Chapter 12
Surrogate Pregnancy

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Introduction

A surrogacy arrangement involves one woman (the Surrogate Mother) agreeing to bear a child for another woman (the Intended Mother) or a couple (the Commissioning Parents). The majority of surrogate pregnancies will utilise assisted reproductive techniques of one sort or another, although these will not always involve health care professionals. While many of the obstetric risks are similar to those of any pregnancy achieved using assisted conception, the legal, ethical and communication intricacies involved in providing care may be outside the usual scope of practice for many obstetricians. This chapter aims to explore some of the potential issues which may be encountered by the health and social care team in the perinatal period.

The Legal Status of Surrogacy Agreements

In UK law, surrogacy is not illegal, provided that any payment is only to cover the reasonable expenses incurred by the Surrogate Mother in the course of the pregnancy (altruistic surrogacy). It is not illegal to be a surrogate, nor to ask someone to be a surrogate, but it is illegal to advertise to be a surrogate or seeking a surrogate; the editor responsible for the publication of such an advert would be the guilty party in law. The surrogacy arrangement is NOT legally enforceable. Commercial surrogacy is illegal, as is any part in its negotiation, including the offer of negotiation or compilation of information for others seeking to partake in commercial surrogacy. These points are within the Surrogacy Arrangements Act 1985 [1].

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All those pregnancies where a health professional is involved in the insemination in any way are governed by the Human Fertility and Embryology acts of 1990 and 2008 [2, 3].

Australian law is similar to that of the UK.

In the USA, commercial surrogacy is legal, but surrogacy itself is completely illegal in some states. In Israel, commercial surrogacy is legal but altruistic surrogacy is illegal.

It is critical therefore that the clinician is aware of how the law applies in their country, and to seek legal advice if necessary.

Prenatal Counselling

Surrogacy is a planned pregnancy which allows the opportunity for pre-conception counselling. For most prospective surrogates/commissioning parents, any advice sought prior to undertaking a surrogate pregnancy is likely to be from the legal profession, but many of the potential risks and conflicts of interest can be anticipated from a medical perspective so pre-conceptual counselling is to be strongly recommended. It affords the opportunity to fully explore the physical and emotional risks of surrogate pregnancy for the prospective surrogate, as well as to clarify the legal implications of different types of surrogacy and raise some of the possibly unanticipated dilemmas or conflicts of interest which may occur. Some aspects of the counselling will be best provided by specialist organisations, such as the British Infertility Counselling Organisation [4].

If the prospective surrogate mother is married or in a Civil Partnership, her partner should be included in the discussions and be aware with the woman of the implications (particularly emotional) for the partnership and any other children in the family. Also, provided the partner consents to the surrogacy process going ahead, he or she will have equal parental responsibility for the baby until any other legally-binding arrangements are made with the commissioning parents after the baby has been born, as in the UK he or she would be the other legal parent (along with the surrogate mother).

As for most aspects of care in a surrogate pregnancy, it is ideal that the surrogate mother and commissioning parents should have a different health professional providing care, to avoid bias in advice for either party. The ultimate responsibility of the obstetrician is unequivocally to the surrogate mother, although with her uninfluenced consent, commissioning parents may appropriately be included in some of the care or discussions.

The suitability of the prospective surrogate mother should be examined with her, and any risks from the pregnancy fully discussed. The risks are likely to be lowest in a parous woman, provided previous pregnancies have been uncomplicated, as she avoids the increased risks due to placental dysfunction (pre-eclampsia, intra-uterine growth restriction) inherent in a first pregnancy and she will have an examinable track record in pregnancy. However, certain findings in the obstetric history may be

relative contra-indications to surrogacy. This would include a history of previous caesarean section with an expressed wish to consider vaginal birth (VBAC), as this would introduce a potential conflict of interest between mother and fetus, which could result in conflict between surrogate mother and commissioning parents. Any relevant medical history which may carry a risk to the fetus (known or suspected carriage of genetically transmittable disease, history of pre-term delivery or intra-uterine growth restriction, for example) should be encouraged to be disclosed to the commissioning parents and these risks factored into the care plan for the pregnancy.

As in any pre-conceptual counselling, the prospective surrogate should be encouraged to avoid smoking, alcohol and illicit drug use and should aim for a body mass index within normal range (18–25 kg/m^2), as well as to be Rubella immune, on folic acid supplementation and have relevant infectious diseases excluded (syphilis, hepatitis B and C, HIV). Any additional risk due to maternal age should be avoided by the Surrogate being ideally no older than 35 years, and she should be over the age of 18 (21 in the USA). Most licensed fertility clinics have their own guidance on acceptable age range for Surrogate Mothers [5].

The Surrogate should be encouraged to discuss all antenatal screening fully with the Commissioning Parents and reach agreement on those screening tests which will be accepted, as well as how they will proceed if screening detects a problem or an increased risk of a problem. Attitudes of both parties to risk of aneuploidy and fetal anomaly should be as clear as possible, as well as the nature of problems which would make either party wish to consider termination of pregnancy. Although such discussions will not exclude potential conflicts of interest when the time comes, they may help to avoid these being entirely unanticipated, as well as allowing either party to reconsider the surrogacy undertaking if a likelihood of being unable to find a common ground on such areas is identified.

Part of the discussion of assisted conception will need to include the differing types of surrogacy, resultant genetic relationships to the child and implication for achieving legal parenthood, as well as the medical implications for those involved and successful pregnancy rates.

Conception and Types of Surrogacy

When discussing assisted conception, the different types of surrogacy should be discussed. All surrogacy arrangements in the UK must be altruistic (although agreement of reasonable expense payments to the surrogate is permitted), as commercial surrogacy is illegal in this country. Traditional (“partial” or “gestational”) surrogacy involves the sperm of the commissioning father being used for conception by intra-uterine insemination or by artificial insemination (or, more unusually by natural conception). The latter two methods may be used at home by couples agreeing a surrogate arrangement without medical involvement, and clearly carries the risk that many of the issues covered above may not have been considered. With traditional surrogacy, the Commissioning Mother has no genetic relationship to the baby.

Gestational ("full") surrogacy requires some form of in-vitro fertilization as it uses an embryo created from the egg and sperm of the Commissioning Parents. In this approach, both Commissioning Parents then achieve a genetic relationship with the baby, but at the expense of a technique with a significantly lower ongoing pregnancy rate [5], considerable cost, and invasive treatment to the Intended Mother which would not otherwise have been required. The biological relationship of the Intended Mother to the conceptus has no influence on her legal relationship to the baby, which is non-existent until a Parental or Adoption order bearing her name has been issued. This situation has recently been examined in Ireland, when an Intended Mother, who provided the egg for a gestational surrogate pregnancy wished to be recorded as the mother on the birth certificate. The High Court ruling on the application that the Surrogate Mother is the biological mother and should be recorded as the mother on the birth certificate was over-ruled by the Supreme Court judgement as contrary to statutory law [6].

It should be noted that whether the Intended Father is the donor of the sperm for the conception and whether conception is achieved via a licensed clinic may both have a bearing on legal fatherhood according to the initial birth certificate of the baby (see the section on Parental Responsibilities and Rights in this chapter).

Antenatal Care

The Surrogate Mother is the patient and has all legal responsibility for decisions about care for her or the fetus throughout the pregnancy. All providing care must respect the confidentiality of the patient and no information should be disclosed to the Commissioning Parents without the express consent of the Surrogate Mother.

As in all pregnancies, the pregnant woman has the right to accept or decline any screening, investigation or treatment during the pregnancy. It is extremely helpful if discussions about antenatal, peri-partum and postnatal care have taken place preconceptually or very early in the pregnancy, and all decisions have been documented, as this will help to minimise conflicts and misunderstandings on the part of both parties, as well as by those providing care. However, the Surrogate Mother has the right to amend any of her previously-expressed decisions regarding care, and these wishes must be respected as they would be for any other patient.

Anyone providing treatment or care during the pregnancy must satisfy themselves that consent for treatment (written or verbal) from the pregnant woman is her own, and not given as a result of coercion by others, including the Commissioning Parents.

Additional thought should be given to the potential increased risk for pre-eclampsia. This is likely to be highest if the surrogate is primiparous and the pregnancy is with donor gametes from both prospective parents. Although there are no data to advise aspirin at low dose (75 mg o.d.) this may be prudent in some cases. Surveillance for hypertension in the last trimester should be no less frequently than fortnightly.

Potential Areas for Conflict in the Antenatal Period

Antenatal screening and prenatal diagnosis are an area often poorly counselled for in all pregnancies. The fact that there may be at least five parties (Surrogate Mother, Partner, Commissioning Parents and fetus [one or more in multiple pregnancy!]) with differing vested interests in screening, testing and their outcomes makes early, specific counselling particularly pertinent in a surrogate pregnancy. Ideally, discussion of all options and responses to different possible outcomes would have been explored pre-conception, and the Surrogate Mother will be clear about what is wished. However, it is not uncommon in a Fetal Medicine setting to find that preconceived ideas of parents about how they will feel and react when faced with concerning or bad news turn out to be different to their response at the time. Additionally, although the Surrogate Mother is the only party with the legal right to consent to undergo any screening, diagnostic testing, or therapeutic procedures for herself or the fetus, it is the Commissioning Parents who will be anticipated to be bringing up the child, with any associated consequences of disability or limited life expectancy, so ethically the pregnant woman may wish to discuss any concerns with them, although she is not required to do so. Remember that a Surrogate Mother would have the option of terminating a pregnancy that the Commissioning Parents would have wished to continue, but also that the Surrogate carries the risk of being left responsible for a baby with long-term care requirements if the Commissioning Parents decided to end the arrangement late in the pregnancy; they have no legal obligation to take the baby should they choose not to, and termination of pregnancy, other than for life-threatening maternal or seriously disabling fetal conditions, is not permitted by UK law after 24 weeks' gestation. Again, the legal partner of the Surrogate Mother may also, with the woman's consent, wish to be party to these discussions, as he or she would carry equal parental responsibility should the Commissioning Parents decide to withdraw from the agreement and the pregnancy continue.

With good pre-conception counselling, it is reasonable for the parties involved to accept that where decisions regarding the mother's health are concerned, the Surrogate Mother should make decisions on treatment, in conjunction with the professionals providing care. Conversely, if decisions relate solely to the health of the fetus, then the Commissioning Parents would decide on management, with the understanding that the Surrogate Mother would not be compelled to accept their decision if she was not in agreement.

Intra-partum Care and Midwifery Care

In the UK, The Royal College of Midwives has guidance for the role and responsibilities of the midwife when caring for a Surrogate Mother [7] which can provide a good framework for care in other jurisdictions. These emphasise the importance of maintaining the right to confidentiality of the pregnant woman, with information

only being shared with the Commissioning Parents with the express permission of the Surrogate Mother. The guidance also clarifies that in any conflict of interest, the duty of the midwife lies with the wishes of the Surrogate Mother. The guidance is also clear that the midwife must take no part in handing the baby over to the care of the Commissioning Parents; this must occur outside of the hospital after the mother and baby have gone home. However, the notifying midwife has a responsibility to notify the maternity services in the Commissioning Parents' area of the impending transfer of the baby's care, as well as giving details of the baby's birth. The Commissioning Parents' address, contact number and GP details must also be documented in the maternal and neonatal notes.

With the reported increase in incidence of surrogate pregnancies over recent years, it would be prudent for all Trusts to have access to clear guidance regarding surrogate pregnancy and the responsibilities of its employees providing care.

It is the professional responsibility of health care workers involved in care in this situation to be aware of the law as it pertains to surrogate pregnancy and to remain non-judgemental towards all participants in the surrogacy agreement.

Birth Planning

Ideally, birth planning should be done in advance, with clear documentation of the wishes of the Surrogate Mother. She may wish her choice of birth partners to include one or more of the Commissioning Parents, and will need to ensure that such plans are within the confines of what is acceptable within the setting she chooses for delivery; for example, it is common for Trusts to limit numbers of birth partners to two, with only one permitted in an operating theatre if operative delivery is required and with restricted visiting in high-dependency settings. Openness in these discussions is to be encouraged so that her wishes can be most closely adhered to with sensitivity to all parties involved.

It should be remembered that this is likely to be both an exciting and worrying time for the Commissioning Parents, and that emotions may also be different from those expected in the pregnant woman and her partner, if present. Whilst many of those directly or indirectly involved in care provision may be unfamiliar with surrogate pregnancy, breach of confidentiality by discussion of the situation with those who do not need to know the circumstances to provide appropriate care must be avoided.

Potential Conflicts of Interest Around Delivery

Birth plan formulation should involve discussion of situations where there may be conflict of interest between fetus and pregnant woman. While the responsibility of healthcare professionals is entirely to the mother until the baby is born, as in any

birth, she is likely to also want to protect the interests of the baby and hence the interests of the Commissioning Parents, for whom she is performing an altruistic act. However, in some circumstances, the best interests of mother and fetus would be best served by different management. An example would include mode of delivery in very pre-term delivery with malpresentation (28 weeks breech presentation), where evidence suggests that the neonatal outcome may be better with a caesarean section, even though this may require an upper segment incision in some cases, with prejudicial effect on future pregnancies. Similarly, in the presence of severe shoulder dystocia, the consideration of damaging maternal procedures like symphysiotomy versus fetal cleidotomy or prolonged anoxia may have different implications for the mother in a surrogate pregnancy. While counselling regarding decisions for such rare events cannot be specific in advance or adequately balanced in an emergency, the possibility of being faced with such decisions is important to understand for all involved, as well as the anticipation that the choice of the Surrogate Mother may be different from that if she were planning to keep the baby.

A much more common example, and one which should be considered in advance, is if the Surrogate Mother is considering a vaginal birth after caesarean section (VBAC). While the risks of loss of life of the mother due to scar dehiscence are very small in most cases [5] and the risks of complications in this or future pregnancies from repeated caesarean sections relatively higher, the one-off risk to the fetus, for whom scar dehiscence carries a high risk of death or lifelong severe disability, is almost certainly lowest with a planned, appropriately-timed caesarean section. Added to this, the acceptance of surgery is likely to be higher in a woman anticipating having a baby to take home at the end of the process, compared to a Surrogate Mother going home with an operation to recover from and no baby to take home, whose only rewards are altruistic. Discussions about such potential conflicts of interest would ideally have been covered before a Surrogate Pregnancy was conceived in women with a previous caesarean section, but as the obstetrician may only meet the woman once the pregnancy is underway, it is important that these issues and the outcome of any prior discussions are explored in this situation.

As in all parts of the pregnancy, the wishes of the pregnant woman at the time they are expressed over-ride any previous consents, provided the staff involved in her care are as sure as they can reasonably be that they are her own informed preferences and not influenced in any way by the coercion or undue influence of others (particularly if her influencer(s) may not have her best interests as their primary motivation).

The Post-natal Period and Parental Rights and Responsibilities

After birth it is important that postnatal care of the surrogate is provided as usual and that she knows how to seek help if needed.

Following the birth of the baby and until a Parental Order or Adoption Order has been made, the Surrogate Mother is always the legal mother of the baby and has the right to make any decisions about treatment, even if these conflict with the wishes of the Commissioning Parents. If she is married or in a civil partnership, then her legal partner also has parental rights, unless he/she did not consent to the treatment resulting in the pregnancy. If the Surrogate Mother is not legally partnered, then the Intended Father may rarely be eligible to be registered as the Legal Father if all of the exacting 'fatherhood conditions' are fulfilled. Most notably, the Intended Father CANNOT be the Legal Father if he donated the sperm for the pregnancy. It may seem counter-intuitive that a genetically-related father may have less automatic legal rights than one unrelated, but it is governed by the law that a sperm donor cannot be treated as the father of a child (section 41, Human Fertility and Embryology Act 2008) [3].

Conditions for Legal Fatherhood

These are the conditions for legal fatherfood:

- The Surrogate Mother is unmarried.
- The Surrogate Mother was treated in a UK licenced clinic for the assisted conception.
- The Surrogate Mother and the Intended Father both gave written, signed consent to the Intended Father becoming the father.
- The consent was given at the time when the embryo or sperm were placed in the Surrogate Mother.
- The consent has not been withdrawn.
- The sperm used to fertilise the egg was NOT from the intended father.
- The man was alive at the time of conception.

If all of these conditions are met, then the Intended Father can be registered on the original birth certificate as the father and will share parental responsibility with the Surrogate Mother. Should there be disagreement between the Legal Father and Surrogate Mother about the baby's medical care, then legal advice should be sought.

Transferring Legal Parental Responsibility

There are two ways in which Commissioning Parents become the legal parents, these being the ONLY ways that the Intended Mother can become a legal parent following a surrogate pregnancy:

1. Parental Order
2. Adoption Order

On the issuing of either order, a new birth certificate is issued, citing the parents named in the order, and parental rights transfer completely from the Surrogate Mother to the new parents.

The Commissioning Parents must seek independent legal advice on the transfer of parental rights.

Parental Order

A Parental order is a form of expedited adoption, obtained via the family courts by parents who satisfy a number of conditions. At least one of the parents must be genetically related to the baby (sperm or egg donor) and be a couple who are over 18 years of age and married, in a civil partnership or in a demonstrable long-term, stable relationship with each other. The application for the order must be after 6 weeks (prior to which the agreement of the legal mother is not considered valid) and within 6 months of the baby's birth, and the baby must be living with the Intended Parents at that time. No payment, other than of 'reasonable expenses' must have been made, and at least one of the Intended Parents must reside in the UK and the baby must then live with them. A Parental Order cannot be obtained by Intended Parents who are both genetically unrelated to the baby, or by a single person.

Adoption Order

Adoption is the only option for Intended Parents genetically unrelated to the baby or by a single Commissioning Parent. The process of adoption is governed by the Adoption Act (1971) [8] and must be administered by a registered adoption agency.

Outcome of Surrogate Pregnancies

In the majority of cases it appears that the outcome of surrogate pregnancies is satisfactory for the different parents involved. An overview of case series found that achievement of a clinical pregnancy in gestational surrogacy ranged from 18 to 69 %, and that in a total of 158 pregnancies, only 5 had significant complications: one woman developed pregnancy-induced hypertension, one fetus had intrauterine growth restriction, two patients developed gestational diabetes, 1 patient had placenta accreta and post-partum hysterectomy (triplet pregnancy) and one had spontaneous uterine rupture in the absence of previous uterine scar (fourth parity) [5]. Clearly, embarking on a multiple pregnancy intentionally using assisted reproductive techniques will increase a number of obstetric risk factors, including prematurity and risk of placenta praevia and operative delivery.

Although a potential vulnerability of the Commissioning Parents is that the Surrogate Mother may decide not to respect the surrogacy agreement and to keep

her baby, a situation in which they would have no legal redress, in practice only 4 % of Surrogate Mothers are reported to have done this.

It might be anticipated that the emotional effects of taking part in a surrogate pregnancy agreement, with the potential uncertainties for the Commissioning Parents and the eventual relinquishing of a child by the Surrogate Mother would have a detrimental effect on mental health, but there is no apparent increase in the incidence of post-natal depression in Surrogate Mothers and no recognised burden of psychiatric illness or psychological ill-effects in the Commissioning Parents [9].

Conclusion

Surrogate pregnancy is a subject that requires a clear knowledge of the physical issues presented to the surrogate as well as the legal and psychological issues that face both the surrogate and Commissioning Parents. Decisions regarding the pregnancy can only be made by the pregnant woman and careful counselling needs to be undertaken to ensure that the needs of the pregnant woman are fully understood, without coercion from the Commissioning Parents.

It is important that the teams caring for these pregnancies have a clear understanding of the roles and responsibilities of each team member, that the legal framework for the Country in which the pregnancy is pursued is followed to avoid later problems, and that confidentiality for all is maintained within the law.

Postnatally, the wellbeing of the surrogate mother must be borne in mind, though it is heartening for these women that perinatal psychiatric issues are not a larger problem than in the general population.

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