# Surrogate motherhood: a critical perspective

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**"Birth registrations are critical in legitimizing family membership and countries differ in who they consider the legal mother of a child, which can be the gestational, genetic or social mother if donor gametes are used."**

Over the last 25 years, treatment to overcome involuntary childlessness in single women, lesbian and gay couples and infertile heterosexual couples has progressed at a momentous pace. It is highly likely that further significant changes in treatment will become available in the next 25 years and these, in turn, will be subject to the public debate and media attentions that are necessary to acculturate these practices into mainstream societies [101]. Of the various forms of treatment currently available, surrogate motherhood continues to be one that instills doubt in the minds of many people [1]. This stems, in part, from the fact that surrogates are involved in the creation and bearing of a genetically related or unrelated child, with the express purpose of giving it up upon delivery and, in part, because of fears of the overt commodification of procreation [2]. The behaviors go against the traditional norms of family formation across societies, religions and cultures [3].

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The media's continued reporting on the good, the bad and the downright ugly of surrogate motherhood, using examples of worrying arrangements from around the world [102], has had an unsettling effect. Although social science research has addressed numerous aspects of welfare, motivations and short-term outcome [4], no long-term data are available yet. A note of caution is, therefore, necessary, balancing the commissioning couples' needs with those of the surrogate mothers and the children. Through continued monitoring and progressive debate relating to non-normative family formation and health inequalities, we should develop universal strategies for problem-free progress of surrogate motherhood practices.

## Surrogate practice

Surrogate motherhood involves carrying and giving birth to a baby for another woman using one of two methods of conception: genetic (the surrogate uses her own oocytes and conceives using donor insemination); or gestational surrogacy (the surrogate undergoes embryo transfer using the commissioning couple's or a donated embryo). Surrogate mothers have altruistic [5] and financial [6] reasons for being a surrogate. They tend to be of a lower socioeconomic background, with many also reporting lower educational achievements than their commissioning opposites, particularly in cross-border arrangements [7].

Worldwide, of the estimated one in seven couples who experience infertility, only a minority opt for surrogacy, despite the fact that success rates are similar to traditional IVF [8]. The commissioning mother usually has good reason to use surrogacy to overcome her inability to carry a child to term [9]. She is nearly always infertile. Gay men have also been known to commission surrogate babies. Commissioning couples invest financially and emotionally into the process of having a surrogate baby [10]. Those using embryo transfer invest a (full or partial)

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genetic link, time, energy, expectations and, usually, a fairly hefty financial outlay into the arrangement, which carries little legislative certainty in outcome.

### Variability in surrogate practices

International surrogacy is usually carried out owing to the unavailability of surrogates in the intended couple's country of residence, legislative issues or financial considerations. Birth registrations are critical in legitimizing family membership and countries differ in who they consider the legal mother of a child, which can be the gestational, genetic or social mother if donor gametes are used. For example, in India, clinical guidelines stipulate that the birth certificate has the genetic parents on the birth certificate [103]. A commissioning couple will have to apply for adoption in their home country if the infant was conceived using genetic surrogacy (which is relatively less common in India). In the USA, commissioning couples do not have to formally adopt; instead, they can add the infant to their passport so that it obtains US nationality just like the commissioning parents. In the UK, the regulations are stricter. It is estimated that, each year, approximately 50 applications for the formal process of Parental Orders for registration with the commissioning couples are made, most of these through UK surrogacy arrangements. Once Parental Orders have been agreed, birth certificates will record the commissioning couple as the legal parents of the child. The differential legitimization has resulted in a drive to accurately record genetic parentage on birth certificates in surrogacy and in the registration of children conceived through gamete or embryo donation, so that the children have accurate information about the circumstances of their birth [11].

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The consequences of these differing surrogate motherhood practices on the surrogates, the children and the extended family remains relatively unknown [12]. For surrogacy and other forms of third-party conception, reproductive-health inequalities seem to be widening between and within developed and developing countries [13]. Surrogacy involves a triad of people, and the involvement of agencies and clinics are expensive and not routinely available to all people [2]. Instead, the more affluent are able to commission a surrogate baby, whereas the less affluent are more likely to provide a surrogate baby. Relinquished surrogate and surrogates' own children could grow up (un)valued or (un)valuable, depending on the cost of their arrangement and the family they ultimately did or did not grow up in. These inequalities should be dissipated and destigmatized. Removing the stigma may encourage more and less affluent fertile women to help involuntary childless couples equally [14], decreasing these demand and provision reproductive health inequalities in surrogacy.

### Conclusion

Surrogate motherhood is unusual and relatively problem free, but it has the potential to have traumatic consequences for the surrogate, the commissioning couple and the surrogate baby, child or adult. Long-term follow-up of surrogates who experienced complications of pregnancy or following relinquishment need to be carried out to ensure they are well supported. In successful surrogacy arrangements, surrogates relinquish the baby at or soon after delivery. Research into the surrogate's own children and her extended family, who lose a genetically related or unrelated infant, needs to be explored. The health, wellbeing and family functioning of commissioning mothers, fathers and the commissioned surrogate baby are also under-researched. Future research, theory and practice should focus on the effects of health inequalities in the triads involved in surrogacy. Healthcare professionals involved in surrogacy need to address the psychosocial circumstances within the socio–cultural settings in which these reproductive arrangements take place.

#### Financial & competing interests disclosure

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### References

1 Poote A, van den Akker OBA. British women's attitudes to surrogacy. *Hum. Reprod.* 24(1), 139–145 (2009).

2 Spar D. The baby business: how money, science, and politics drive the commerce of conception. Mass: Business School Publishing Corporations Harvard, MA, USA (2006).

3 van den Akker OBA. The acceptable face of parenthood: psychosocial factors of infertility treatment. *Psychol. Evol. Gen.* 3(2), 137–153 (2001).

4 van den Akker OBA. A longitudinal pre pregnancy to post delivery comparison of genetic and gestational surrogate and intended mothers: confidence and gyneology. *J. Psychosomat. Obstet. Gynecol.* 26(4), 277–284 (2005).

5 Blyth E. I wanted to be interesting. I wanted to be able to say 'I've done something interesting with my life'. Interviews with surrogate mothers in Britain. *J. Reprod. Infant Psychol.* 12(3), 189–198 (1994).

6 van den Akker OBA. Genetic and gestational surrogate mothers' experience of surrogacy. *J. Reprod. Infant Psychol.* 21(2), 145–161 (2003).

7 Pande A. Not an 'angel', not a 'whore': surrogates as 'dirty' workers in India. *Indian J. Gen. Studies* 16, 141–173 (2009).

8 Assisted Reproductive Technology in the United States: 2000 results generated from ASRM/SART Registry (2004): the American Society for Reproductive Medicine/Society for Assisted Reproductive Technology Registry. *Fertil. Steril.* 81(5), 1207–1220 (2004).

9 van den Akker OBA. The importance of a genetic link in mothers commissioning a surrogate baby in the UK. *Hum. Reprod.* 15(8), 110–117 (2000).

10 van den Akker OBA. Psychological trait and state characteristics, social support and attitudes to the surrogate pregnancy and baby. *Hum. Reprod.* 22(8), 2287–2295 (2007).

11 Segev J, van den Akker OBA. A review of ART family functioning. *Clin. Eff. Nursing* 9S2, e162–e170 (2006).

12 van den Akker OBA. Psychosocial aspects of surrogate motherhood. *Hum. Reprod. Update* 13(1), 53–62 (2007).

13 Potter J, Trussell J, Moreau C. Trends and determinants of reproductive health service use among young women in the USA. *Hum. Reprod.* 24(12), 3010–3018 (2009).

14 Kirkman M, Kirkman A. Sister to sister gestational surrogacy 13 years on: a narrative of parenthood. *J. Reprod. Infant Psychol.* 20(3), 135–147 (2002).

### *Websites*

101 van den Akker OBA. Changing attitudes to alternative families in British women. *Bionews* 21 July 2008. www.bionews.org.uk/page.asp?obj_id=2567#BMS_RESULT

102 Goodchild S. Couples who hire foreign surrogate mothers risk their children being taken away from them, a legal expert said today. *This is London* (2009) www.thisislondon.co.uk/standard/article-23700689-parents-who-hire-foreign-surrogates-risk-losing-children.do

103 ICMR. National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India (2005) www.icmr.nic.in/art/art_clinics.htm