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A Guide for Clinicians supporting Women and Families navigating Surrogacy

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Abstract

Surrogacy is an increasingly common alternative option for those wishing to start a family. Global instability and the contentious Assisted Human Reproduction Bill currently under review has highlighted some important clinical and legal questions that surrogacy may present in Ireland. Surrogate pregnancies are donor egg in vitro fertilisation pregnancies which have independent risk factors for the surrogate mother requiring appropriate pre pregnancy counselling. Surrogacy is associated with the risk of multiple gestation, premature birth, and low birth weight. As the commissioning parents are currently not considered the legal guardians under Irish law, they are not involved in clinical decisions regardless of their genetic link. Premature babies born through commercial surrogacy may not have the appropriate follow up on return to Ireland as they are not linked to any maternity hospital. This paper highlights the important clinical and legal questions that surrogate pregnancy may present.

Paper

Surrogacy offers an alternative option for those wishing to start a family. The true prevalence of surrogacy is unknown. Ireland permits altruistic surrogacy only, so most commissioning parents use commercial services internationally. Due to ethical concerns, some previous major stake holders in the surrogacy market have been removed, including Thailand and Nepal in 2015 [1] and India in 2020, which meant that by the time of the recent Russian invasion, Ukrainian surrogacy clinics were estimated to be providing over 25% of the global surrogacy market [2]. Recent events in Ukraine and the current review of the Assisted Human Reproduction Bill have highlighted some of the potential clinical and legal issues which may be encountered with surrogate pregnancies. In this article we describe the important clinical and legal questions that surrogate pregnancy may present.

Clinical vignette 1:

A healthy 28-year-old woman with one previous caesarean section presents for preconceptual counselling. She is considering acting as an altruistic surrogate. How should the potential surrogate mother be counselled about risk in pregnancy?

Background

Surrogate pregnancies are donor egg IVF pregnancies. Donation of an ovum is an independent risk factor for pre-eclampsia (PET), pregnancy induced hypertension (PIH) and postpartum haemorrhage (PPH) and is associated with an increased risk of caesarean section [3]. This is a high-risk pregnancy warranting extensive pre conceptual counselling.

Clinical Practice

A systematic review of 28 studies including 2308 pregnancies demonstrated the risk of PIH in surrogate mothers carrying a donor egg to be 22.6% compared to the estimated 5-9% risk of PIH in all pregnancies[4]. A cohort study conducted in 2016 suggested a 17.8% incidence of PIH in donor egg pregnancies compared to 5.3% in autologous assisted reproductive technologies and an increased incidence of PET (11.2%) in the donor egg group compared to 2.8% in the autologous egg group [5]. PET is also strongly associated with chronic renal disorders in later life [6].

The risk of abruption in donor egg recipients is estimated to have an OR of 2.5 compared to autologous IVF and OR of 3.8 compared to spontaneous pregnancies [7]. Donor egg pregnancy is a significant risk factor for major obstetric haemorrhage. An 11-fold increased risk of postpartum haemorrhage >1000 ml has been described in donor egg recipients in comparison to natural conception and 4-fold increase compared to autologous IVF[8]. The risk of prematurity increases with multiple pregnancies and The Ethics Committee of the American Society for Reproduction (ASRM) protects the gestational surrogate ensuring she is fully informed regarding all the possible risks multiple pregnancies entail and she has the final decision on the number of embryos transferred[9]. Surrogate parents should follow a high-risk antenatal care pathway.

Legal implications

The obstetrician's duty of care in this case is to the surrogate mother and the fetus regardless of who commissions their services.

Clinical vignette 2:

A healthy 30-year-old commercial surrogate has a screening ultrasound scan which detects a serious anomaly in the fetus. The commissioning parents would like to terminate the pregnancy but the surrogate mother refuses to do so.

Background

With all pregnancies there is a risk of congenital anomaly, the EUROCAT Register (European Surveillance of Congenital Anomalies) reports a background rate of major congenital anomalies of 23.9 per 1000 births. Congenital anomalies are reported in 6.5% of surrogate pregnancies in comparison to 2.7% of IVF pregnancies[10].

Clinical Practice

Consent for genetic testing is complex, the surrogate mother should be counselled about the risks associated with prenatal invasive diagnostics including infection, abruption, and early rupture of membranes. The commissioning parents must also be counselled if their genetic material has been used as the implications of an abnormal finding will potentially relate to them and their wider families. It would be best practice to take consent for the surrogacy separate to the consent form for the genetic material in this situation. Approximately one in forty cases will raise findings of uncertain significance and testing of the genetic parents may be required[11]. The duty of care of the obstetric team is to the surrogate mother and the fetus during pregnancy, labour, and delivery.

Legal implications

According to Irish law, the surrogate mother is the legal mother, and retains the right to make decisions including choosing whether to inform the commissioning parents or not of the anomaly [12]. In altruistic surrogacy the surrogate mother retains the right to make these decisions, but the commissioning parents are free to decide not to adopt the baby postnatally[12]. For altruistic surrogacy in Ireland, it is important to note that Irish legislation provides only for termination of pregnancy where there is a fetal anomaly so severe that is likely to cause death in the first 28 days of life[13].

Clinical vignette 3:

In a commercial surrogate pregnancy, spontaneous preterm labour occurs at 24 weeks' gestation. The baby is born weighing 715g and remains critically unwell in the neonatal unit. The surrogate mother does not wish to express breast milk and following 4 weeks of donor breast milk the baby is not growing well and is converted to preterm formula. The baby develops necrotising enterocolitis (NEC).

Background

Admission to the neonatal unit for care during the preterm period can be a major additional stressor and unanticipated cost for commissioning parents.

Clinical Practice

Major risk factors for NEC include prematurity with very low birth weight (6.6% in babies <1500 g at birth) and mortality rates can reach 50%[14]. Breast milk is the best source of nutrition for premature neonates. In surrogacy, they do not have access to breast milk, with pooled pasteurised term donor milk representing an inferior substitute. The use of formula milk compared to expressed maternal milk increases the risk of NEC up to 12 fold[15]. Given the increased rate of prematurity associated with surrogacy we recommend pre-pregnancy discussions of potential breast milk expression by the surrogate.

Legal implications

In some jurisdictions, if the baby is unwell post-delivery the surrogate mother is responsible for all care decisions regardless of the commercial surrogacy contract. This can be further complicated if the surrogate mother is unwell post-partum and unable to make decisions for the baby's care. Here healthcare professionals make decisions in the best interest of the baby. The commissioning parents do not have any legal standing except in Ukraine, where legislation recognises the commissioning parents as the legal parents from conception and registers their names on the birth certificate.

Clinical vignette 4:

A term infant is born via commercial surrogacy. At 5 weeks of age the commissioning parents take the baby home to Ireland. En route, the baby begins vomiting frequently, this increases in severity and becomes projectile within 24 hours of return to Ireland. They attend the Emergency Department where the baby is diagnosed with pyloric stenosis requiring surgery.

Clinical Practice
There are several issues for clinicians looking after the baby including who is able to give consent for investigations, admission, and surgery. In reality, most initial investigations will be carried out without question as clinicians are unlikely to ask for proof of parentage when a baby presents unwell.

Legal implications
Under Irish law, this baby is "stateless", without a legal guardian who can consent to medical care as Irish law currently recognises the surrogate mother as the legal mother. Even if the commissioning mother is able to prove a genetic connection to the baby, it does not give her any legal parental rights in Ireland. Although the baby's commissioning parents may have the right to consent for treatment in the baby's birth country, this will not apply on return to Ireland under current Irish law.

On return to Ireland, the commissioning father, if genetically connected to the baby, will make the following urgent legal applications to establish parental rights through the Irish legal system; a declaration of parentage which requires DNA confirmation; a request to be appointed joint guardian as the gestational surrogate has automatic guardianship in Ireland and a court order to disregard the need for the gestational surrogate's consent. This is necessary, for example, as passport offices require the signature of both guardians, and a court order will negate this.

The commissioning mother can establish her parental rights through formal adoption. Commissioning parents who are not genetically connected to the child can apply for legal guardianship after a period of two years caring for the child. In the setting of a baby needing acute surgery the commissioning mother cannot provide consent. Acute medical care is not the only issue as registering for audiology screening, new-born blood spot screening or hip ultrasound screening all require parental consent. Babies born through surrogacy outside of Ireland may have difficulty accessing any necessary neonatal follow-up as they have no links with an Irish maternity hospital.

Summary

Surrogacy has become increasingly common, and clinicians can expect to contend with this more regularly. The clinical scenarios highlighted here, cover critical issues which may be encountered and are important for clinicians to help optimise care of their patients and families. Amendments to the Assisted Human Reproduction Bill are necessary to improve patient safety.

Declaration of Conflicts of Interest:
None declared.

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