Gestational surrogacy: a call for safer practice

Gestational surrogacy is an important fertility treatment that particularly benefits women with medical conditions that make pregnancy unsafe or impossible, men in same-sex couples, and single men. Though many countries and several states within the United States have laws against gestational surrogacy, most U.S. states allow the practice with few regulations. In this issue, Perkins et al. (1) document the resulting trends in increasing use and improving outcomes in the United States.

In the past 15 years, the number of gestational carrier (GC) cycles increased by more than 470%, and a large majority (69.4%) of clinics now offer this treatment. The pregnancy outcomes are encouraging, as GC cycles using either donor or intended parent (nondonor) oocytes had higher implantation, clinical pregnancy, and live-birth rates compared with treatment cycles in which the intended parent carried the pregnancy. Another trend is an increase in cross-border reproductive care, or “medical tourism,” involving gestational surrogacy, with 18.5% of GC cycles performed for non-U.S.-resident intended parent(s) (1).

Although we are heartened to see improvements both in access to this important treatment and in the resulting pregnancy rates, the higher multiple-birth rates described by the authors is cause for concern. It is clear that a significant number of GCs and the resulting children are being exposed to the increased risks associated with multiple-gestation pregnancies.

With the privilege of providing gestational carrier treatment comes the professional responsibility to practice safely and ethically: mitigating risks for the gestational carrier and the children born from gestational surrogacy and, in turn, the risks to our professional autonomy. Arguments in favor of surrogacy include the right to procreative liberty, privacy, and autonomy. Gestational surrogacy gives hope to individuals or couples who could not otherwise build a family outside of adoption. Arguments against gestational surrogacy include the commodification of women for reproduction, undue inducement related to compensation, and concerns about the best interests of the resulting child. Unlike traditional in vitro fertilization (IVF) cycles where the intended parent(s) take on any risks associated with the treatment, subsequent pregnancy, and delivery, gestational carriers are taking on many medical risks for a third party. The extreme variation in laws and practices between countries and even within the United States demonstrates the myriad legal and ethical complexities inherent in these arrangements (2).

The Ethics Committee of the American Society for Reproductive Medicine (ASRM) recognizes the unique need to protect the interests of the GC through psychological counseling, independent legal counsel, and full informed consent regarding the risks of the gestational surrogacy process. As the committee opinion states, “Special consideration should be given to transferring a single embryo in an effort to limit the risks of multiple pregnancy for the carrier.” However, allowance is made for the transfer of additional embryos based on the age of the genetic parent (presumably the oocyte source) in an effort to improve the probability of pregnancy. Furthermore, “as with any decisions that relate to her body, the carrier should make the final decision regarding the transfer of more than one embryo” (3).

We argue that as providers of infertility care, it is our responsibility to do our utmost to ensure the medical safety of the GC and resulting children. One of the most effective means for achieving this goal is to minimize the number of multiple gestation pregnancies by maximizing the use of elective single-embryo transfer, yet this was performed in only 15% of GC cycles described in this issue (1). We strongly agree with the authors’ call for the transfer of fewer embryos per cycle to reduce the greater than 30% preterm delivery rate from all GC cycles and the 42.5% multiple-birth rate from donor egg gestational surrogacy. It is important to note that GC cycles are associated with a higher embryo implantation rate, likely due to frequent use of donor oocytes, preimplantation genetic screening, and embryo transfer on days 5 to 6. Despite this, the transfer of two embryos was more common in GC cycles than non-GC cycles, leading directly to the multiple-gestation and preterm birth risks documented in this report.

Because GCs have typically had a previous full-term pregnancy, some providers may feel that multiple-gestation pregnancies will be well tolerated by these individuals. Indeed, the risk of preterm delivery and low birth weight was slightly lower in GC multiple-gestation pregnancies as compared with non-GC multiples, but only when donor eggs were used. Regardless, the risk of premature delivery was still many times higher for multiples than for singletons in GC pregnancies. Although the complications of pregnancy for the GC herself were not listed in this report, it is well-documented that multiple-gestation pregnancies are associated with a significantly higher risk of hyperemesis, gestational hypertension, gestational diabetes, anemia, preterm labor, hemorrhage, cesarean delivery, and cesarean hysterectomy than singleton pregnancies (4). These risks also hold true for GC pregnancies (5). Modern in vitro fertilization (IVF) practices including blastocyst transfer and embryo vitrification lead to excellent cumulative pregnancy rates with elective single-embryo transfer for the intended parents and improved medical outcomes for the GC and resulting children.

It is unlikely that there will be domestic or international consensus on gestational surrogacy practices in the foreseeable future. This makes it particularly critical that we maintain the highest medical and ethical standards in IVF cycles involving gestational surrogacy. We acknowledge that limiting the number of embryos transferred per cycle increases the out-of-pocket expenses for the intended parents who desire more than one child. Gestational carrier cycles can cost in excess of $60,000, so “two for the price of one” may be appealing to intended parents. As physicians, we have a moral, professional, and ethical obligation to ensure the safety of our patients. To that end, we must support and promote policies to limit the number of embryos transferred in GC cycles. Though it may come at a higher price, it is
imperative that we practice good medicine—or we will run the risk of losing the privilege to provide this important treatment altogether.

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http://dx.doi.org/10.1016/j.fertnstert.2016.04.028

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REFERENCES