Surrogacy

SYDNEY IVF

What is surrogacy?

"Surrogacy" literally means "help". In reproductive medicine it has come to mean a special kind of help: it's when a woman gets pregnant on behalf of someone who herself can't carry a pregnancy and have a baby. This is usually because the infertile woman has been born without a uterus or has had a hysterectomy.

Surrogacy at Sydney IVF means having IVF (see separate Sydney IVF Guide to Assisted Conception on what this involves). It's expensive, and there are no Medicare rebates for surrogacy. The eggs from the woman affected by infertility, (known as the commissioning woman) are fertilised with her own partner's sperm. The embryos are then transferred to the uterus of the intended surrogate, who carries the pregnancy and has the baby. Genetically it's the child of the infertile or commissioning couple, but it is a child the surrogate will have an understandable and ongoing attachment to.

Surrogacy is illegal in several states. It is not illegal in NSW, but it's not a widely accepted practice. Surrogacy has contentious social, legal and mental health implications in addition to the medical and scientific considerations usual with IVF. These are discussed here - and you will be considering them further with a number of professionals as surrogacy proceeds at Sydney IVF.

Surrogacy at Sydney IVF

Sydney IVF can help you with surrogacy arrangements when several conditions are all satisfied.

1. There is a clear medical indication for surrogacy
2. There must be a close and ongoing relationship between the commissioning couple and the surrogate
3. The surrogate must have had at least one child, and be over the age of 21

The COMMISSIONING woman

The commissioning woman needs to have at least one ovary - so that eggs can be obtained for fertilisation with IVF, alternatively she needs to have a known egg donor willing to help her. If she, the commissioning woman or donor, is older than 35 the chance of successful pregnancy for the surrogate is reduced; after 42, the intended surrogate (whatever her age) hardly ever gets pregnant.

Occasionally a uterus can be sufficiently abnormal due to inoperable abnormalities (such as extreme fibroids or intrauterine adhesions) so as to make pregnancy impossible. Rarely the uterus may be normal but a missing protein is causing repeated miscarriages. Sometimes there may be a medical condition making pregnancy potentially life threatening to the mother and/or the child.

We point out that having an apparently normal uterus and normal-looking embryos, but not getting pregnant, is still usually an embryo-based weakness and is not cured by surrogacy.

Stage 1 Preliminary referral

In the first stage, as well as your GP, you will need to see a Sydney IVF infertility specialist and a Sydney IVF counsellor. If you are travelling to Sydney from any distance away, make these appointments well in advance as they may be able to be made on the same day.

The Sydney IVF doctor's usual medical consultation fees will apply for all who attend the appointment with the Sydney IVF doctor (typically the commissioning couple, and the intended surrogate, with her partner). Medicare rebates are usually payable for these consultations, provided that each individual has been medically referred (at a minimum, those who attend need to be mentioned by name in your referring doctor's letter or letters).

You will also be responsible for a counselling fee, payable to Sydney IVF, which will cover the counselling for these appointments and the subsequent organisation and coordination of the review process. There is also a fee for the review panel assessment.

Stage 2 Expert reports

(usually takes several weeks)

You will then require:

1. **From an independent specialist obstetrician**: a written opinion on the likely safety or otherwise of the intended pregnancy for the birth mother (the surrogate), including the possibility of her having a twin or multiple pregnancy, preferably from the doctor who would supervise the pregnancy and perform the delivery;
2. **From an independent specialist psychiatrist**: a written opinion on the psychological state of the infertile couple and the intended surrogate and her partner;

3. **From an independent psychologist**: a written account of the circumstances of the commissioning couple and the surrogate mother's existing family and relationships;
4. **From lawyers experienced in family law and adoption procedures**: a written confirmation of your particular legal circumstances for the state in which you are resident; it should confirm that certain mutual obligations are met, including:
    a. Making sure, if pregnancy occurs, that a suitable life-insurance policy is in place for dependents in the event that there is death or permanent disability from complications of pregnancy
    b. Defining financial obligations for medical and other expenses
    c. Restrictions caused by adoptions law and planning how guardianship of the child can be lawfully transferred after the birth
5. **From your Sydney IVF specialist doctor**: a written referral and a request to the surrogacy review panel for approval.

Stage 3 Ethical review by the Sydney IVF surrogacy review panel

Every planned case of surrogacy facilitated by Sydney IVF needs the individual prior sanction of the Sydney IVF surrogacy review panel, which comprises a layperson selected by the (independent) Ethics Committee, an infertility doctor other than your own doctor, and a counsellor.

Before approval can be given, the review panel needs to know the medical and social details about everyone involved (privacy is guaranteed), including access to all of the above expert reports.

The panel may set further requirements, including further expert reports. Decisions of the review panel can be reviewed by the Sydney IVF Professional Advisory Board, which will seek the advice of Sydney IVF's Ethics Committee before overturning a decision of the panel.

Stage 4 IVF and embryo production

The steps for controlled stimulation of the infertile woman's (or egg donor's) ovaries and for egg retrieval are generally the same as those for anyone else undergoing IVF (please see the relevant separate information for details).

Stage 4 continued

Please note that the Health Insurance Act presently prohibits paying Medicare rebates for this step. This means an expense of about $12,000, including embryo freezing and GST.

The surrogate

Surrogacy must involve no payment or commercial element between the commissioning couple and the surrogate (it is against Commonwealth law and national ethical guidelines). Pregnancy is a risk for any woman, however, and the surrogate needs to be strongly motivated by a desire to help the commissioning couple, usually within the context of a close and continuing relationship with the particular couple and their intended family.

In practice, there are many expenses that commissioning couples and their surrogates need to discuss and agree on before proceeding with an arrangement that can be financially costly and emotionally risky.

These expenses include: medical and social expenses associated with presenting for medical treatment; initial reports and counselling costs; life-insurance for the surrogate during pregnancy and legal costs; IVF and embryo storage and transfer expenses; medical and other expenses associated with the pregnancy; and legal costs associated with the transfer of the baby from the birth mother to the genetic parents, usually via orders for Residence and Specific Issues from the Family Court (formal adoption is neither automatic nor easy).

Please remember that there is no way of enforcing a surrogacy agreement should there be dispute over whose child it is after the birth. The legal framework in place today makes it difficult to legally recognise a woman as the mother other than the woman who gives birth. In other words, if a dispute goes to court, the birth mother will probably be assumed to be the true and legal mother.

The best general protection of everyone's interests comes from an enduring prior relationship between all the people concerned.

The child

Genetically, the baby will be the child of the commissioning couple and will not share genes with the birth mother.

Experience has shown that you should avoid secrecy and be open and frank with the child from a very early age. In adoption and in

donor sperm pregnancies, for example, the later the discovery by a child (or adult) of his or her true origins the more hurt he or she is likely to feel (and usually the more shame is experienced by the parents).

Pregnancy and motherhood eventuates less commonly than you will be hoping for. If, as the commissioning woman, you are younger than 35, the chance of successful pregnancy for the intended surrogate can be up to about 60% from one round of IVF treatment. After 35, however, the chance starts to fall quite quickly; after 40 it is uncommon, and after 42 it almost never happens.

The surrogate mother's family

The surrogate mother, who is expected to relinquish a child she has carried, is compensated by her sense of generosity and by the opportunity for a continuing association with the child, even if at some distance.

The surrogate mother will most likely have a partner and children, who also need to be comfortable with what she is doing, both in the short-term and in the longer term. Sydney IVF's health professionals will support a surrogacy arrangement if there is an overwhelming likelihood that this will be the case.

Children in both families need to know well in advance what will happen after the baby is born.

Remember, having a baby is occasionally fatal. Sydney IVF will facilitate surrogate pregnancy only if the risk, though never zero, is about as low as it can be. This means the surrogate mother must have had at least one child before without serious complications. She must be over 21 and ideally should have completed her intended family. A satisfactory insurance policy in favour of her dependents must be taken out for the birth mother's pregnancy and to cover death or permanent disability.

Stage 5 Embryo transfer

If embryos result (which is usual but not inevitable) they then need to be transferred to the uterus of the surrogate mother after the lining of her uterus has been prepared with sequentially administered estrogen and progesterone (similar to the hormones normally produced in this sequence by the ovaries in a natural menstrual cycle). Alternatively the embryo may be transferred during a carefully monitored natural cycle.

Typically, the embryo transfer is technically straightforward, involving placement of a soft catheter through the cervix while having a speculum exam (similar to having a PAP smear). Further embryo transfer cycles from stored embryos cost about $4,000.

As with any "donation" of living human tissue, an infection can inadvertently be transmitted. Examples include hepatitis C, cytomegalovirus and HIV (the AIDS virus). The only way of virtually excluding this hazard is to "quarantine" embryos for six months before transfer, at the end of which, before proceeding with embryo transfer, such infectious agents are looked for a second time by blood test in the infertile couple (in case the infectious agent was undetectable but incubating when the eggs or sperm were retrieved and the embryos produced).

Stage 6 Pregnancy

The chance of pregnancy depends overwhelmingly on the age of the commissioning woman and the number of eggs retrieved, and hence the number of embryos that are produced and available for the surrogate to attempt pregnancy.

Remember that if more than one embryo has been transferred there will be a risk of multiple pregnancy (even a single embryo sometimes produces identical twins). Make sure you have settled questions such as prenatal genetic testing and what you will do if there is an abnormality.

Stage 7 Birth and post-birth legal procedures

Make sure that everyone who needs to know what is happening does know. The more people you take into your confidence, among your health professionals as well as friends and relatives, the less the burden of secrecy you will carry. It's essential that existing children understand well beforehand what will happen.

Make an early application to the Family Court for a parenting order. Your legal advisor is important here.

'Traditional' surrogacy

This is less common than purely gestational surrogacy. It involves the insemination of an intended surrogate using semen from the partner of the infertile woman. The woman is both the genetic mother and the pregnancy and birth mother. At the moment of birth it is her baby in every way except that she has planned to give the baby to another woman.

Unlike gestational surrogacy using IVF embryos from an infertile couple, experience has shown that it is possible for the surrogate who is also the genetic mother to regret the commitment and to change her mind and to keep the baby. In Australia her legal right to do so has been confirmed by the courts.

In Sydney IVF's experience the risk of traditional surrogacy going wrong is too high. Sydney IVF will not assist traditional surrogacy arrangements.

no better chance, no greater care.

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