during pregnancy or even choosing termination depending on the severity of the misconduct and any discovered injuries, assuming the surrogate would voluntarily comply with such decisions by the intended parents.

Additionally, as with non-surrogate pregnancies, knowledge that a fetus may be harmed by drug and alcohol use or other actions of a pregnant patient may cause moral distress for the physician or other staff members, which is heightened by the knowledge that the intended parents who have a higher stake in the outcome of the pregnancy have no control over or knowledge of the harm being caused. Neither of these considerations, however, justify violation of the surrogate's right to privacy and confidentiality as a patient. Instead, they highlight the inherent ethical difficulties in the practice of gestational surrogacy. The physician's duties do not arise from the surrogacy contract; rather, they arise from the standard of care owed by an obstetrician to any pregnant patient, whether or not the fetus she is carrying will remain in her custody.

CONCLUSION

As with any other physician–patient relationship, a physician's professional and ethical duty is to the patient. The presence of additional stakeholders does not, in any way, diminish the autonomy of the pregnant patient to make decisions for herself,

including decisions regarding both bodily autonomy and confidentiality. The existence of a legal contract purporting to govern the pregnancy does not affect the physician–patient relationship, and for these reasons the ASRM statement is contrary to long-standing legal and ethical consensus on the nature of the physician–patient relationship and should be changed to reflect a surrogate's absolute right to confidentiality in the clinical setting.

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