

5.4 Surrogacy

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Introduction

Surrogacy has been described as an emotional and ethical minefield that is putting human nature under pressure (British Medical Association, 1996; Appleton, 2000; Brinsden *et al.*, 2000). In most countries in Europe it is banned, in many others it is not practised, and only the UK and Israel openly allow for surrogacy. In the USA it is practised more frequently in the Western part of the country.

It can be undertaken in two ways: (i) by artificial insemination of the surrogate, so that she will be carrying a child derived from her oocytes. Very often no clinic or doctor is involved and a ‘do it yourself’ surrogacy comes about, often without any counselling; and (ii) by IVF, in which the embryos are transferred to the uterus of the surrogate. She is therefore carrying a child with no genetic relationship to her. Clinics will usually provide extensive counselling and support. Many will refer each case to an ethics committee for approval before proceeding.

Purpose

Counsellors often find it difficult to provide assessments about their patients. Yet in surrogacy there will always be some element of assessment involved in the work of the counsellor. To some extent this can be mitigated by separating the counsellor’s role from that of the person(s) who must make the decision on whether a particular case of surrogacy should proceed.

The objectives are therefore directed in two directions:

- (i) To help all those involved understand all the implications involved (see the Typical issues subsection below), to draw upon their own resources and to cope with the uncertainties involved. This will include: the commissioning couple; the surrogate, her partner/husband if applicable and any existing children of the commissioning couple or of the surrogate; the wider circle of families, friends and work colleagues; and the health care professionals, particularly those involved in the handing over of the child at birth.
- (ii) To relay to those who must make the decision as to whether

the case can proceed, with the consent of all involved: that there is sufficient confidence that the case is built upon a sound and trusting relationship between the commissioning couple and the surrogate; that there is an adequate support structure to help them through the difficult times ahead, and for as long as is needed or is possible; that the welfare of any existing children, or the prospective child, has been taken into account; that an adoption procedure or a change in parentage can take place; and that the aggregate of foreseeable hazards is not too great for any of the parties, including existing or future child/children.

Typical issues

There are several areas which will need to be explored and which may raise problems in the future. Counsellors may be needed for many years to help all the parties through the issues involved, including:

- The relationship between commissioning couple and surrogate. In the UK ~50% of the cases are between relatives and friends. The remainder are between people who did not originally know each other, but who have spent some time together so that there is understanding and trust.
- Marital status. Most commissioning couples are either married or in a stable relationship, while some surrogates are single, divorced or separated. Care is needed to establish that there is sufficient family support in all surrogacy undertakings.
- Indications for surrogacy include hysterectomy either as a result of complications in a previous pregnancy/labour (often with the loss of a baby) or as a result of cancer diagnosis and surgery/therapy, genetic absence of the uterus, repeated failed infertility treatment, repeated miscarriages or ectopic pregnancies. The reasons for needing surrogacy are distressing. Social reasons for surrogacy (e.g. busy lifestyle, etc.) are not usually acceptable to clinics.
- Motives of surrogate. Most surrogates have seen the distress which childlessness causes in their friend, are grateful for their own experiences of parenting and want to help others less fortunate. Sometimes the motives may be financial and counsellors must be sensitive to those possibilities.
- The effect of surrogacy on any existing or future children

must be considered. The welfare of children must be taken into account whether they are in the family of the surrogate or the commissioning couple. The arrangement for surrogacy should not proceed if a child in the surrogate's family finds the idea of surrogacy offensive.

- The legal situation must be taken into account. In those countries where the initiation of surrogacy is illegal, it may not be illegal to 'have' a child born as a result of surrogacy. Many patients will seek help in countries such as the UK or USA. Counsellors will need to help patients establish a proper legal framework for the future of any children born through surrogacy before a surrogacy pregnancy is initiated.
- Surrogate mothers are initially clear in their own minds that the child they are carrying is either wholly genetically that of the commissioning couple or partly so.
- Surrogacy which involves donor gametes may present additional problems for commissioning parents and the children—parenthood then becomes difficult to define and may involve the genetic mother, social mother, birth mother and her partner, genetic father, social father.
- Handing over the child and bonding. Surrogate mothers expect that the child will be handed over at birth so that there is minimal physical contact leading to bonding. A surrogate will never be able to forget that they have given birth to another child who they have 'given' to the commissioning couple. Any regrets should be compensated by knowledge of the happiness they have given the commissioning couple.
- Registration of the child. There will need to be some form of parental change in law or adoption procedures, which may involve international boundaries.
- Complications in pregnancy and postnatal depression. No pregnancy is immune from complications and with surrogacy there is no child as 'compensation'.
- Abnormalities with possibilities of termination of pregnancy can occur and cause distress to all the parties concerned.
- Failure of treatment (a miscarriage) is particularly distressing. Surrogacy arrangements between friends or relatives can cause particular emotional problems. In surrogacy arrangements where there is no such tie the distress may be mitigated by being able to 'walk away from the situation'; this is not possible between friends and relatives.
- Future access/contact to the child by the surrogate must be

considered. Within families and friends there will inevitably be further contact between birth mother and child. Surrogate mothers will need sensitivity and often help in handling this situation.

- Expense versus payment. In Europe, payment for adoption/surrogacy presents legal problems in changing parentage. It is often difficult to distinguish between genuine expenses paid and what is effectively a payment for services. Courts may need some evidence of what payments have been made.
- Telling the child. The complications of family relationships in surrogacy are such that the child will have to be told about their conception and birth. In most countries the adoption and parental change arrangements will mean that the child has the right to their original birth certificate on reaching 18 years of age.

Communication skills

In addition to the usual skills of infertility counselling, the counsellor in surrogacy must have a detailed knowledge of all the issues involved in surrogacy and the legal situation which exists in the country in question. Legal knowledge is necessary because there will be procedures which may involve adoption after the birth of the child. In many cases, successful parents are so delighted with the outcome that they may forget what those procedures are and may well need further contact with the counsellor to remind themselves of the proper steps forward. Counsellors may need a couple's permission to divulge to the courts the fact that they were counselled.

Good information in the form of booklets often provides a reference for parents at a later stage. There should be the opportunity for follow-up counselling and an awareness for all the parties concerned that further counselling support will be available for the commissioning couple, the child and the surrogate for as long as they may need it.

Counsellors must be aware of their own role in surrogacy and be clear that the couples understand that role.

References

- Appleton, T. (2000) *Surrogacy*. The IFC Resource Centre, Cambridge, UK.
- Brinsden, P.R., Appleton, T.C., Murray, E., Hussein, M., Akabousu, F. and Marcus, S.F. (2000) Treatment by *in vitro* fertilisation with surrogacy: experience of one British Centre. *Br. Med. J.*, **320**, 924–929
- British Medical Association (1996) *Changing Conception of Motherhood: The Practice of Surrogacy*. London, UK.