

ESHRE Task Force on Ethics and Law 10: Surrogacy

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This 10th statement of the Task Force on Ethics and Law considers ethical questions specific to varied surrogacy arrangements. Surrogacy is especially complex as the interests of the intended parents, the surrogate, and the future child may differ. It is concluded that surrogacy is an acceptable method of assisted reproductive technology of the last resort for specific medical indications, for which only reimbursement of reasonable expenses is allowed.

Key words: commissioning parents/enforceability/ethics/surrogacy

Introduction

The aim of this paper is to consider the ethical issues related to surrogacy. A ‘surrogate’ is a woman who becomes pregnant, carries and delivers a child on behalf of another couple (intended or commissioning parents). The term surrogacy covers several situations. In the first situation (full surrogacy), the gestating woman has no genetic link to the child. In that case, (i) the gametes of both commissioning parents are used; (ii) both gametes come from donors (donation of either supernumerary or *de novo*-created embryos); or (iii) one of the commissioning parents provides the gametes and a gamete donor the other. In the second situation (partial surrogacy), the surrogate mother has a genetic link by providing the oocyte. In either case, the gestating woman intends to relinquish the child to the commissioning parents, who want to assume parental responsibility.

Surrogacy presents several problems in the context of treatments involving third parties (collaborative treatments), e.g. the intended relinquishment by the gestating woman of the child she has carried; the relationship of the commissioning parents towards that child and towards the surrogate; and potential commercialization.

Background and scientific facts

Potential indications

Surrogacy without genetic link

Gametes provided by both commissioning parents. A distinction can be made between: (i) indications such as absent or scarred uterus/endometrium (congenital causes like Mayer–Rokitanski–Küster syndrome, inoperable scarred uterus, hysterectomy) which are absolute; and (ii) medical contraindications to pregnancy which are relative and can vary according to the magnitude of the risk and the severity of the condition for either the gestating woman or the future child (e.g. heart or renal failure, severe Rhesus iso-immunization). There is no consensus for other indications such as repeated miscarriages and repeated IVF failures. They should be confirmed by research.

In some countries surrogacy is performed for social reasons (‘for convenience’).

Double gamete donation or embryo donation. The indications are a combination of all the above together with the absence of gametes of both commissioning parents or severe genetic problems in both commissioning parents. The latter case seems a rare possibility.

Single gamete donation. The indications are a combination of the indications for full surrogacy plus absence of gametes or genetic problem in either commissioning parent. In the case of a problem with the commissioning mother, this may be due to premature ovarian failure, ovariectomy, Turner’s syndrome or cancer treatment.

Surrogacy with genetic link

The indications are identical to those for single gamete donation in the commissioning mother; the only difference is that the surrogate also provides the oocytes.

Kinds of surrogates

There are different kinds of surrogate women linked to the system of recruitment: in a largely non-commercial system, surrogates will usually be family members or friends, whereas in a commercial system the number of unrelated women, is higher.

Pregnancy risks

These include miscarriage, ectopic pregnancy, risk of multiple pregnancy which may be more common, and medical complications of pregnancy; the latter increase with age and complicated reproductive history.

Success rate

Pregnancy rates are satisfactory and comparable to those reported for similar technologies without surrogacy. Success rates are affected by the same factors such as age of the oocyte provider.

Psychosocial aspects

The available evidence is based on a limited number of cases and small studies.

The commissioning parents. Within the appropriate context (implication counselling, screening protocols of all parties involved), it is generally experienced as a positive procedure by the commissioning parents, which is understandable as it is their only chance to become parents. However, on some occasions major (legal and psychological) problems arise. The procedure is also likely to be less problematic when both commissioning parents have a genetic link with the offspring.

Surrogates. Surrogate women do not generally experience major problems under the same conditions mentioned above (appropriate counselling and careful selection of candidates). Nevertheless, some of them experience psychological problems at the moment they relinquish the child, and there have been reports of exceptional cases where the surrogate woman decides to keep the child.

The surrogate's child(ren). The available information is extremely limited. The psychological consequences for the surrogate's child(ren) of giving away the newborn birth sibling are unknown.

The prospective child of commissioning parents. Again the available information is extremely limited; some risks are known (risk of rejection or risk of being the object of a conflict between the parties), others are not known as long-term follow-up studies have only just started.

General ethical principles

Surrogacy is an acceptable procedure if it is an altruistic act by a woman to help a couple for which it is impossible or medically contraindicated to carry a pregnancy. We are aware of the moral objections against the procedure and of the potential risks and complications. However, these objections are insufficient reasons to prohibit surrogacy altogether. But it is essential that there are measures and guidelines in order to protect all parties, to guarantee well-considered decision-making and to minimize risk.

Payment

Several arguments have been presented against payment for surrogacy. These include insult to human dignity, the instrumentalization of the human body, potential exploitation of vulnerable women and inappropriate inducement (coercion) of women. When all these arguments are taken into account, altruistic surrogacy is the only acceptable form. Reimbursement of medical expenses incurred during the pregnancy and directly pregnancy-related complications, which are not covered by the national health service or private insurance, should be reimbursed. The surrogate should also be compensated for pregnancy-related expenses as well as the loss of actual income (but not potential income) if this is not covered by the national social security system.

Autonomy

By the very nature of the agreement, both parties involved (the commissioning couple and the surrogate) have voluntarily accepted certain restrictions on their autonomy. The agreement

creates prevailing moral obligations for both parties. They cannot unilaterally change their minds after the start of the pregnancy. Even in the case of divorce, the original agreement stands and the commissioning parents will still be the parents. Only in the case of the commissioning parents' death before birth would the surrogate have first choice to keep the child or to give it up for adoption.

Since the surrogate freely accepted to conceive and deliver a child on behalf of another couple, she simultaneously accepted certain restrictions to her autonomy. She is expected to behave as a responsible woman (i.e. to adopt a healthy life style etc.) and to conform to the original agreement with the future parents with regards to prenatal screening and testing. This includes the possibility of considering a termination of pregnancy in case of severe malformation of the fetus.

Informed consent

The surrogate. Generally, when a woman carries a child, there is a legal rule (presumption) that the care of this child is going to be undertaken by her, and that she will assume this moral responsibility. Surrogacy is intended to bring about a child for the commissioning parents. The implication of the process is therefore that the surrogate woman cannot keep any right or responsibility for the child after delivery. The woman who gestates is not expected to have parental rights or responsibility to the child she delivers. Therefore it should be made clear at the outset of the procedure that the intended parents have the primary responsibility for the child. The information provided to the future surrogate should thus be that she will have to hand the child over to the commissioning parents. We are aware of particular concerns when the gestating woman also provides the oocyte (partial surrogacy). Until we have further evidence, we would discourage this kind of surrogacy agreement.

The commissioning parents. They should be informed that they are the parents of any born child. For the best interest of the future child, their moral responsibility is engaged from the start of the project.

The gestational woman's family. The consent of the current partner is necessary in order to protect their relationship, and also because, as the law stands in a number of countries, the male partner would be the legal father of the child till the commissioning parents become the legal parents. The interest of her child(ren) must also be taken into consideration during the implication counselling process.

Safety

The same precautions should be implemented as for gamete donation (see Task Force 3), including screening for HIV, hepatitis B and hepatitis C. We also strongly recommend the transfer of only one embryo of good quality as a general rule, and two at the most if the embryos are of less good quality, the oocyte provider is aged >35 years and/or the number of fertilized oocytes is low (see Task Force 6). The surrogate should be fit for pregnancy as judged by appropriate medical and psychological criteria. We also recommend one act of surrogacy per woman, unless the pregnancy is for the same commissioning couple.

Specific ethical principles

Pregnancy

Antenatal screening. A mutual agreement should ideally be reached along the usual recommendations of antenatal screening unless all parties decide otherwise consensually.

Preconception and prenatal care: The surrogate undertakes the pregnancy freely and deliberately. As a consequence, she should behave as a reasonable pregnant woman by taking all the precautions advised in modern antenatal care (vitamins, no smoking, moderate alcohol use, etc.).

Termination of pregnancy. A termination of pregnancy can be justified for medical reasons (for the surrogate). From an ethical point of view (as mentioned in the section on general ethical principles), it is inappropriate to terminate a healthy pregnancy against the wish of the commissioning parents. However, the surrogate has a legal right to do so and this risk should be taken into account by the commissioning couple when stepping into the agreement. Given the principle of respect for autonomy and bodily integrity of a pregnant woman, it is impossible either to prevent the gestating woman from terminating the pregnancy, or to force a termination upon her. Nevertheless, since she freely accepted this project, she has the *prima facie* moral obligation to continue the pregnancy.

Mode of delivery. Taking into account the principle of autonomy of the pregnant woman, she cannot be forced to accept the advice of the obstetric team, but she still has a *prima facie* obligation to accept the advice that will ensure the best outcome for the child as well as for herself.

Enforceability of the agreement

Legal enforcement of the surrogate's behaviour is not possible before delivery. Therefore counselling should raise all points detailed above, and the parties should reach a mutual agreement on all foreseeable hazards. Since the commissioning parents are fully responsible for the born child, a surrogate has no right to keep the child. Like a gamete donor, she never acquired parental rights or responsibilities. On the other hand, the agreement is also binding for the commissioning parents in case the child would be handicapped or in case of a multiple pregnancy. Regardless of what was stipulated in the agreement, the child or children born are their responsibility.

The welfare of the future child born from surrogacy

There is little empirical evidence and no long-term follow-up studies regarding the social and psychological consequences of such an arrangement. No information is available for instance on the potential confusion about maternal roles. Long-term consequences if the surrogate woman keeps in contact with the resulting family have not been studied either. The possibility of conflicts cannot be excluded.

Openness by the parents towards the child about its mode of conception is advisable. The wish of the child to know its genetic origin should be taken into consideration by the parents in cases where donor gametes or the oocyte of the surrogate have been used.

The duty and responsibility of the doctor

There is neither a moral nor a legal obligation on the part of the doctor to collaborate in a surrogacy project. If he or she decides

to collaborate, he or she has: (i) a duty to inform all parties about the medical, social, psychological, emotional, moral and legal issues involved in surrogacy; (ii) to make sure that the candidates fulfil the indications; and (iii) to ensure that the parties receive appropriate screening and counselling in order to reduce risk and promote free and well-informed decision-making. The practitioner has the same obligation of care towards the pregnant surrogate as to any pregnant woman, although additional counselling and emotional support may be necessary.

Intrafamilial surrogacy

Different types of intrafamilial surrogacy can be distinguished: between sisters and intergenerational, either of mother for her daughter or vice versa. The main concerns in the literature are moral coercion and relational bewilderment for the offspring. We have no principled objection to known surrogacy either by mother or sister. No evidence is available at present that such arrangements have generated additional problems but careful counselling of both parties is indispensable. For those cases where the daughter serves as a surrogate for her mother, there may be an increased risk of dependency and undue pressure.

Recommendations

Surrogacy is a morally acceptable method of assisted reproduction of last resort. The least problematic indication is the absence of the uterus regardless of aetiology (absolute indication). Other indications may include serious health risks for the intended mother and difficulties in becoming pregnant (relative indication). Because of the risks and uncertainties for all parties involved, reluctance regarding the broadening of relative indications is advisable.

Payment for services is unacceptable; only reimbursement of reasonable expenses and compensation for loss of actual income should be considered.

All parties involved should be counselled and screened separately by independent specialists.

The surrogate should be aged <35 years for partial surrogacy and <45 years for full surrogacy. In order to ensure free and well-considered decision-making by the surrogate/gestating woman, it is required that the woman has at least one child.

A 'cooling off period' is recommended so that all parties can think through their decision.

It is strongly recommended that only one embryo should be replaced in order to prevent multiple pregnancies and to avoid unnecessary endangerment of the surrogate's and the future child's health. For special conditions, the replacement of a maximum of two embryos can be considered.

Long-term follow-up studies both of the resulting family and of the family of the gestating woman should be conducted, especially to gain insight in the psychological impact of the arrangement on the child(ren).

The commissioning parents should be well aware that the surrogate has the legal right to make decisions about her pregnancy against their will and against the original agreement.

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