Review Surrogate pregnancy: an essential guide for clinicians

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Key content:

- The incidence of surrogacy is rising.
- Literature on associated obstetric risks is scarce and caution must be exercised when labelling surrogate pregnancies as low risk.
- Although obstetricians' responsibilities lie with the surrogate mother, they must ensure her wishes do not conflict with the best interests of the baby.
- Prepregnancy counselling is the key to a successful surrogacy arrangement.

Learning objectives:

- To gain an awareness of the different types of surrogacy.
- To understand the law surrounding surrogacy.
- To learn about antenatal, intrapartum and postpartum care in surrogacy.

Ethical issues:

- When the surrogate mother's wishes and the interests of the child conflict, do obstetricians have the right to discuss this with the commissioning parents without her consent?
- When should obstetricians seek ethical and legal support?

Keywords gestational surrogacy / HFEA Code of Practice / parental order / traditional surrogacy

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Introduction

In a surrogacy arrangement a woman agrees to bear a child for another woman or couple and surrender it at birth. Whilst some people come to terms with their childlessness or find adoption or fostering acceptable alternatives, others see surrogacy as a solution. It provides an opportunity for couples to have a child with some genetic contribution from them where the woman is infertile or has, for example, had a hysterectomy for carcinoma, or where she has had recurrent miscarriages or where pregnancy would be a life-threatening condition.

There is limited evidence about the true incidence and nature of surrogacy arrangements. Surrogacy is a social arrangement made through a private agreement; therefore, there is no requirement for data to be collected. Although an estimate of the number of surrogacy cases per year could be obtained from couples undergoing assisted conception and couples obtaining parental orders (a legal requirement in the UK), it would be virtually impossible to do so from private arrangements that involve neither health nor social services.

With better recognition, social acceptance and regulation of surrogacy, and with medical advances in assisted conception techniques, the recognised incidence is rising. The purpose of this review is to provide an update and guidance for obstetricians and midwives on legal issues surrounding surrogacy and care of the surrogate mother during pregnancy, labour and the postpartum period.

Definitions

The term 'surrogate mother' or 'surrogate' is usually applied to a woman who carries and delivers a child on behalf of another couple.[1,2] The couple who are intending to parent a child resulting from a surrogate pregnancy are referred to as the 'commissioning parents'. Surrogacy can be either 'traditional' or 'gestational'.

Traditional surrogacy

Also called 'straight', 'natural' or 'partial', traditional surrogacy uses the egg of the surrogate mother and the sperm of the commissioning father. This can be performed in a fertility clinic using intrauterine insemination but, more often, artificial insemination is performed at home. In this situation, the baby is biologically related to the surrogate mother and commissioning father. Although this is the simplest type of surrogacy, in as much as conceiving is less complicated, psychologically it may be harder to accept. The surrogate mother must give up her own biological child and the commissioning mother must accept a child that her husband has fathered with another woman. Evidence to support this concern, however, is lacking.[3–5]

Gestational surrogacy

In contrast, 'gestational' surrogacy, also called 'full', 'host' or 'IVF' surrogacy, requires *in vitro* fertilisation (IVF). It is carried out using embryos created from sperm and oocytes from the commissioning couple, which are transferred to the surrogate mother. The surrogate 'host' is genetically unrelated to any child born as a result of such arrangements and many people may find this a more acceptable treatment. Success rates are, however, thought to be lower with this method and it involves more time and greater expense.

Traditional and gestational surrogacy are either:

- commercial, where the surrogate mother is compensated by the commissioning parents (this is illegal in most countries, including the UK); or
- altruistic, where the surrogate mother chooses to carry the child for reasons other than financial gain.

The ethics of surrogacy

The main ongoing debate relates to commercial surrogacy: is it ethical to pay the host or not? Those who favour commercial surrogacy value the freedom to do what they choose with their own body, to raise their own child and to privacy. The opposition argue that the moral nature of childbearing and the parent–child relationship suffer when they are commercialised, that children should not be seen as commodities and that the duty of a parent to their child cannot be sold or abandoned.[6]

Other ethical dilemmas encountered include:

- the possibility of the surrogate mother wanting to keep the child
- rejection of an abnormal child by the surrogate mother and the commissioning parents
- the uncertain long-term psychological effects on all concerned.

Recent studies comparing surrogate mothers' experiences of surrogacy found no differences in the difficulty of relinquishment between genetically-related and nongenetically-related surrogate mothers. Only 4% of surrogacy arrangements fail because of a surrogate mother's refusal to relinquish the child.[3] Studies of psychological relationships in families created by surrogacy have found no differences in the warmth or affection of the commissioning mother to her child between traditional and gestational surrogacy arrangements.[4,5,7] The desire to parent a child seems to overcome the potential negative consequences of the lack of a biological link.

With regard to who makes the decisions during pregnancy and labour, it is generally agreed that this should be the surrogate mother if they affect

her health.[8] If only the health of the baby is affected, only the commissioning parents should decide. It is important to be aware that there is potential for coercion of the surrogate mother in cases where she is a friend or family member of the commissioning parents.

The law and surrogacy

Differing ethical and social opinions have led to legal frameworks that vary between jurisdictions. In the USA, commercial surrogacy arrangements are allowed, with different levels of legality given to surrogacy contracts, although many states have banned all forms of surrogacy.[2] In Israel, commercial surrogacy is legal, yet familial and altruistic surrogacy is banned for religious reasons related to incest and adultery.[9]

The UK and Australia both permit altruistic but not commercial surrogacy. The UK is one of the few regions in Europe that allows surrogacy and, indeed, it has a number of charitable, nonprofit organisations (such as I N UK [Infertility Network UK], COTS [Childlessness Overcome Through Surrogacy] and Surrogacy UK; see **Websites**) that help commissioning parents who cannot find a surrogate mother. Surrogacy is regulated by the Surrogacy Arrangements Act 1985[10] and the Human Fertilisation and Embryology Act 1990.[11] Although commercial surrogacy is prohibited, 'reasonable expenses' can be paid to the surrogate mother.[10,12–14] It is illegal for an individual or agency to act on a commercial basis to organise or facilitate a surrogacy arrangement for another person. Agencies or individuals may perform this function on a noncommercial basis. Advertising by potential surrogate mothers or commissioning parents is prohibited.

In the UK, gestational surrogacy is already fully regulated: it can only be practised in centres licensed by the Human Fertilisation and Embryology Authority (HFEA), with full provision of clinical, scientific, counselling and legal services for surrogate mothers and commissioning parents.[14] Where insemination with the commissioning father's sperm in traditional surrogacy is performed by a healthcare professional (thus using donated sperm), the premises on which the procedure takes place must also be licensed by the HFEA. Surrogacy arrangements are not legally enforceable and, therefore, it is important that both parties draw up a written agreement clarifying their feelings on all difficult issues, either through an agency or a solicitor.

The legal status of the child and the UK parental order

The surrogate is always the legal mother. The status of the legal father is more complicated. If the surrogate mother has a partner, he will be the legal father of the child unless he can show that he did not consent to the treatment. In Scotland, if the surrogate mother's partner can produce a document in the presence of a justice of the peace stating that he is not the father, this allows the commissioning father to appear on the birth certificate. If the surrogate mother does not have a partner and the treatment did not take place in a licensed clinic (i.e. self-insemination), the commissioning father will be the legal father. If treatment was undertaken in a licensed clinic and the surrogate mother has no partner, the child will be legally fatherless.[10,12]

For the commissioning parents to become the legal parents of the child, they must either apply to adopt the child or apply for a parental order, even if they are the genetic parents of the child (i.e. their sperm and eggs were used). If the commissioning parents change their minds about taking the child for any reason, the surrogate mother and her partner, if she has one, will be legally responsible for the child.

A parental order (under section 30 of the Parental Orders [Human Fertilisation and Embryology] Regulations 1994) has the same effect as adoption but allows for a quicker route in cases of surrogacy.[11] This can be obtained by application to the courts and the criteria to be met are shown in **Box 1**. The law on surrogacy is under review as part of the new HFEA bill, particularly with regard to the criteria for parental orders. It is likely that these criteria will be broadened to include commissioning parents who are cohabiting or in civil partnerships (thus including same-sex parents).

A parental order cannot be given until 6 weeks after birth. The surrogate mother and the commissioning father can sign a parental responsibility agreement (see **Websites**) as soon as the baby is born (often in hospital) to cover the period until a parental order is obtained. This gives them equal rights over the baby, so that commissioning parents have a say in the welfare of the child and in any decisions that have to be made soon after birth.

Level of medical involvement prior to pregnancy

The amount of medical assistance required depends upon individual circumstances. If IVF is

- The baby must be genetically related to one or both of the commissioning parents.
- The commissioning parents must be over 18 years of age and married.
- The surrogate parents must consent to the order and consent cannot be given until 6 weeks after the birth.
- The application must be made within 6 months of the birth of the baby.
- There must be no payment for the surrogacy arrangement apart from 'reasonable expenses'.
- One or both of the commissioning parents must be living in the UK and the baby must reside with them.

Box 1
Criteria for obtaining a parental order in the UK[24]

used, there is considerable medical involvement and the treatment is carried out in a clinic licensed by the HFEA. With traditional surrogacy, insemination is sometimes performed by a healthcare professional or medical advice provided on the timing of insemination and monitoring of ovulation. Couples may choose self-insemination, which does not require any medical knowledge or advice. It is advisable for a woman considering surrogacy to discuss the matter with her general practitioner, who can provide advice and support and who needs to be aware of any medical details that could affect her care.

Transmission of infection

In all surrogacy arrangements there is a risk of transmitting infection, such as HIV and hepatitis, to the surrogate mother from the commissioning parents through sperm or eggs. For this reason, it is very strongly recommended that the parties involved undergo testing to minimise this risk. Where treatment is given in a licensed clinic, the sperm or embryos are usually stored in quarantine whilst repeated tests are carried out, to minimise the risk of passing on any infection. With self-insemination, it is also strongly recommended that the commissioning father is tested prior to the insemination. Testing for genetically transmissible conditions is also recommended. Before consenting to tests, however, consideration should be given to the implications of receiving a positive result.

Counselling

All parties concerned must be clear about the implications of their decision before proceeding and, hence, counselling is mandatory, even if the surrogacy is an uncomplicated altruistic act. A potential surrogate mother must carefully consider her likely emotional reactions to the developing child, the possibility of miscarriage or termination and the effect of parting with the child if the pregnancy is successful. The commissioning mother may worry about her potential ability to bond with a child carried by another woman or fear that the surrogate mother will decide to keep the child. The surrogate mother and the commissioning parents all need to consider carefully how they would react if the child was born with physical or mental health problems, how they would wish to proceed and how this would affect the surrogacy arrangement. All of these issues can be raised during counselling and, although they are not legally binding, it is advisable to commit all discussions and agreements to paper for future reference.

Where treatment is provided in a licensed clinic, counselling will be available and offered to those taking part in a surrogacy arrangement. Those couples making their own arrangements should also give serious consideration to seeing a counsellor. Most general practitioners can provide details of the counselling services available in their area; a list of counsellors can also be obtained from the British Infertility Counselling Association (see **Websites**).

Health risks to the surrogate mother

To minimise the amount of overall risk to the surrogate mother during pregnancy, there are generally agreed criteria for surrogacy. Awareness of these criteria needs to be disseminated, particularly to those considering traditional surrogacy using artificial insemination at home without any medical input. A potential surrogate mother must be in good overall mental and physical health and have no known significant medical or social factors, such as obesity, heavy drinking or smoking. It is strongly recommended that a potential surrogate mother has borne at least one child, as she is in a better position to give informed consent and because the risk of complications is much higher in a first pregnancy. The risk of chromosomal abnormalities increases with advancing age: because of this, the HFEA Code of Practice[14] recommends that the surrogate is up to 35 years of age for genetically-related surrogate mothers (exceptionally, up to 38 years) and, because of the risks of pregnancy, less than 40 years of age for nongenetically-related host mothers.

The literature reporting the medical risks associated with surrogate pregnancy is limited to a few case series. It remains to be determined whether the obstetric risks are the same as those for any other pregnancy derived by IVF or insemination with the same number of fetuses. Most case series report no increase in adverse events related to surrogate pregnancy.[1,2,15–18] In a recent report, however, 2 out of 9 surrogate mothers had a postpartum hysterectomy: the first for placenta accreta following delivery of triplets; the second following uterine rupture during the delivery of a macrosomic infant.[2,19] The limited evidence on risks associated with surrogate pregnancy means that clinicians should have a high index of suspicion for complications and a low threshold for referral to higher levels of care. Any complications should be reported to the centre where the surrogacy treatment took place so that outcomes can be tracked and a better evidence base built.

Medical expert opinion and the literature on ethics and psychology raise many theoretical concerns about the emotional well-being of surrogate mothers and commissioning parents, especially after delivery of the child.[7,20,21] Studies exploring the experiences of surrogate mothers and commissioning parents, however, have not noted any substantial psychological issues.[1,3–5,17,18,22] Surrogate mothers did not experience an above average postpartum

depression rate.[3,17] One possible explanation for the discrepancy between expert opinion and clinical experience is that thorough counselling before conception reduces the psychological risk. An alternative explanation is that, knowing the child is not intended to be raised by them, surrogate mothers view their pregnancy differently and do not form the same bond to the infant.

Care of the surrogate mother during pregnancy and labour

Conflicts of interest

It is important that all those looking after a surrogate mother ensure that they are aware of the law relating to surrogacy. All healthcare workers should adopt a neutral position on the moral or ethical basis of surrogacy–their only concern should be to ensure that a surrogate mother is treated with the same respect as any woman in their care.

The clinician should avoid the possibility of a conflict of interest by caring for either the surrogate mother or the commissioning parents but not both parties. The surrogacy process can be compared to an organ transplant with a live organ donor: the surrogate mother and commissioning mother may face medical and psychological risks and their needs may conflict.[7] To avoid conflicts, a different physician should care for each woman during the IVF process and during pregnancy, so that each clinician is free to pursue the best interests of their patient.

Guidelines

Although the Royal College of Obstetricians and Gynaecologists has not issued any guidance, the Royal College of Midwives (RCM) has issued clear guidelines[23] for midwives looking after surrogate mothers during pregnancy. The RCM recognises that surrogacy arrangements should be the subject of strict confidentiality, with appropriate information disclosed on a need-to-know basis and even then only with the consent of the surrogate mother. In any situation of conflict or disagreement, a midwife's legal duty of care lies with the surrogate mother and her child, rather than with the commissioning parents: this is the same for obstetricians. In the best interests of all parties, however, healthcare workers should establish a supportive relationship with the surrogate mother and the commissioning parents throughout the pregnancy, labour and into the postnatal period, especially in the event of any complications.

Consent

In the eyes of the law, the developing fetus is a part of a woman's body. A surrogate mother, therefore, has the right to accept or refuse any medical procedures during the pregnancy. When seeking informed consent from a surrogate mother, the clinician needs to take special care to ensure that the commissioning parents are not coercing her. She alone has the right to determine what information about the pregnancy the clinician can share with the commissioning parents. Although the surrogate mother is free to consider the wishes of the commissioning parents, it is unclear whether she can voluntarily surrender her autonomy over medical decisions to the commissioning parents. A patient can choose to allow another person to make medical decisions on their behalf but that person must still act in the best interests of the patient. It is unclear, however, whether the commissioning parents would be able to act in a surrogate mother's best interests if a conflict of interest were to develop between the woman and the fetus. Indeed, ethical and legal opinions should be sought if a surrogate mother wishes to allow the commissioning parents to make medical decisions on her behalf.

Once an arrangement has been made and the pregnancy is established, decisions need to be made on ultrasound scanning or serum screening for trisomy 21 and amniocentesis or chorionic villus sampling to detect chromosomal abnormalities. Prior discussion and counselling about these issues and their possible ramifications helps minimise the likelihood of any problems.

Decisions also need to be made about the preferred place and method of delivery and the use of drugs during delivery for pain relief. Again, these discussions should take place in advance of the pregnancy. The surrogate mother, however, with the advice of healthcare professionals, makes the final decisions about delivery, depending on the progress of pregnancy and any obstetric problems, such as fetal malpresentation or fetal growth restriction. If there are any potential problems with the baby, the obstetrician should inform their paediatric colleagues in advance, so that they are also familiar with the legal issues and can arrange a meeting with both parties before delivery.

Deciding the mode of delivery in a surrogate mother who has had a prior caesarean section can be a challenge for the clinician, particularly when the surrogate mother strongly wishes to avoid the additional risks associated with a repeat caesarean section. There could be further complications when labour is prolonged at her request, with potential for the baby being born in poor condition and other wide-ranging effects on surrogacy arrangements. The ethics of allowing a surrogate mother to exercise her rights with regard to consent need to be balanced against potential harm to the baby if she chooses to decline medical advice or delay treatment. In the rare event of any serious concerns, legal assistance should be sought as soon as possible. A low-risk woman who has had a single prior caesarean delivery (with the added maternal and fetal risks from vaginal delivery after caesarean)

should, indeed, be considered high risk for the purpose of surrogacy.

Postpartum care of mother and baby

Important decisions on which the parents would normally be consulted may need to be taken immediately after delivery in certain cases, such as premature birth or the unexpected birth of a baby in poor condition. Ideally, a joint decision should be reached after signing a parental responsibility agreement soon after birth. Where a parental responsibility agreement has not been signed, it is the surrogate mother (registered as the birth mother) who has the right to make decisions about the child until it is more than 6 weeks old and a parental order has been obtained. All attending paediatricians need to be aware of this. Once the court has granted a parental order, the responsibilities for the newborn pass solely to the commissioning parents. Given the legal uncertainties surrounding surrogacy, a clinician who encounters any dispute between the parties should quickly seek help from social services and ethical and legal support.

The immediate postnatal period is a time of great emotional upheaval in a surrogacy arrangement and great sensitivity is required in handling the surrogate and commissioning parents. Midwifery support will be needed for the surrogate mother and the commissioning parents. If plans made by both parties are adhered to, this makes the situation easier for the midwife.

Conclusion

Providing health care for a woman during a surrogate pregnancy involves unique challenges. All healthcare providers, including obstetricians, general practitioners, midwives and paediatricians, need to be aware of the law surrounding surrogate pregnancy, which is being reviewed. Although our main responsibility is to care for the surrogate mother according to her wishes, obstetricians also have a duty of care to the unborn baby and they must make sure that the surrogate mother's wishes are in the interests of the baby. There is a paucity of literature on the associated obstetric risks and caution needs to be exercised with regard to labelling surrogate pregnancies as low risk.

Websites

COTS [www.surrogacy.org.uk]
Surrogacy UK [www.surrogacyuk.org]
Her Majesty's Courts Service. Parental Responsibility Agreements [www.hmcourts-service.gov.uk/infoabout/children/famcourt/agreement.htm]
British Infertility Counselling Association [www.bica.net]
Infertility Network UK [www.infertilitynetworkuk.com]

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