

## **SURROGACY (THIRD PARTY PARENTING, GESTATIONAL CARRIER)**

VICTORIA  
FERTILITY



### **WHAT IS SURROGACY?**

Historically, there are two types of surrogacy. The original type was called classical surrogacy, and involved inseminating the surrogate with the sperm of the father-to-be. The surrogate therefore contributed a genetic egg and was therefore the genetic and biological mother of the child – who was then given to the intended parents after delivery. This type of surrogacy now rarely occurs. Since the introduction of in vitro fertilization technology it is now possible to perform a more acceptable type of surrogacy – called gestational surrogacy. In this particular process the gestational carrier is not the genetic parent of the child. For this to take place, the genetic mother undergoes in vitro fertilization. The eggs are harvested, and fertilized in the laboratory with her partner's sperm. At the same time that this process is taking place, the gestational surrogate has her uterus prepared artificially with hormones. The fertilized egg develops into an embryo, which is usually cultured in the laboratory for between 3 and 5 days. The embryo/embryos are then selected and inserted into the uterus of the gestational carrier. After birth, the surrogate then gives the child back to the intended parents.

Here, in broad outline, are the sequence of events that take place with gestational surrogacy as conducted through the Victoria Fertility Centre:

1. The intended parents (IP) undergo a thorough clinical, psychological and laboratory assessment. We first of all need to ensure that the ovarian reserve is satisfactory, and that there is a good chance of harvesting eggs during the in vitro fertilization process. Secondly, we need to make sure that the female partner is healthy enough to undergo the in vitro fertilization process and the surgical retrieval of eggs. We need to exclude any infections that could be carried potentially to the surrogate at the time of embryo transfer. Infectious disease screening would normally include HIV, HTLV, hepatitis B and C, gonorrhoea, Chlamydia, syphilis and cytomegalovirus.
2. The intended parents are extensively counselled with regards to the IVF procedure itself, and expectations regarding egg harvesting. Discussions would include such subjects as selective foetal reduction (when multiple gestation occurs), termination of pregnancy for identified birth defect, the risk of ectopic pregnancy and miscarriage, and the physical and emotional impact of all of these treatments. The intended parents and their surrogate will also be advised to seek legal counsel.
3. Evaluation of the surrogate – In Canada, it is illegal to coerce someone financially to be a surrogate. In other words, one cannot deliberately advertise for a surrogate with a promise for financial reward. It is legal, however, to compensate the surrogate reasonably for financial expenses. The surrogate may or may not be a family member or personal friend. There are various ways in which our patients meet surrogates. Once the surrogate is identified, she is carefully physically and psychologically evaluated here at VFC. It is very important for us to ensure that the surrogate has not been subjected to any pressure or coercion. Physical

examination will be done to ensure that her health is good, and that a pregnancy would not pose any specific risk to her immediate or long term health. Blood tests will be done to assess her hormonal status and to exclude the possibility of any infectious diseases. These would be similar to those outlined above. Issues such as the risk of spontaneous miscarriage, multiple pregnancy, risk of birth defects, the potential need for prenatal testing such as amniocentesis, risk of pregnancy complications such as premature delivery, hypertension and gestational diabetes will all be discussed. Preferably, the surrogate would have had a successful pregnancy before.

4. Legal issues pertaining to custody and the rights of the intended parents and the surrogate need to be discussed, and appropriate contractual agreements and consents need to be completed following full disclosure. We recommend that the surrogate and intended parents get separate legal counsel to avoid any conflict of interest that may arise where the same attorney counsels both parties.
5. At the Victoria Fertility Centre the prelude to the cycle treatment is usually initiated by placing both the surrogate and the egg provider on the birth control pill to try and synchronize their cycles. It is extremely important that the surrogate's uterus is carefully primed to receive fresh embryos at exactly the right time (which is usually 3-5 days after the eggs are harvested from the egg provider). After the surrogate has been on the birth control pill for a few weeks, she is usually started on a medication to suppress the pituitary gland and allow us to assume control of her uterus. This medication may be in the form of a nasal spray called Synarel or an injection called Lupron. Once she has been on this particular medication for about 7-10 days, she will stop the birth control pill and will then expect to have a period. After her period has started a hormone test will be done and the ovaries will be examined by ultrasound. If all is well, she will then continue with the Lupron or Synarel, and start taking an estrogen product to prepare the uterine lining (called the endometrium). This is usually in the form of a pill called Estrace or an injection of an estrogen product called estradiol valerate. We also encourage the use of low dose aspirin which can improve blood flow to the uterus. Vitamin C, E and folic acid supplements are also recommended, as these have been shown to help with the development of the endometrium. After taking the estrogen medication for 7 to 10 days, the uterus is then examined by ultrasound to assess the thickness of the endometrium. If necessary, the dose of estrogen may be increased. Usually, a minimum of 12 to 15 days of estrogen stimulation is required to develop a healthy endometrium. At the time that the egg donor undergoes egg retrieval, the surrogate will start taking a progesterone medication called Prometrium. She will continue with her estrogen product, which as mentioned before, is taken either orally or by injection, and will start taking Prometrium tablets intravaginally three times a day. Between 3 and 5 days later, the embryos will be inserted into her uterus. After the embryo transfer the surrogate will continue to take estrogen and progesterone supplements until the pregnancy test a couple of weeks later. She will also be prescribed a steroid called Medrol for a few days at the time of embryo transfer, to suppress the immune system slightly and encourage implantation of the embryo.
6. At the same time that the surrogate is having her uterus prepared, the egg donor will be prepared for egg harvesting. At around the same time that the surrogate

starts taking Lupron/Synarel, so will the egg donor. Just like the surrogate, she will also stop the birth control pill about 7 days after starting the Lupron/Synarel and will have a period. The egg donor will then have a blood test and an ultrasound before being started on fertility drugs to super ovulate the ovaries. The egg donor will then continue with her Lupron/Synarel and will start daily injections of a fertility drug (Puregon, Gonal F and Repronex) to stimulate the ovaries. After being on these drugs for about 6 or 7 days, a blood test will be done to measure her estrogen levels, and an ultrasound to monitor the ovarian follicles (the follicles are the capsules of fluid containing the eggs). When the eggs are ready, a drug will be given to mature the eggs, and then the eggs will be retrieved by using a small needle, which is passed alongside an ultrasound probe through the vagina. The eggs are then collected and will be fertilised in the laboratory using her partner's sperm. Depending on the quality of her partner's sperm, the eggs will be fertilized either by mixing the sperm and eggs together (called standard IVF) or by selecting and deliberately injecting a single sperm into each egg (intracytoplasmic sperm injection).

7. The embryos are then cultured for between 3 and 5 days. This will depend upon specific circumstances. Depending on the age of the egg donor, either one, two or three embryos will then be selected and inserted into the uterus of the surrogate. The role of the egg donor in this particular process is now over, and the surrogate will continue to take her hormonal therapy until the pregnancy test two weeks later.
8. If the surrogate is pregnant, she will be given advice about weaning herself off the supportive hormones, and will be scheduled to have an ultrasound at the Victoria Fertility Centre when she is between 6 and 7 weeks pregnant. The surrogate will have the final say about how many embryos are transferred. Obviously, the more embryos that are transferred, the higher the risk of a multiple pregnancy. Although many surrogates are willing to accept the risk of twins, we do need to ensure that the risks of even twins are carefully explained. Many of our patients are unaware that the obstetrical and foetal risks with twins are approximately ten times that of a singleton pregnancy. This includes all risks such as miscarriage, premature delivery, toxemia, cesarean section, forceps, cerebral palsy, intrauterine growth restriction, etc. Thankfully, in most cases the outcome with twins remains good, but the ideal outcome from in vitro fertilization is a singleton pregnancy.

## **COMMONLY ASKED QUESTIONS ABOUT SURROGACY**

### **1. What is the role of the attorney in surrogacy?**

It is very important that a contract be drawn up between the intended parents and the surrogate. There are many areas of potential conflict that can arise during the relationship. For this reason, the ground rules need to be clearly established and well understood by both parties. To avoid conflict of interest, we also recommend that the surrogate and intended parents have separate attorneys. Preferably, the attorneys involved should be familiar with this process. Here in Victoria we have consulted the services of Ms. Trudi Brown of Brown Henderson.

Just to give some idea of the potential areas of conflict – these may include any one of the following:

- The number of embryos to transfer and the risk of multiple pregnancy.
- If there is a multiple pregnancy – the option for selective reduction.
- Prenatal care – diet, avoidance of alcohol and smoking, regular medical visits, vitamin supplements, etc.
- Genetic testing – such as triple marker screening, amniocentesis and detailed ultrasound.
- The management of a prenatally identified foetal abnormality –which may be mild or severe.
- Termination of pregnancy should an abnormality be identified.
- Compensation for time off work should an obstetrical complication arise.
- Risks related to surgical delivery.
- Long term maternal health risks to potential complications which could arise during pregnancy.
- Visiting rights to the child.
- Medical and other pregnancy related expenses.
- Details regarding the handing over of the child after birth.
- Clearly establishing that the intended parents will be the parents of the child whatever the outcome.
- And many more issues.

## **2. What is the role of the reproductive psychologist in surrogacy?**

The psychological evaluation is usually the first step in the screening process. Our reproductive psychologist evaluates both the surrogate and intended parents regarding the suitability for surrogacy. She will also provide ongoing support to both parties throughout the process and help mediate any disputes which may arise.

## **3. How are the intended parents established as the legal parents of the child?**

In British Columbia, the birth mother is the legal mother. For this reason it is usually necessary for the intended parents to formally adopt their genetic child after birth. This legislation was recently challenged in court by a couple who felt uncomfortable about the legal need to adopt their own genetic child. The court ruled in their favour, however, the legislation remains - in that the birth mother is legally the guardian of the child. So, at this time, it would appear that it is still necessary for the intended parents to adopt their child after the child has been given to them following delivery. This does not mean that the intended parents need to wait for this process to take place before taking the baby home. Indeed, it is the intention that the intended parents take the baby home as soon as the baby is discharged healthy from the hospital.

## **4. What are the primary components of a successful relationship between the intended parents and surrogate?**

Mutual respect, goodwill, shared expectations, trust and kindness all form the foundation for a successful relationship between parties. It is not uncommon to face times of disappointment and hardship in the surrogacy process.

#### **5. Do most parties maintain contact after the birth of the child?**

In many cases the surrogate may be a family member or a close friend – and as such it is obviously very natural for this intimate relationship to continue. If the surrogate was previously not known to the intended parents, it is also common for friendships to develop during the course of the surrogacy and for the parties to consider each other “extended family by completion”. Many surrogates enjoy occasional photographs and updates about the child’s development.

#### **6. What are the expectations of pregnancy following an IVF/surrogacy arrangement?**

As long as both parties are healthy, the expectations for pregnancy are directly proportional to the age of the egg donor. If the egg donor is under the age of 35, and two good quality embryos are transferred to the surrogate, the expectation for pregnancy would be in the region of 50-60%. The risk of miscarriage is also related to the egg donor – and for somebody under 35 years would be in the region of 10-15%. The older the egg donor, the lower the chance of successful pregnancy. Generally speaking, if the egg donor is between the ages of 35 and 40, the chance for successful pregnancy with the transfer of three good quality embryos, would be in the region of 40-50%, and for egg donors above 40, the success rates start declining further. The miscarriage rates obviously also increase with advancing age of the egg donor.

#### **CONCLUSIONS:**

Surrogacy can be an extremely rewarding process for both the surrogate and the intended parents. The success of their relationship is very dependent on the process. Adequate psychological assessment, careful discussion and explanation about expectations is paramount to a good result.