21 Gestational Carriers and Surrogacy

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Key Points

- The most common form of surrogacy involves a gestational carrier, a clinical arrangement in which the woman carrying the fetus is not genetically related to the baby.
- Difficulty in relinquishing the baby has led to a discontinuance of the practice of traditional surrogacy where the birthmother is also the genetic parent.
- The first case of a gestational carrier surrogate occurred in 1985. Today more than 2,500 cycles occur annually in the USA alone.
- Surrogates and intended parents need to have personalities that can deal with ambiguity and stress, as well as be empathic, adaptive, and resilient.

Surrogacy is likely the earliest treatment for impaired fertility dating back to the beginning of reported history. The term is derived from the Latin word *surrogatus,* meaning "substitute" or "appointed to act in place of." Historically, from Babylon to the Bible, there have been laws and customs allowing a substitute woman, or surrogate, to act in the place of a barren wife, thus avoiding the inevitability of divorce in a childless marriage [1].

Today, "traditional surrogacy" occurs when a woman carrying a pregnancy is genetically related to the baby by providing her own eggs. In this instance, the pregnancy can be established medically by intrauterine inseminations or through in vitro fertilization (IVF). However, the most common form of surrogacy, accounting for approximately 95 % of all surrogate pregnancies in the USA, is "gestational surrogacy" or "gestational carrier." In this arrangement, the woman carrying the pregnancy is not genetically related to the baby, and the egg(s) is from the intended biological mother, who generally for medical reasons cannot carry a pregnancy herself, or is from an egg donor. Women acting as surrogates may be commercially recruited and paid for their service (the most common) or may be altruistic as when a family member or friend volunteers pro bono.

The Bible tells the story of Abraham and Sarah who, when unable to conceive, asked Sarah's handmaiden Hagar to carry a child for them. Abraham had intercourse with Hagar and she subsequently gave birth to a boy, Ishmael, who

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she then gave to Sarah to raise. Fourteen years later, when Sarah was 90 years old and Abraham 100, she miraculously became pregnant and gave birth to a son, Isaac. This story, also, describes the emotional consequences of years of infertility and the problems surrounding the arrangement: Hagar was E slave and thus had no rights or choice; Sarah became extremely angry and resentful of Hagar after she was impregnated, causing great tension in the household, and Sarah never accepted Ishmael as her son, in fact insisting that Abraham cast him and his mother out of the tribe after Isaac was born. Abraham was greatly distressed as he loved Ishmael but did as he was told.

While traditional surrogacy no doubt continued to be practiced over the centuries, it was only within the last 35 years that surrogacy came into the mainstream of reproductive options when other treatments failed. In 1976, the first legal agreement in the United States between a traditional surrogate and intended parents was brokered by lawyer Noel Kean, who later was connected with the infamous Baby M case. No compensation was paid to the surrogate in this first arrangement. Four years later, the first documented case of a surrogate being paid occurred when Elizabeth Kane gave birth to a son for the compensation of $10,000. She was considered a good candidate to be a surrogate as she was married, had children, and had also given up a child for adoption prior to marriage. However, after relinquishing the child and giving up parental rights, she spoke out against the practice of surrogacy as she and her family later felt completely unprepared for the feelings and distress surrounding the arrangement. Other legal cases, including Baby M in 1986, illustrated the difficulty in relinquishment that may occur in traditional surrogacy and have led to the general denunciation of this practice.

The advent of in vitro fertilization, and later oocyte donation, created the possibility that a surrogate could become pregnant and carry a child that was not genetically related to her. The first successful case of a gestational carrier giving birth occurred in 1985, after the biological mother had undergone a hysterectomy. These technological advances have allowed for gestational possibilities that not many people would have imagined a few years ago: grandmothers giving birth to their own grandchildren, the oldest occurring in 2008 when a 61-year-old Japanese woman whose daughter had no uterus gave birth; gay male couples having babies; surrogate arrangements that cross borders, cultures, and socioeconomic strata; and the creation of an industry that some critics refer to as "rent-a-womb" [2].

While no data is available on traditional surrogate births, statistics on the number of gestational carrier cycles and births in the USA have been compiled by the ASRM-SART Registry Reports since the 1980s. Between 2004 and 2009, the number of initiated gestational cycles grew by almost 70 % (1,508–2,566), while the number of births more than doubled (530–1,013) with almost 6,600 live-born babies during this period [3]. See Fig. 21.1. However, since surrogacy is highly regulated or banned in many countries, the majority of these arrangements occur in the USA, and it is likely that these numbers are much higher than those currently available.

Indications

The first pregnancy following IVF and the use of surrogacy was reported in 1985 [4], and since then this form of assisted reproduction has become, not without controversy, an integral part of IVF and the only option to parent their own biological (genetic) child for many couples [5].

Candidates for gestational surrogacy include:

1. Women born without a functional uterus, for example, patients with Rokitansky-Kuster syndrome, a condition characterized by the congenital absence of the uterus and the upper third of the vagina; patients with uterine malformations not amenable to surgical corrections (e.g., small unicornuate uterus); patients with extensive uterine scarring like in the Asherman's syndrome; or patients treated with endometrial ablation for severe menometrorrhagia
2. Women post-hysterectomy (for intractable postpartum hemorrhage, for abnormal placentation like the placenta percreta or accreta, for endometrial cancer, or for menorrhagia

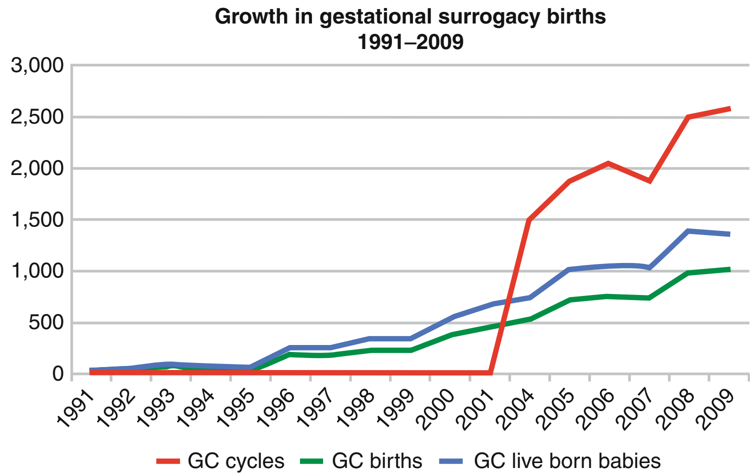

Fig. 21.1 Growth in gestational surrogacy births

due to diffuse and large fibroids or severe adenomyosis)

3. Any woman with severe medical conditions incompatible with pregnancy (e.g., severe heart disease, severe pulmonary hypertension, kidney failure requiring dialysis, status post organ (liver, pancreas, lungs, heart) transplant, severe clotting disorders)
4. Patients with recurrent pregnancy loss strongly suspected due to a uterine factor or patients with multiple and unexplained implantation failures
5. Male same-sex couples

Medical Assessment and Preparation

Medical Evaluation of the Gestational Carrier

Gestational carriers should be healthy women of reproductive age who have previously carried a pregnancy to term without complications. Generally, gestational carriers are recruited through agencies and matched with commissioning parents (intended or biological). Once a potential carrier has been identified, the physician treating the commissioning parents should establish the suitability of the carrier for pregnancy. A thorough medical evaluation, including a review of the past medical and surgical history and family and social history together with a complete physical exam, is carried out. At the time of the visit, the carrier is also informed of the various treatment protocols, the possible side effects, and the potential for medical complications. A specific set of laboratory screening tests for the gestational carrier is listed in Table 21.1.

Table 21.1 Laboratory testing for the gestational carrier and her partner

CBC, blood type and Rh, TSH, PRL
HIV 1 and 2; hepatitis B (HbsAg, anti-HBc); hepatitis C (anti-HCV); RPR; CMV (IgG and IgM)
Rubella, varicella
Urine drug screen
PAP smear, cervical culture screening for gonorrhea and chlamydia

Does not need to be performed in an FDA-approved laboratory

The uterine cavity is assessed with a saline sonohysterogram. Some programs, perhaps in an excess of prudence, perform a “mock cycle” prior to the real transfer to establish whether the endometrial response of the surrogate uterus to the standard dosages of hormones is appropriate. Rarely, the results of the endometrial biopsy performed during the “mock cycle” indicate a need to adjust the dosages of estradiol and/or progesterone.

Finally, if the gestational carrier is 40 years or older, a mammogram and a maternal-fetal consultation are typically ordered. The male partner of the gestational carrier is also tested for hepatitis B (anti-HbsAg and anti-HBc) and hepatitis C (anti-HCV), RPR, and HIV.

Table 21.2 Laboratory testing for the intended parents

(a) CBC, blood type and Rh, TSH, PRL, AMH; day 3 FSH and E2
(b) HIV 1 and 2; hepatitis B (HbsAg, anti-HBc); hepatitis C (anti-HCV); RPR*
(c) Rubella and varicella
(d) PAP smear
(e) Cervical culture screening for gonorrhea and chlamydia*
For the male partner:
(a) Blood type and Rh, semen analysis
(b) HIV 1 and 2; hepatitis B (HbsAg, anti-HBc); hepatitis C (anti-HCV); RPR and CMV (IgG and IgM)*
(c) Urine culture for gonorrhea and chlamydia*

Note that those indicated by the *asterisk* need to be performed in an FDA-approved laboratory

Laboratory Testing for the Intended Parents Requiring Gestational Surrogacy

The intended genetic mother is screened and tested like an oocyte donor, thus requiring the following exams performed in FDA-approved laboratories (*summarized in* Table 21.2): HIV 1 and 2, hepatitis B (anti-HbsAg and anti-HBc) and hepatitis C (anti-HCV), RPR, and cervical culture screening for chlamydia and gonorrhea. To be FDA-compliant, the testing needs to be done twice, the first time before the intended genetic mother is accepted into the program or prior to the carrier beginning her medical evaluation; the second set of the same tests must be obtained no more than *30 days* before the oocyte retrieval (in practicality, this second set of testing can be drawn at the baseline ultrasound appointment).

The intended genetic father is considered like a sperm donor, and also for him, there are FDA-required tests (Table 21.2): HIV 1 and 2, hepatitis B (anti-HbsAg and anti-HBc) and hepatitis C (anti-HCV), CMV (IgG and IgM), RPR, and urine culture for chlamydia and gonorrhea. Also for the intended genetic father, the FDA requires two complete sets of laboratory tests, the second being no more than *7 days* prior to the egg retrieval.

If the intended parents (mother or father) are not providing the gametes (i.e., are using donor oocytes or donor sperm), then the FDA-required set of laboratory screening applies to both providers of gametes (as for oocyte and sperm donors).

Choice of a Protocol for Ovarian Stimulation for the Intended Genetic Mother and Preparation of the Gestational Carrier

The choice of a protocol for ovarian stimulation protocol varies according to the age of the patient, her body mass index (BMI), the ovarian reserve, and the ovarian response to previous cycles. In general, the ovarian stimulation protocols can be divided into two groups: (1) long or luteal phase protocols using a GnRH agonist (the most commonly used) and (2) short or follicular phase protocols using GnRh antagonists (ganirelix or Cetrotide).

In the long protocol, a GnRH agonist (commonly leuprolide acetate) is started in the midluteal phase of the previous cycle, with 0.5 mg subcutaneous daily until the onset of menses. At the same time, the menstrual cycle of the gestational carrier is also synchronized with the use of leuprolide acetate started in the midluteal phase of the previous menstrual cycle. Generally the menses of the surrogate are manipulated so to start in advance (about 5–7 days) of the menses of the intended mother. Two days prior to starting the ovarian stimulation of the intended mother, the gestational surrogate in addition to leuprolide acetate begins the assumption of estradiol tablets at fixed incremental doses (2 mg per 5 days, followed by 4 mg for 4 days, and then 6 mg from cycle day 10), while the intended parent starts the gonadotropin stimulation (rFSH and/or hMG). The ovarian response is monitored by ultrasound and serum estradiol level and dosage adjustments are implemented if necessary. The hCG is administered when an appropriate number of follicles have reached a mean diameter between 18 and 20 mm.

On the day that the intended parent receives hCG, the gestational carrier stops taking leuprolide acetate and decreases Estrace to 4 mg daily

instead of 6 mg daily. The day before oocyte retrieval, the gestational carrier is instructed to commence the evening use of progesterone (vaginal preparations). The day of egg harvesting, the gestational carrier increases the vaginal progesterone to twice daily. Some still prefer the use of daily intramuscular progesterone injections (50 mg), and few others add intramuscular progesterone to the vaginal preparations. This protocol is generally continued with progressive decrements in estradiol from gestational week 6–7, until the completion of the tenth gestational week of pregnancy is achieved. Embryo transfer occurs 3–5 days after the retrieval. The day of the transfer is determined based on the number and morphology of available embryos.

Psychological Assessment and Preparation

The story of Abraham and Sarah gives credibility to the importance of psychological preparation, education, and assessment of all parties involved in gestational carrier and surrogacy arrangements. Like Abraham and Sarah, couples who pursue gestational surrogacy often do so after years of infertility and failed treatment. For others, such as women without a uterus or gay male couples, gestational surrogacy offers the only option for having a child that is at least partially genetically connected to them. Whatever the path that has brought patients to pursue using a gestational carrier, it has taken an emotional toll on them and the stakes are high for all involved. The gestational carrier or surrogate, like Hagar, also has a history that has shaped her decision to enter into this agreement and, most likely, a family that will be impacted by the experience. Lastly, a child, like Ishmael, who is created and born from the arrangement, will always carry a reflection of the legacy of his/her birth within the family, possibly affecting psychosocial development. Hence, appropriate psychological assessment and preparation of surrogates/gestational carriers (GCs), her partner if in a relationship, and the intended parents (IPs) is crucial.

Only recently has the American Society for Reproductive Medicine (ASRM) published practice guidelines on the medical and/or psychological evaluation of gestational carrier/surrogacy participants [6]. With the legal risk that exists with these arrangements and the ability to be sure all participants are in a good place to move forward with treatment, withstanding the uncertainties ahead, counseling becomes an important part of medical care and should occur before treatment begins. Standard of care with the psychological evaluation involves a three-pronged process with separate counseling sessions of the GC (with partner, if applicable) and IPs, culminating with a group meeting of all parties.

Oftentimes IPs and GCs come in for the psychological assessment having met, talked, and established that they want to work together. However, they may have little concept of what is entailed in a successful surrogacy relationship: They present like couples who just met, fell in love, and want to get married but have no idea who they are marrying, how hard marriage is, and what happens to the relationship after the honeymoon ends. The following sections will outline issues that should be considered and discussed during the counseling to help assess and prepare for a successful surrogacy relationship.

Gestational Carrier/Surrogate Interview

Whether traditional or gestational, minimal research is available on the experience of surrogate mothers. Common motivations for becoming a surrogate include financial gain, enjoyment of pregnancy, self-fulfillment, value and worth, and wanting to help others [7]. It takes a special woman to be a surrogate: She must be able to work with the IPs before, during, and after the pregnancy; she will need to relinquish the baby she has carried after giving birth; and she will have to handle these relationships and experiences while caring for her own family, dealing with her own feelings as well as the reactions of others in regard to her decision to be a surrogate. Although research indicates that overall women

do not experience psychological problems as a result of being a surrogate [7, 8], the challenges are significant and the potential for problems exists at every turn.

Hanafin [9], who has been working with surrogacy arrangements for over 25 years, identifies personality, characteristics, and qualities, which are positive indicators of a woman's appropriateness as a surrogate. To begin, a woman needs to have given birth so that she has experienced pregnancy, birth, and postpartum adjustment to be able to provide full informed consent about what she is undertaking. Having given birth previously will also provide important information on both her psychological adjustment and medical condition. A potential GC should be in a stable home and life situation, and not in the middle of transition or personal crisis. GCs who are dealing with job loss or stress, health and family problems, and marital difficulties may be at risk for emotional complications. Besides emotional stability, it is important that a GC be financially stable and not receiving forms of welfare or public assistance, so that acute financial need is not her primary motivation, effecting decision-making and consent. She should also have no history of problems with authority or the legal system that could indicate the potential for difficulties within the contractual relationship. Consequently, it is recommended that IPs see that a criminal and financial background check has been conducted prior to working with a GC.

Another consideration is the GC's husband's job situation as an increasing number of military wives are applying to be surrogates. These women are often sought out as they are seen as being accustomed to adapting to change, following direction, working with structure, and having strong values. At times, military wives will consider becoming a GC while their husbands are deployed overseas as a way to earn money and focus their energies. However, with many of our troops being deployed to combat areas with the risk of injury or death, it is time of anxiety, transition, and unknowns, and thus, it is recommended that surrogacy not be undertaken until her partner has returned safely home.

A surrogate needs to have a personality that can deal with ambiguity and stress as well as being empathic, adaptive, and resilient [9]. To be able to identify these qualities and psychological characteristics, it is recommended that all potential GCs be given standard psychological testing which will provide important information about her personality. The analogy can be drawn between standard medical tests, such as blood checks for FSH levels that are given to ovum donors to determine acceptability, and standard psychological testing: a woman can seem great to the eye and ear, but the blood test tells something that cannot be identified in an interview. Mental health professionals consider personality testing with the Minnesota Multiphasic Personality Test-2 (MMPI-2), which has been used in psychiatric, employment, and forensic settings for over 70 years, or the Personality Assessment Inventory (PAI) to be good choices in third-party assessments and standard of care (detailed in *Infertility Counseling*, GC Task Force, [10]). These tests will indicate not only the presence of psychopathology or difficult personality characteristics but also whether the GC is being open, honest, and forthright in her test-taking attitude and approach to the assessment. Recent research on the use of MMPI-2 with GCs has found that majority of applicants are within normal clinical limits yet score higher on validity scales that indicate, not surprising, a positive presentation of high personal standards and values [11, 12].

The clinical interview involves assessment and psychosocial preparation of the GC and, if applicable, her husband/partner, as his support, involvement, and understanding are crucial. Often it begins with a discussion of motivations for becoming a GC; the decision-making process; description of the contact and quality of the interactions thus far with the IPs; and sense of the GC's general support system (partner, family, community, etc.). History taking is an important part of the assessment and should include: family and marital history; psychiatric history; reproductive history, including fertility, pregnancy, and postpartum; history of previous loss or trauma including abortions, adoptions, perinatal death, and physical/sexual abuse; and history of

interaction with the legal system. A discussion of expectations and fantasies/wishes about the relationship during pregnancy and after birth should be addressed: How does the GC feel about abortion, multiple pregnancy, and fetal reduction, and who should be making these decisions? What contact does she desire and imagine will occur while pregnant, during birth, and after relinquishing the baby? How does she see her relationship and contact changing with the IPs and child after birth and in the future? What issues does she see occurring within her own family during this time, and how will she deal with it? These questions and discussion will help in preparing the couple for what is ahead. (A list of positive and negative indications for being a gestational carrier can be found on Table 21.3).

Table 21.3 Psychological indications of surrogate/gestational carrier appropriateness

Positive indicators
History of healthy full-term pregnancy
Experience and competence with motherhood
Motivations that reveal obtainable goals
Motivations that reflect empathy
Spousal support if applicable
Stable lifestyle
No major conflicts or transitions in the next 2 years
Cognitive ability to provide informed consent and conceptualize risks
Absence of psychopathology
History of making successful decisions for herself
Financial stability
Demonstrates tolerance for ambiguous and unclear situations
Able to express and articulate concerns and questions
Negative indicators
Poor pregnancy, postpartum, and/or medical history
Lack of martial/social support
Acute financial need or coercion
Psychopathology and/or history of poor psychological functioning
Defensive psychological testing
Elevations on the psychological test scales that are more than two standard deviations above the mean
Unrealistic expectations regarding time involved
Significant current stressors or life transitions
Chaotic lifestyle
Impulsivity or high anxiety
Limited cognitive ability
History of antiauthority behavior and rigidity in thinking
Unresolved or untreated history of child or sexual abuse
History of drug/alcohol addiction/abuse
Unresolved issue concerning prior abortion or reproductive loss issues
Lack of empathy
Inability to communicate in her native language with medical professionals

Ref. [8], adapted with permission

Intended Parents Interview

Intended parents, whether heterosexual, gay, or single, need similar personality qualities as surrogates. They need to be empathic, adaptive, trusting, and resilient as well as have the ability to tolerate lack of control. For patients that have struggled with years of infertility and treatment failure, it is important that they have had the opportunity to emotionally work through associated losses and hurts. Sometimes having spent years of dealing with the loss of control during treatment, IPs will approach using a GC as means of regaining control. This behavior may also be experienced in interactions with the treatment team. Hanafin notes "observing how (*IPs*) treat the professionals and other team members can be revealing and predictive of future behavior" with the surrogate and her family [9].

The clinical interview will follow a similar course as the GCs, with history taking, a discussion of decision-making, and relationship expectations. It is necessary to obtain a full medical, psychological, marital, and family history from the IPs to understand the process that has brought them to gestational surrogacy. How they have coped with losses, disappointments, and failures in the past should be discussed as well as how these issues have impacted their marriage. Expectations regarding contact with the GC and her family during the pregnancy and after birth should be reviewed. If they will be using an egg and/or sperm donor, the issues related to raising a nongenetically related child will need to be addressed. In addition, it is important to discuss

and confirm that legal consultation and contracts for both the IP and surrogate have been obtained prior to treatment.

Time should also be allocated to talking about the future, not only in regard to the relationship and contact with the GC but also to what they will be disclosing to their child about the origins of his or her birth. It is comforting to note to IPs that despite the difficult road to become a parent, ongoing research is indicating that families conceived via surrogacy are doing well and adapting normally [13].

Group Interview

Once both individual interviews of the GCs and IPs have been held, a final meeting is needed whereby all parties involved are brought together to review what was learned in the sessions and discuss how the relationships will work moving forward. At times, logistical issues may occur when the IP and the GC live many miles apart and will necessitate a coordination of the evaluations by different mental health professions. The GC may have already been psychologically screened by an agency before matching as well as the IPs having received prior counseling, particularly if coming from another country for treatment. The group interview at the clinic may be the first time the GC and IP have met in person. Thus, it is important that the clinic counselor has all supporting documentation and reports prior to facilitating the group session. An official translator may be required for patients traveling from abroad and not fluent with the English language.

The mental health professional will need to address any current or potential problem areas that were identified during the separate meetings and help the parties come to an understanding of how these issues will be dealt with. It is helpful to review the salient points from each session regarding their motivations toward surrogacy and expectations of each other regarding contact during and after the pregnancy. This should include their expectations about degree of openness and future relationships with the child, each other, and their families. It is also necessary to discuss how decision-making regarding embryo transfer, medical care, multiple pregnancy, multi-fetal reduction, fetal anomaly, termination, etc., will be handled. IPs and GCs having similar approaches to decision-making are extremely helpful. Finally, discussion of the future should include a plan for support and assistance when differences or difficulties arise. Counseling and support resources need to be identified, and legal contacts should be confirmed.

Both the IP and GC must understand that empathy will be the glue that makes this relationship work and hold it together to a successful outcome. There may be notable differences between the two couples (or individuals), such as culture, religion, race, and backgrounds, yet they must find common ground and the ability to empathize with each other and adapt to the unexpected will help greatly. All parties should leave counseling with a clear understanding of expectations, communication, and how needs and differences will be handled when they inevitably occur in this and all relationships.

Surrogacy Agencies

With the growth of technology allowing for gestational surrogacy, a whole industry has developed that identifies and brings together potential surrogates and intended parents. The Internet has created a means for people to meet and pursue these arrangements with numerous websites devoted to surrogacy: a recent search on Google brought up over 500,000 hits regarding agencies, agents, and resources on the topic. What to do and how to do it can be overwhelming.

The decision to use a gestational surrogate often occurs for a couple or individual after years of treatment failure and disappointments, which may make them financially and emotionally vulnerable in their decision-making. At times, IPs may try to find a GC on their own, through the Internet or word of mouth, sometimes because of financial concerns or wanting to regain a sense of control lost during infertility. However, as in private adoptions, this may open patients up to

exploitation, and working with a reputable surrogacy agency or agent can alleviate many potential problems. On the other hand, the motivation to become a surrogate, also, may involve vulnerabilities and risks to the woman and her family pursuing this arrangement. Thus, how these arrangements and relationships are facilitated becomes crucial in their success.

There is wide variation in screening and services offered by surrogacy agencies and lawyer/agents. Some act as a "matchmaking" service, while others provide full legal and psychological services throughout the process. Matchmaking agencies/agents will search and find women interested in being a GC but often do only minimal prescreening, usually outsourced to independent practitioners, before matching the IPs and GC. If the IP and GC decide to move forward, the IP incurs the cost of medical and psychological screening, which ultimately may find the GC unsuitable. While the financial loss is difficult, what is often more distressing is that the IP and GC have formed a relationship and are upset that it cannot proceed forward. Without adequate agency prescreening prior to matching, IPs are more vulnerable to continued loss, disappointment, and sadness. If they move forward and become pregnant, the GC and IPs are pretty much on their own to navigate the relationship, pregnancy, and birth. Furthermore, if there are problems or differences between the IP and GC during this period, there is no infrastructure of professionals or counseling in place to help navigate the difficulties.

Surrogacy agencies providing full service to IPs and GCs have legal, psychological, and medical staff in-house to assess, facilitate, and support both parties before treatment, during a pregnancy, at birth, and after relinquishment to ensure the best interests of everyone involved. These agencies will have the IPs and GCs fill out an in-depth application that identifies background, history, and desires regarding the arrangement. Potential GCs will have medical screening; criminal, credit, legal, and driving background checks; psychological testing and clinical interviews of the GC and her husband/partner; home visits; and legal consultation. Only after both the IPs and GCs have been fully screened and accepted by the agency will a match take place. At this time, some agencies will have the GC select the IP, while others do it the opposite way. The GC will be provided support throughout a pregnancy and after birth by participating in monthly support groups with other GCs and counseling. The IPs will be supported similarly and have the agency staff available for assistance in understanding how to work best with their surrogate, manage their own anxieties, and be available if difficulties or problems occur.

While each clinic will have their own requirements for medical and psychological screening, many issues should be addressed before IPs contract with an agency or GC. Table 21.4 provides a list of questions patients should consider when choosing a surrogacy agency or agent/lawyer to work with.

Cross-Border Surrogacy

International travels have proliferated for intended parents requiring the service of gestational surrogacy. The growing interest in "reproductive tourism" and "reproductive outsourcing," including a dramatic rise in Indian gestational surrogacy, has generated both legal and ethical concerns [14].

There are a number of factors that may promote cross-border surrogacy: (1) individual countries may prohibit the service for religious, ethical, or legal reasons; (2) the specific service may be unavailable because of lack of expertise or lack of affordability and supply of donor gametes and surrogates; (3) the service may be unavailable because it is not considered sufficiently safe; (4) certain categories of individuals may not receive a service in their countries, especially at public expense, on the basis of age, marital status, or sexual orientation; (5) individual patients may fear lack of medical privacy and confidentiality and thus travel abroad; and finally, (6) services may simply be cheaper in other countries [15, 16].

Particularly for gestational surrogacy, the economic motivation is the most cited reason for Americans traveling abroad (mainly to India).

Table 21.4 Questions to consider when choosing a surrogacy agency

1. What criterion is utilized by the agency or agent/lawyer when recruiting and screening a potential gestational carrier (GC)? Is the medical and psychological screening done before or after the matching and introduction meeting with intended parents (IPs)?
2. Does the agency/agent meet in person with the GC before matching? Do they meet in the office? Is there a home visit?
3. Has a criminal background check been completed on the GC and her husband/partner by the agency/agent? Does the agency/agent check whether the GC and her husband/partner have been involved in any other legal cases or lawsuits?
4. Does the agency/agent complete a credit check? Does the agency/agent check if the GC or her family is receiving any public assistance (i.e., food stamps, Medicaid)?
5. Has the agency/agent obtained a driving record on the GC and her husband/partner?
6. Has the potential GC ever been a surrogate before? What was this experience like for her and the IPs? Has a reference been obtained from the previous IPs?
7. Has GC ever applied and been turned down by another agency/agent/clinic before? Has she ever applied and been turned down as an egg donor before?
8. Has a psychological evaluation on the GC and her husband/partner been completed by a licensed mental health professional trained in third-party assessment? Did it include standardized psychological testing and clinical interview with both?
9. Was the psychological evaluation completed in person or over the telephone or the Internet/Skype?
10. Has the GC obtained clearance from her obstetrician? Have her medical records been reviewed?
11. What services do agency staff members provide and what is outsourced?
12. How long has the agency been in business? What legal problems, if any, have the agency incurred any legal with their arrangements?
13. Does the agency/agent utilize an independent escrow agency? What access does the client have to the distributions?
14. Is the entire agency fee due if a pregnancy does not occur or is it broken into installments?
15. What are the legalities of the states in which GCs are recruited? Is her state surrogacy friendly or will the GC have to travel to give birth?
16. Does the GC already have health insurance or will the agency be obtaining it for her? If she has health insurance, has it been checked to see if it excludes surrogacy pregnancy care?
17. Will the IP and GC each have their own legal representation?

The entire process can cost $25,000 (inclusive of airfare, accommodations, and the surrogate's fee), which is significantly lower (about one-third) than the total medical costs for the same service in the USA. Surrogacy is legal in India, and the carrier's name does not appear on the birth certificate. However, it has been already reported that for reproductive travelers to India using gestational carriers, after birth determining parentage for children born in India may become a legal and quite distressing quagmire.

In India, many of the women live together in a group setting, physically attached to the IVF clinic and stay there for the duration of the pregnancy. Some programs also offer egg donors. One recent profile of Rotunda – the Center for Human Reproduction in Mumbai – which offers both surrogacy and egg donation, does not allow any of the parties to meet (the gestational carriers are in confined "gestational wards" until the delivery). Recently this clinic coordinated a process with a gay male Israeli couple, an Indian egg donor, and an Indian gestational surrogate. The gestational surrogate was not told she was carrying a child either for a same-sex couple or foreigners. The article profiling the arrangement noted that "on some contracts, the thumbprint of an illiterate surrogate stands out against the clients' signatures." Other concerns have been raised about the carriers' level of understanding, including whether their lack of knowledge regarding with whom they are contracting undercuts any agreement, whether donor egg information is adequate for recipients, and whether immigration and citizenship issues are clearly and reliably established [17].

Conclusion

Surrogacy has been practiced throughout the ages and now, with the help of assisted reproductive technology, may involve up to five adults (gestational carrier, intended mother, intended father, sperm donor, egg donor) in the creation of a child. While the medical treatment involved in gestational surrogacy is fairly straightforward, the emotional, legal, and social issues of this complex relationship are significant. However, with appropriate preparation and support, this arrangement can be a positive, life-giving experience for all involved. The growth of cross-border surrogacy raises ethical concerns, and further research is needed on the impact on children created across continents and cultures as well as on the GC, her family, and intended parents.

Editor's Commentary

The practice of surrogacy in the United States has experienced its own evolution over the past several decades. Similar to egg and embryo donation, surrogacy has engendered much controversy and criticism, and yet it endures. Even the nomenclature has changed and can lead to much confusion and misunderstanding. The terms "surrogate," "gestational surrogate," "gestational carrier," and "intended parent(s)" are often used quite generally when discussed publically or in the lay press. Yet, medically and legally all of the above parties must be very specifically defined and consented.

Covington and Patrizio clearly elaborate the importance of the multidisciplinary approach to the modern practice of gestational surrogacy. Perhaps more than any other form of assisted reproduction, a thorough understanding of the medicine, the psychology, and the law that relates to this important clinical activity is absolutely requisite to the successful practice of the method. Close collaboration of the professional entities and the careful integration of the necessary component parts require a great deal of time and skill as well.

The public often views surrogacy askance. The commercial nature of the arrangements and commodification of eggs, uterus, and sperm makes it an easy target for more traditional-minded individuals who would prefer reproduction to occur "naturally." However, there is really nothing "natural" about our field of medicine, and gestational carrier surrogates are a rather "natural" extension of egg and embryo donation services. Certainly for women unable to carry a baby, for a variety of reasons, this gestational surrogacy provides them with an alternative that is both efficacious and relatively safe. However, it remains important that the profession carefully monitors the practice and develops published professional and ethical guidelines, in order to avoid unwanted controversy, particularly as it relates to cross-border arrangements that might be exploitive or illegal. This is an important clinical service that should be nurtured which will allow it to continue to grow in popularity for years to come.

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