

Is concurrent gestational surrogacy an ethical practice?

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PRO: Concurrent Gestational Surrogacy is an Ethical Practice

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CON: Concurrent Gestational Surrogacy is Not an Ethical Practice

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The ethics of concurrent gestational surrogacy

Concurrent gestational surrogacy refers to the practice in which a patient engages more than one gestational carrier (GC) to carry a pregnancy at the same time. Although no formal studies have surveyed fertility clinics on concurrent surrogacy, the practice is discouraged by some clinics and restricted by others, either for practical reasons related to reducing laboratory errors or ethical concerns. Other clinics encourage concurrent surrogacy as an alternative to transferring more than one embryo into a GC, aiming to reduce the risks of multiple gestation for GCs and fetuses (1, 2). In such cases, children born around the same time from two different GCs have been colloquially called “twiblings” (3).

Currently, no federal or state laws specifically regulate concurrent surrogacy. Clinics may not even be aware of whether a patient has engaged with another GC through a different agency or clinic simultaneously. Professional standards are somewhat ambiguous. The American Society for Reproductive Medicine (ASRM) Practice Committee states that one criterion for rejecting an intended parent (IP) is when the “reproductive plan is to pursue concurrent pregnancies by embryo transfers to more than one GC” (4). By contrast, the ASRM Ethics Committee recommends that GCs be informed if the IPs plan to engage concurrent GCs, and although it acknowledges the potential benefits and drawbacks of concurrent surrogacy, it does not take a definitive stance on the practice (5).

The frequency of concurrent surrogacy remains unknown; however, several high-profile, concerning cases have recently been reported. In December 2025, the *Wall Street Journal* published an exposé on a Chinese billionaire, Xu Bo, who reportedly has had over 100 children by using multiple simultaneous GCs in the United States. Bo has spoken openly about wanting sons to run his business empire, and according to the article, has not even met some of his children (6). In December 2024, an article in *Bloomberg Businessweek* highlighted disgraced American billionaire Greg Lindberg. Although incarcerated for convictions of money laundering and fraud, Lindberg engaged oocyte donors and several GCs to produce children using his sperm

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The use of GCs has risen steadily in the United States over the past decade, accounting for 2.7% of assisted reproductive technology (ART) cycles in 2014 to 4.6% of cycles in 2020 (19). This trend reflects the advances in ART, increased knowledge about third-party reproduction, as well as the diversity of family-building goals among IPs. As utilization grows, so does the need for clear and ethically grounded guidance on best practices in third-party reproduction.

This expansion has also drawn heightened public and professional attention to the complex landscape of the GC industry in the United States. Media coverage has focused on the lack of uniform oversight within the United States GC industry, as regulation varies widely by state and no federal framework governs this practice (20, 21). Although the US Food and Drug Administration offers some oversight for third-party reproduction, this is primarily focused on infectious disease screening of the gamete source, whereas the ethical, psychosocial, and legal aspects of GC use are largely left to professional judgment.

Recent high-profile cases have illustrated how even well-intentioned GC arrangements can become complicated and extremely public. In 2024, *Business Insider* profiled IPs pursuing concurrent surrogacy to create what are referred to as “twiblings” (22). These IPs acknowledge the great financial and ultimately social burden of this choice, highlighting that certain challenges were underestimated. Other publications have detailed disputes between GCs and IPs over decisions related to pregnancy termination, with one notable case in Connecticut in which the GC declined the IP’s request for termination in the setting of a fetal anomaly (23). These situations, although rare, highlight that these arrangements can become ethically fraught even when all parties are acting in good faith. As such stories emerge, there is a risk of influencing the public’s perception of a medically necessary intervention into a commodity.

The ASRM provides detailed guidance on establishing an ethical foundation for GC arrangements, including the medical and psychological evaluation of all involved parties and informed consent practices designed to ensure transparency (24). Although these recommendations address several key considerations, certain emerging practices such as the use of

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at multiple clinics simultaneously across the United States (7). At the time of the article's publication, Lindberg already had eight children for whom he was the sole legal parent. During his incarceration, the children resided together under the care of several paid domestic caregivers.

In July 2025, a case emerged in Arcadia, California, of a couple who had registered as a surrogacy agency and presented themselves as such to potential GCs, but actually had engaged multiple GCs at the same time to carry pregnancies for them. A National Broadcasting Company (NBC) news report indicated that 21 children were connected to the couple, and the children were reportedly in protective custody (8).

All of these cases are concerning for a number of reasons, including a lack of transparency with GCs, underlying suspicious or outright objectionable motivations on the part of the IPs, and potential challenges in providing adequate, loving care for the resulting children. These incidents also raise critical questions about whether IPs should be permitted to pursue simultaneous GC cycles, and if so, what limits, if any, should be established?

Concurrent gestational surrogacy raises several ethical concerns. One concern is that engaging multiple GCs at the same time may further commercialize the role of the GC, implying that carriers are not unique and are interchangeable with one another. Framed another way, concurrent surrogacy may highlight the commercial nature of the IP-GC relationship, and a carrier may feel insufficiently valued if she is aware that she is only one of multiple GCs carrying a pregnancy for the same IP(s). However, the fundamental ethical tension with commercialization is not the number of GCs engaged concurrently, but the underlying fact of paying women to carry pregnancies for others. Although concurrent surrogacy may exacerbate this tension, the potential ethical concern lies in payment, not concurrency.

Commercial surrogacy has been extensively debated in the ethics literature (9, 10), lay press (11), and legal fora (12) and is prohibited in many places, including in China, Thailand, and several European countries (13). Although controversial, compensated gestational surrogacy is legal in multiple US states, and a 2015 public opinion poll showed that 57% of Americans support the practice (14). Unless we intend to limit surrogacy to altruistic or uncompensated arrangements, concerns about commercialization alone do not provide sufficient justification to restrict the practice of concurrent surrogacy.

Another concern with concurrent surrogacy is that engaging multiple GCs simultaneously may create a power imbalance between IPs and GCs. If a particular GC is perceived as having less value to the IP(s) because they are working with more than one GC, she may feel pressured to comply with the IP(s)'s wishes and less empowered to advocate for herself. The ASRM Ethics Committee acknowledges this concern, noting that "comparisons to another GC may add pressure to meet the same expecta-

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concurrent GCs remain incompletely explored (24). The Ethics Committee specifically identifies the IP's plan to "simultaneously engage an additional gestational carrier" as a circumstance that warrants additional consideration and discussion, however, beyond briefly outlining arguments for and against this practice, the Committee offers limited concrete guidance on how clinicians should navigate such situations.

These evolving practices challenge the field to balance innovation and patient autonomy with responsible stewardship. In the absence of robust external oversight, the field of reproductive medicine bears the responsibility to critically consider these complexities and self-regulate. Clinicians must therefore evaluate not only the medical feasibility of interventions, but also their ethical implications, considering the perspectives of IPs, GCs, and society as a whole.

Acknowledge pros

Supporters of the concurrent simultaneous use of two GCs argue that this approach may reduce the obstetric risk associated with multiple gestations. From a medical standpoint, two singleton pregnancies are indeed safer than one twin pregnancy; however, this rationale rests on the assumption that the IPs' primary goal is to have two children born at the same time. Yet, two sequential singleton pregnancies would achieve the same family-building outcome, while avoiding the ethical complexities associated with the use of two concurrent GCs. For some, such as those facing advanced reproductive age, parallel singleton pregnancies may seem to offer a time-sensitive solution.

Beyond the medical rationale, many IPs also hold very personal visions of what they imagine their family to be. For some, this means children close in age who can grow up together and share experiences, a goal that reflects a desire to shape their family in accordance with their personal ideals. Similar motivations may also underlie other ethically nuanced practices such as sex selection, in which ART is used to both facilitate parenthood and fulfill specific preferences as it relates to family composition.

Although such preferences are inherently human, they highlight the evolving ethical landscape of ART in which the purpose may shift from overcoming infertility to constructing an "ideal family." As this boundary between medical necessity and preference becomes less clear, clinicians must balance reproductive autonomy with professional responsibility.

Ethical considerations (i.e., cons)

Beneath these perceived advantages lie substantial ethical and social concerns that warrant serious consideration.

Even a single GC arrangement requires the navigation of a delicate balance between altruism, autonomy, and financial compensation. Introducing a second simultaneous GC for the same IPs tilts this balance toward commodification, reframing ART as a service of convenience. In this context, ART is being

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tions, relationships, and agreements as to prenatal care or delivery” (5).

Although this concern about the IP-GC power dynamic is valid, it is also somewhat speculative. The IP(s) working with multiple GCs may be cautious not to disrupt their complex family-building plans, and the GC may actually hold great influence in the relationship. The power dynamic within an IP-GC dyad can vary for many reasons unrelated to whether surrogacy is pursued singly or concurrently. Therefore, the potential for power imbalance also seems an inadequate reason to limit concurrent surrogacy.

A third potential concern with concurrent surrogacy relates to the commodification of fetuses. Intuitively, engaging with a single GC to carry a long-awaited child may feel different from paying multiple GCs simultaneously to gestate more than one child. One might question whether deliberately choosing to have multiple children at the same time implies that the individual children carry less value for the IP(s). Yet again, the answer seems to be: not necessarily.

Anecdotally, many cases of concurrent surrogacy involve same sex male couples who must engage GCs to build genetically related families and seek to have their children born close together for personal or logistical reasons. Sometimes, each member of the couple uses his sperm to fertilize eggs from the same donor. Choosing to have more than one child at the same time in this way does not necessarily imply that each child will be any less loved or valued as an individual. There is no reason to believe that these children would not be cherished in the same way that families love twins or triplets. If concerns about fetal commodification primarily center on paying GCs to “produce” a child, then, like the commercialization of GCs, this issue is inherent to compensated gestational surrogacy and not specific to the practice of concurrent surrogacy.

Perhaps the most significant ethical consideration related to concurrent surrogacy is the well-being of the children. There may be a fear that the IPs lack the resources to care for multiple children or may be unable to provide adequate, individualized attention. However, gestational surrogacy is an expensive undertaking, costing IPs up to \$200,000 per GC (15). If the IP(s) can afford multiple GCs simultaneously, it is likely that they have the financial means to provide for the resulting children. Regarding whether children will receive adequate care, the ASRM Ethics Committee provides guidance for fertility care when concerns exist about a parent or couple’s ability to sufficiently care for offspring. The guideline states that clinicians may decline treatment for “well-grounded reasons that those patients will be unable to provide minimally adequate or safe care for offspring.” ASRM emphasizes that the threshold for refusal should be set very high and policies should be established in advance to prevent arbitrary or biased treatment of patients (16). There is no reason to assume that all IPs pursuing concurrent surrogacy will be unwilling or unable to care for their children, although well-founded concerns may exist in

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used to enable the design of an “idealized” family structure as opposed to helping individuals overcome infertility.

Autonomy. The use of concurrent GCs honors the autonomy of the IPs, but risks compromising that of the GCs. Pursuing this arrangement would require full disclosure and transparency that a second carrier was pregnant with genetically related offspring for the same IPs at the same time. This disclosure may impact the carrier’s willingness to participate; however, this transparency is paramount to maintain the respect and autonomy of the carriers.

Not only does an arrangement of this nature duplicate risk, but it also risks altering how GCs are perceived. When multiple GCs are engaged for the same family, it can create a sense of dehumanization by reducing individuals who agree to this deeply personal act to facilitators of a goal. The altruism that motivates many GCs is grounded in personal connection and a shared purpose, which may be compromised when another carrier is simultaneously involved for the same IPs, unintentionally diminishing the meaning of the experience. True autonomy requires not only informed consent but also the genuine freedom to decline participation in an arrangement that challenges the altruistic motivation underlying many GC experiences.

Beneficence. The ethical principle of beneficence demands that clinicians act in a way that maximizes benefit and minimizes harm to all parties involved: the IPs, GCs, and offspring. Although the use of two GCs may appear to maximize benefit to the IPs by expediting family building, it offers no benefit to the carriers themselves and introduces ethical complexities that outweigh this perceived efficiency.

From a patient-centered perspective, managing two simultaneous pregnancies on behalf of one family doubles the number of individuals exposed to medical and psychosocial risks. There is also a heightened risk of undue emotional burden if a complication arises in one pregnancy, such as miscarriage, preterm delivery, or fetal anomaly. These events, although uncommon, can create a profound sense of moral distress for both the GCs and IPs, particularly when outcomes differ between pregnancies. The IPs may experience guilt or conflicting emotions toward the carriers, whereas the carriers themselves may grapple with feelings of responsibility or grief. Even in uncomplicated cases, the parallel nature of the pregnancies can amplify feelings of anxiety because of the emotional investment involved.

The principle of beneficence must also extend to consideration of the offspring. Data suggest families with closely spaced or same-age siblings are associated with increased parental stress and strained resources (25). These challenges parallel those observed among families with twins, who have been shown to experience higher rates of postpartum depression and divorce (26, 27). Such stressors may inadvertently compromise the well-being of the offspring.

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certain cases, such as those highlighted in the high-profile examples discussed earlier.

The central issue appears to be the motivation and attitudes of the IP(s) toward the GCs and future offspring. Although it is possible that some IPs who seek concurrent surrogacy may insufficiently value the GC or their children, this is unlikely to be the norm. More commonly, IPs seek to complete their childbearing within a short timeframe. In such cases, it is reasonable to defer to the reproductive autonomy of the IP(s) and allow them to pursue concurrent surrogacy. Psychological evaluation should be conducted to assess motivations, attitudes, and goals before deciding whether to proceed, enabling clinics to make individualized decisions.

Part of the ethical conundrum of concurrent surrogacy is the question of whether nonmedical gestational surrogacy should be permitted. There is a difference between a patient or couple with uterine factor infertility seeking to complete their family in a short timeframe by engaging multiple GCs simultaneously and a couple without a medical indication choosing to build their family via surrogacy with multiple carriers. However, the ethical issue hinges on the permissibility of nonmedical surrogacy itself, rather than the number of GCs involved concurrently.

Professional societies in the United States and Europe agree that gestational surrogacy should be reserved for medical indications. The ASRM Practice Committee states that “Gestational carriers may be used when a true medical condition precludes the IP from carrying a pregnancy or would pose a significant risk of death or harm to the woman or the fetus” (4). Similarly, the American College of Obstetricians and Gynecologists Ethics Committee notes that “because of the ethical, legal, and psychosocial complexities and potential medical risks to the gestational carrier, it is recommended that the use of gestational surrogacy be restricted to situations in which carrying a pregnancy is biologically impossible or medically contraindicated for the intended parent(s)” (17). The European Society of Human Reproduction and Embryology also states that surrogacy “is an acceptable option to help the intended parent(s) for whom it is impossible or medically contraindicated to carry a pregnancy” (18). Although these organizations discourage nonmedical gestational surrogacy, the practice is not illegal in the United States and occurs with some regularity. By choosing not to offer nonmedical gestational surrogacy, clinics and providers may also reduce the occurrence of ethically questionable cases of concurrent surrogacy.

Even for patients with a medical indication for gestational surrogacy, the question arises: Can there be *too many* simultaneous GCs? A definitive, nonarbitrary threshold is difficult to establish, and requests will need to be evaluated on a case-by-case basis. In most cases, two simultaneous GCs may represent a reasonable maximum before the IP(s)'s motivations might be called into question. As recommended by the ASRM Ethics

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Thus, the concurrent use of multiple GCs introduces disproportionate risk and complexity relative to the provided benefit. Sequential pregnancies remain the more ethically aligned means of achieving the desired family size.

Nonmaleficence. Acting as a GC is associated with inherent medical risk, beyond the normal risks of pregnancy and delivery. Even among carefully screened and otherwise healthy individuals, pregnancies achieved through ART are associated with higher rates of obstetric complications (28). In a recent national analysis of more than 14 million deliveries using the National Inpatient Sample, Masjedi et al. (29) identified nearly 2,000 GC deliveries. Despite low-risk baseline characteristics, GCs experienced significantly higher odds of obstetric complications, including placental abruption (adjusted odds ratio [aOR] 2.98), low-lying placenta (aOR 5.14), periviable delivery (aOR 2.54), and postpartum hemorrhage (aOR 3.27) compared with nonGC pregnancies (29).

These findings underscore that even a single GC pregnancy entails measurable medical risk, thus, engaging more than one carrier exposes two individuals to those risks and magnifies the potential for harm. Thus, concurrent GC use violates the foundational tenet of “do no harm.”

Justice. When applying the principle of justice, we must acknowledge that access to GCs is already constrained by limited availability, high cost, and heterogenous legislation across states. By allowing a single set of IPs to engage two GCs concurrently amplifies these inequities, granting privileged access to those with the financial means to secure multiple carriers and thereby reducing this availability for others.

These dynamic risks further transform gestational surrogacy into a luxury commodity rather than a therapeutic intervention. As the demand for GCs continues to outpace availability, prioritizing the convenience or efficiency for one set of IPs comes at the expense of another family's ability to build their family.

Clinicians are expected not only to ensure the medical safety for all individuals involved, but also to promote equitable access and responsible stewardship of this limited opportunity for family building.

Conclusion

The concurrent use of two gestational carriers highlights the tension between reproductive autonomy and professional responsibility. Ethical practice in assisted reproduction demands that the clinician carefully weighs the fulfillment of patient preference against their broader implications. Balancing autonomy with beneficence, nonmaleficence, and justice is essential to protect the best interests and safety of GCs. This approach minimizes unnecessary risk to the GCs and promotes equitable access to a limited avenue of reproductive care. As reproductive medicine continues to evolve, we must continue to remain grounded in ethical integrity,

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Committee, GCs should be notified if IPs plan to engage more than one GC concurrently. Determining whether an IP is pursuing multiple GCs simultaneously presents an additional challenge for clinics. Ideally, a national registry for gestational surrogacy, encompassing both IPs and GCs, could help address this issue. However, establishing such a registry would be fraught with logistical, standardization, participation, and privacy concerns.

In summary, concurrent gestational surrogacy raises several ethical concerns, but these largely reflect the broader debates over compensated and nonmedical surrogacy in the United States and internationally. Concurrent surrogacy is not inherently so morally problematic as to justify a blanket prohibition. Decisions about the acceptability of concurrent surrogacy should be made on a case-by-case basis, after psychological evaluation of IPs and GCs. Whenever possible, examples and rationales should be shared in peer-reviewed fora to promote ethical discussion and clinical best practices.

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ensuring that progress serves not only the interests of individual patients but society as a whole.

CRedit Authorship Contribution Statement

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