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## SPECIAL ARTICLE

## Health concerns and ethical considerations regarding international surrogacy

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## ABSTRACT

Since the advent of IVF, various arrangements for child bearing and rearing have developed. With the confluence of advanced medical technology, reproductive choice, and globalization, a market in international surrogacy has flourished. However, myriad health, social, and ethical concerns abound regarding the well-being of gestational carriers and children, the infringement of autonomy and free choice, and threats to human dignity. The present paper examines the scope, health risks, and ethical concerns of cross-border surrogacy, arguing that the risks may not exceed the benefits.

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## 1. Introduction

The confluence of medical advancement, reproductive choice, and globalization has enabled those who experience the profound sadness of childlessness to enter into an international surrogacy marketplace to craft genetic progeny of their own. The financial and economic forces, legal impediments, issues of control, health and safety, and ethical and social concerns prompt important unanswered questions as to whether this unregulated market is safe and ethical, and whether it should be controlled, outlawed, or further encouraged.

## 2. Scope of international surrogacy practice

Infertility affects much of the world's childbearing population. Worldwide, an estimated 40.2–120.6 million women aged 20–44 years, living in a committed relationship, fail to conceive after 12 months of trying. Of these, 12–90.4 million are likely to seek medical help [1].

For those wishing to satisfy the deep longing for genetically related children and who have the financial means, assisted reproductive technology (ART)—a multibillion dollar industry estimated to be worth more than \$3 billion a year in the US alone—provides myriad therapeutic options for infertility. These treatments include IVF, fertility drugs, donor gametes, and surrogate carriers [2]. While ART is growing on national levels, there are many individuals crossing borders to seek reproductive services and commercial gestational surrogates.

Surrogacy itself can be either traditional or gestational. In a traditional arrangement, a surrogate mother contributes her ovum and is genetically related to the child. In contrast, gestational surrogacy involves a surrogate carrying a genetically unrelated child; IVF allows the commissioning mother to be genetically related to the child in this case. Either form of surrogacy may be commercial (the surrogate is compensated beyond accepted medical expenses) or altruistic (the surrogate carries the child without financial gain). The distinction between commercial and altruistic surrogacy may be obscured depending on the amount a surrogate is compensated.

Legal restrictions forbid surrogacy arrangements in many countries. China, France, Germany, Sweden, and Switzerland prohibit all surrogacy arrangements, whether altruistic, commercial, gestational, or traditional [3]. The UK, Canada, and the Australian Capital Territory permit altruistic surrogacy but ban commercial surrogacy. Israel allows commercial surrogacy but forbids familial surrogacy on religious grounds [4].

In countries where the law is silent or not prohibitive, individuals may face a financial barrier to surrogacy. In the US, for example, surrogacy costs start at around US \$70 000, but can easily exceed US \$100 000. By comparison, in resource-poor countries, such as India, surrogacy can be a quarter of the cost or less where agencies charge prospective clients approximately US \$25 000 [5]. Thus, international surrogacy has become an increasingly attractive option for many individuals. Indeed, India has developed a booming surrogacy business, estimated to be worth between US \$500 million and US \$2.0 billion [6,7]. Unfortunately, the economic growth in India's medical tourism industry has not necessarily reached those it purports to help [8].

With increased cross-border demand and an ample supply of carriers willing to assume the risk and accept lower payment for their services in poorly regulated and low-resource countries, the industry

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of international reproduction has flourished. In India, the number of births through surrogacy doubled between 2003 and 2006 [9]. The Centers for Disease Control and Prevention (CDC) and the Society for Assisted Reproductive Technology (SART) report that the number of infants born to gestational carriers doubled from 738 to 1400 in the US between 2004 and 2008 [10,11]. In comparison, about 2000 babies were born to carriers in India in 2011 alone. Investigators estimate that as many as 1000 of those births could be attributed to British customers, where commercial surrogacy is illegal and where only 100 surrogacy births occurred in 2011 [7]. While the number of surrogate births has increased substantially in India, the exact figure and scope of practice are likely to be larger than reported. Indian databases list some 600 IVF clinics, with another 400 more clinics supposedly operate without any regulation [7]. Thus, the reported scope of international surrogacy practice in resource-poor and unregulated countries is likely to represent a fraction of the entire industry.

### 3. Public health risks

Aside from the standard risks of pregnancy, international surrogacy arrangements raise public health concerns. For the ova donor, ovulation induction therapy can lead to ovarian hyperstimulation syndrome (OHSS) which, in severe cases, may cause renal failure, hypovolemic shock secondary to intravascular volume depletion, acute respiratory distress syndrome, pulmonary thromboembolism, and in some cases, death [12,13].

Unique obstetric risks to gestational carriers are poorly described, though in general, conception by IVF leads to higher rates of hypertension, pre-eclampsia, cholestasis, hyperemesis gravidarum, and venous thromboembolism [14,15]. A study in Denmark found that the venous thrombosis incidence rate ratio was 2.8 and 4.4 in singleton and multiple IVF pregnancies, respectively, compared with reference pregnancies [16]. Cesarean delivery also increased the risk of postpartum venous thromboembolism [16]. While these results may be generalizable to other high-resource nations, it remains unclear whether these data are predictive of outcomes in low-resource nations and whether there are differences between IVF pregnancies and IVF-surrogacy pregnancies.

Women who carry a genetically related single fetus subsequent to IVF therapy are at higher risk of placenta previa (two- to six-fold) and abruptio (two-fold) compared with women who conceived naturally [17]. How these data apply to gestational carriers of genetically unrelated fetuses must be better understood and investigated. In order to accommodate the paying couple in the international setting, gestational carriers are often forced to undergo cesarean delivery. This carries greater potential risks than a vaginal delivery and can lead to increased complications associated with a subsequent vaginal birth after cesarean (VBAC), such as a greater chance of uterine rupture [18]. Whether existing IVF clinics in low-resource countries are adequately equipped to address such complications is unclear.

Children from international surrogacy may also face adverse health outcomes including an increased risk of perinatal morbidity and mortality due to a greater number of twin pregnancies from IVF [19]. Worldwide, about 25% of pregnancies conceived by ART are twins [20]. In general, based on the data we have, morbidity and mortality of surviving newborns could be lessened by reducing the multiple gestation pregnancy to one life. This solution, however, carries its own risks relating to the carrier's health and the contested moral status of both carrier and fetus. Even when considering singleton pregnancies, compared with spontaneously conceived children, fetuses from IVF pregnancies experience more preterm births, lower birth weight, and perinatal mortality [21]. It is unclear whether fetuses from twin or singleton pregnancies carried by a gestational surrogate are at any greater risk than those carried by the genetic mother. One advantage conferred to fetuses of IVF-surrogacy is a lower incidence of low birth weight births compared with those born following conventional IVF [22].

The impact of international surrogacy on maternal–child health remains poorly defined and deserving of further attention.

The potential harmful effects of international surrogacy on donors, carriers, and children should cause us to question whether the risks outweigh the benefits. It may be that the satisfaction childless parents feel and the financial compensation given to carriers still do not justify the potential consequences.

### 4. Ethics

The relatively unregulated market of international surrogacy requires careful and critical ethical reflection about the potential for exploitation and abuse. Not all peoples have the same freedoms and autonomy in a legal or practical sense. For some, societal and economic constraints may functionally limit liberties guaranteed by law. Ethical concerns relate not only to autonomy and free choice, but also to philosophical and social paradigms regarding issues of human dignity, the value of women, and their commodification.

#### 4.1. Autonomy and justice

Many high-resource nations uphold liberty, choice, and the freedom to contract. In the international setting of surrogacy, commissioning couples enjoy these freedoms with the added benefits of significant savings and a reduced likelihood of the gestational carrier claiming maternal rights to the child. This arrangement also benefits the surrogate who receives significant financial compensation, in some cases garnering in nine months what can take as long as 15 years to earn [23]. This empowers poor women to use their bodies as they choose and to care for their families, pay off debt, and save for their own children's future [24].

On the other hand, the financial compensation is not necessarily what is purported by surrogacy agencies, with carriers receiving only a fraction of what is claimed. Some fear that a lack of regulation could cause a price war for surrogacy, with countries underpricing fees and weakening legal protections for gestational carriers. Furthermore, if the practice of international organ selling is any indication, then the majority who vend their body to repay debts will have no economic improvement, may not be compensated the amount quoted, and experience deterioration of their general health [25,26].

Though the majority of citizens in the USA and Europe enjoy significant freedoms, privacy, and legal protection from exploitation and abuse, many women in resource-poor countries, such as India, do not benefit from similar philosophical, political, and legal frameworks. The assertion that Indian women are entirely and freely choosing to subject themselves to the risks of pregnancy without its natural rewards is misguided. The vulnerability of surrogates and the potential for trafficking led the European Parliament to write a resolution asking Member States: "to acknowledge the serious problem of surrogacy...[and] emphasize that women and children are subject to the same forms of exploitation and both can be regarded as commodities on the international reproductive market, and that these new reproductive arrangements, such as surrogacy, augment the trafficking of women and children and illegal adoption across national borders..." [27].

Additionally, whereas gestational carriers in the USA and Europe are granted freedom, autonomy, and legal rights to make healthcare decisions (i.e. whether to abort), women in resource-poor countries do not have such guarantees. In the USA, the American College of Obstetricians and Gynecologists (ACOG) recognizes that surrogate mothers retain sole autonomy for "consent regarding clinical intervention and management of pregnancy, labor, and delivery..." and that the obstetrician is obliged to "make recommendations that are in the best interests of the pregnant woman and her fetus, regardless of prior agreements between her and the intended parents" [28]. By contrast, in India the Assisted Reproductive Technology (Regulation) Rules 2009 states that a gestational carrier must agree to relinquish all parental

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