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A survey of UK fertility clinics' approach to surrogacy arrangements

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Abstract This paper draws on the findings of the first survey of surrogacy arrangements in Human Fertilisation and Embryology Authority (HFEA) licensed fertility clinics since 1998. Given the complex social, ethical and legal issues involved, surrogacy continues to raise debate worldwide and fuel calls for increased domestic provision in developed countries. However, little is known about how recent changes have affected HFEA licensed clinics. A 24-item online survey was undertaken between August and October 2013, designed to improve understanding of recent trends and current practices associated with UK-based surrogacy, and consider the implications for future policy and practice in UK and cross-border surrogacy arrangements. The response rate was 51.4%, comprising 54 clinics. Quantitative data were analysed using descriptive statistics, and open-ended qualitative responses analysed for extending understanding. Of the participating clinics, 42.6% offered surrogacy (mostly gestational surrogacy). Heterosexual couples using gestational surrogacy were the largest group currently using services followed by male same-sex couples. Most clinics reported having encountered problems with surrogacy treatments, suggesting barriers still exist to expanding the UK provision of surrogacy arrangements. It is important that professionals are well informed about the legal implications of surrogacy and that clinics have consistent and appropriate operational protocols for surrogacy arrangements.

KEYWORDS: assisted reproductive clinics, counselling, cross-border reproductive care, surrogacy, third-party reproduction

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Introduction

Medical and technological advances have revolutionized the field of reproduction, giving rise to growing numbers of people worldwide using surrogacy arrangements as a method of family building. For heterosexual couples, surrogacy may be an option if the female partner has a significant uterine pathology, an absent uterus or another medical reason leading to her inability to healthily gestate a pregnancy. The same applies to female same-sex couples where neither partner is able to healthily gestate a pregnancy. For male same-sex couples or single men, surrogacy is also considered as an option, following insemination of a donor oocyte or the oocyte from the woman who will act as the surrogate (American Society for Reproductive Medicine, 2012).

There are two types of surrogacy: genetic and gestational. Genetic surrogacy (also known as straight, traditional or partial surrogacy) uses sperm from the commissioning father and an oocyte from the surrogate. Here, fertilization is achieved either by insemination being undertaken informally between the parties or by clinical intervention via intrauterine insemination (IUI). Gestational surrogacy (also known as host or full surrogacy) always requires medical intervention since it involves the implantation of an in-vitro-derived embryo created one of three ways: by using an oocyte and sperm from the commissioning parents; by using a donated oocyte fertilized with sperm from the commissioning father; or by using a donated oocyte fertilized with donated sperm (the latter is not allowed in the UK). In 2009, the Human Fertilization and Embryology Authority (HFEA) removed its previous guidance that licensed treatment centres should only offer surrogacy where it was physically impossible or highly undesirable for medical reasons for the commissioning mother to carry a pregnancy (Human Fertilisation and Embryology Authority, 2009).

Surrogacy raises a number of social and ethical issues (Imrie and Jadva, 2014; Jadva et al., 2003; MacCallum et al., 2003; Palattiyil et al., 2010; Pande, 2010, 2014; Rotabi and Bromfield, 2012; Teman, 2010) and its regulation varies internationally (Beaumont and Trimmings, 2012; Nelson, 2013). Surrogacy remains illegal in many European countries, including France, Italy and Switzerland. In other countries such as Georgia, Ukraine and South Africa, all surrogacy agreements, including commercial surrogacy, are legal and enforceable (Howard, 2014). In the UK, commercial surrogacy is prohibited under the Surrogacy Arrangements Act (1985), as is advertising for, or as, a surrogate. Payments to the surrogate can cover only what are described as "reasonable expenses", such as loss of income, and surrogacy arrangements are not legally enforceable (Human Fertilisation and Embryology Act, 1990). Commissioning parents can apply to court for a Parental Order, if they wish, within 6 months of the child's birth. Following the recent changes to Section 54 of the HFE Act (2008), people who are eligible to apply for a Parental Order include couples who are married, in a civil partnership or in an "enduring family relationship". However, single people remain excluded (The HFE [Parental Orders] Regulations 2010) (http://www.legislation.gov.uk/uksi/2010/985/contents/made). In October 2013, the HFEA updated its guidance on legal parenthood in surrogacy cases (in particular that relating to the biological parent and "second" parent where the surrogate is unmarried) and the completion of HFEA consent forms in order to improve consistency across clinics and reflect more accurately the legal requirements (http://www.hfea.gov.uk/7955.html).

Parental Orders ensure that commissioning parents have legal parentage status, without which the surrogate will retain legal parentage (for a description of the process see Baron et al., 2012, and for a fuller discussion of associated issues see Crawshaw et al., 2013). It has been suggested that the complexity of the surrogacy process in the UK may be fuelling an increase in travel to countries with well-established commercial surrogacy programmes, readily available surrogates, competitive costs and less restrictive legal requirements (Gamble, 2009). Similar concerns have been expressed in other developed countries facing an increase in cross-border travel for surrogacy (Millbank, 2011).

Anecdotal evidence suggests an increased interest in UK-based and overseas surrogacy from both heterosexual and same-sex couples, the latter perhaps linked to what has been called growing "procreative consciousness" among gay men (Berkowitz, 2007; Berkowitz and Marsiglio, 2007; Murphy, 2013). Since 2007, there has been a marked increase in the number of UK Parental Orders granted, rising from an annual number of 33–50 since their inception in 1995 to 149 in 2011 (Crawshaw et al., 2012). However, recent information suggests that there may be at least a thousand children born annually through overseas surrogacy arrangements whose parents fail to then apply for Parental Orders (Blyth et al., 2014). There are presently no government data recorded with which to map changes to the profiles of those involved. This, in addition to the 2010 changes to eligibility for Parental Orders, the revised HFEA guidance, and growing calls for changes to legislation and practices both in the UK and internationally, provides a timely opportunity to identify surrogacy trends over the calendar years 2010 to 2012, and the views and experiences of UK licensed centres where all surrogacy arrangements requiring medical assistance are undertaken.

Little is currently known about the practices of treatment centres offering surrogacy services or the experiences of their health professionals. The last survey of surrogacy in UK clinics was undertaken for the British Fertility Society 16 years ago, at which time the HFEA only permitted surrogacy in licensed clinics on medical grounds (Balen and Hayden, 1998). Of the 113 clinics surveyed by Balen and Hayden, 29 clinics confirmed that they performed surrogacy, with gestational surrogacy being the preferred option. The authors estimated that surrogacy accounted for only 0.2% of treatment cycles carried out annually in the UK at that time.

In the same year, van den Akker (1998) published the findings from her survey exploring the functions and responsibilities of agencies and clinics involved in surrogacy. Ten centres took part in the survey (six clinics, two surrogacy agencies, and two voluntary organisations) and were questioned about the incidence, accessibility, and the legal, medical and psychological problems encountered. These two surveys identified inconsistencies within the centres surveyed and suggested a need for a more unified policy on surrogacy which addressed the complexity of the arrangement and helped clinics provide appropriate screening and counselling. More up-to-date information has the potential to inform both national and international debates on where and how surrogacy arrangements should take place in the current landscape.