Success Rate of Surrogate Gestational Pregnancies

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Introduction

This paper presents a review of a new procedure involving gestational surrogate mothers. The dramatic increase in vitro clinics and procedures has logically extended to the transferring of embryos from an infertile couple to a gestational surrogate mother. The first such gestational surrogate birth was reported in 1987. Since that time there have been approximately 30 births worldwide. Due to the fact that the surrogates are implanted during unstimulated cycles and are young women with successful pregnancy histories, it was hypothesized that the success of in vitro fertilization will be greater when working with gestational surrogates.

The legal, psychological, and medical dynamics of such a solution to childlessness are indeed complex. There are few or no laws that address legal issues of working with a surrogate mother and there are few studies that outline the psychological risks and considerations. This paper will outline the procedures of one center which specializes in providing legal, psychological, and administrative services to all patients. It outlines issues that any medical team should consider prior to becoming involved in gestational surrogacy. Furthermore, the most current findings on the pregnancies using in vitro fertilization donor findings on the pregnancies using in vitro fertilization donor oocytes will be presented.[1]

Sample

The sample consisted of 22 infertile couples who came to the “Center for Surrogate Parenting” in Los Angeles, California. These couples were of childbearing age, but unable to conceive due to hysterectomy, malformed uterus, extreme health risk of pregnancy, or unexplained infertility. Of the women, 17 ranged in age from 33 to 41 and 4 ranged in age from 42 through 47 years old. All were medically determined to still be ovulatory.

The gestational surrogate mothers consisted of 17 women who had met the psychological and medical requirements of the Center. They all had histories of uncomplicated pregnancies. Within this sample, 16 were under 32 years of age and 1 was 36. All were medically determined to be fertile, healthy, and with regular cycles.

Procedures

A. Psychological

Surrogate mother applicants and their spouses underwent an orientation and psychological screening process. Only women who had successful, uncomplicated pregnancies and who had children of their own were interviewed. Each candidate was told of the risks and demands of

such a program. The orientation emphasized informed consent regarding legal, medical, and psychological challenges. The psychological screening process involved assessing their intelligence, ability to keep commitments, social support systems, self-esteem, coping mechanisms, sensitivity toward others, and stability. Furthermore, their motivations and their expectations were fully explored. Candidates were only accepted if they were motivated by factors other than money, and if they foresaw being a surrogate as a personally rewarding experience.

After initial interviews, selected candidates were given psychological testing. They were required to attend the mandatory support group meetings with other gestational surrogates. They were then medically evaluated for fertility and general health (including social disease testing).

The Center also provided a similar orientation for infertile couples, with each couple meeting with the staff psychologist to assess appropriateness for the program. Alternative solutions to childlessness, marital issues, expectations, informed consent and stability were discussed.

Accepted surrogate mother candidates and infertile couples were subsequently matched and introduced to each other under the guidance of a staff psychologist. Both sets of clients received psychological consultation throughout their participation.

B. Legal

The surrogate and the Intended Parents have a legal relationship because she is carrying a child pursuant to a comprehensive and sophisticated contract that has been entered into. Prior to entering into this legal relationship, both the surrogate and the Intended Parents must undergo a full and comprehensive legal consultation with independent counsel. This consultation includes a full description of the surrogate contract as well as the possible liabilities, duties and responsibilities of each party. The consultation includes an explanation of the ambiguous status of the contract in the United States. Very few jurisdictions have ever passed laws on the legality of surrogate parenting, and in particular, gestational surrogacy has never been addressed by any legislative or judicial body. Because there has never been a situation where a gestational surrogate attempted to renege on her contract or a couple was not willing to go forth under the terms of a gestational surrogacy agreement, the contract has never been tested.

Once the surrogate and the perspective parents had been legally informed of their rights and duties under the contract, a match was made and the parties once again went through the process of reading the contract together. This was done with the assistance of a video tape in which an experienced attorney again explained in full the legal aspects of the relationship.

Prior to the implantation, medical insurance was purchased on behalf of the surrogate and life insurance policies were set into place on behalf of the parties. The entire anticipated expense of the procedure, including medical expenses, payment to the surrogate, legal, administrative and psychological fees and all other anticipated miscellaneous expenses were placed in a trust account.

At approximately the sixth month of pregnancy, a legal petition was filed with the court of appropriate jurisdiction requesting a judgment for maternity and paternity on behalf of the

biological parents. This legal action was initiated to establish the legal relationship between the prospective biological parents and the child. With the granting of the petition of maternity and paternity, the surrogate was deemed to have no parental rights to the child and the biological parents were legally deemed the natural parents of thee child (while in utero). This petition eliminated the necessity of any adoption proceedings and legally recognized the intended relationship that the parties had created. The legal document contains the declaration of parentage and also orders the birth certificate be issued with the names of the biological parents as the natural parents of the child.[2]

C. Medical

The doctor and patient decided whether the in vitro, ZIFT, of GIFT procedure was to be utilized. In the first embryo transfer attempt, estrogen and progesterone, along with HCC were used to synchronize the donor mother's cycle with the cycle of the specified surrogate mother. For all subsequent transfers, the donor mother took Lupron to help synchronize her cycle with her surrogate's cycle. Typically, up to three embryos were implanted with the ZIFT procedures and up to five embryos were implanted with the IVF procedure.

Results

A. Medical

Of the 22 infertile couples, 21 of them underwent embryo transfer procedures. One couple was unable to produce the necessary oocytes. 31 embryo transfers into surrogate mothers were conducted. There were a total of 5 dropped cycles due to problems with synchronization of the two women's cycles and 4 dropped cycles due to lack of proper oocyte development.

Of the 31 transfers performed, 22 utilized the IVF procedure, 5 utilized ZIFT, and 4 utilized GIFT procedure. (The GIFT and ZIFT procedures have only been offered in the last year.)

Of the 31 transfer attempts, 10 resulted in pregnancy. Of these pregnancies, 1 resulted from GIFT, 2 resulted from ZIFT, and 7 resulted from IVF. None of the 5 transfers conducted on behalf of donor mothers who were over 41 years have been successful to date.

Of the pregnancies achieved, 7 occurred on the patients first embryo transfer attempt, 1 was achieved on the patient's second trial, and 1 occurred on the patient's fourth trial.

Currently, the status of the pregnancies is as follows: 4 have delivered (one twin pregnancy); 2 are in the third trimester; 1 is in the second trimester; 1 is in the first trimester; and 2 of the pregnancies ended in miscarriage at 9 weeks.

The pregnancy rate for this sample group is 32% per transfer. The "take-home baby rate" per transfer is 25.8%. Overall, of the 22 couples attempting to end their childlessness thus far 8 of them will take home a baby, resulting in a 27.5% of the patients.

B. Legal

All of the gestational pregnancies in the program resulted in successful legal outcomes. These legal actions for maternity and paternity were filed in four different counties in California. The courts have been inclined to allow these as a matter of course. All have been granted with no opposition and extreme ease. Therefore, the biological parents names were on the birth certificates immediately with the gestational surrogate having no parental rights.

C. Psychological

Of the four surrogate mothers who have delivered, all were able to relinquish the child without grief reactions or ambivalence. All of the pregnant surrogates appear to see themselves as clearly a gestational mother and have not expressed a need or desire to keep the child.
Furthermore, the surrogates, pregnant experience and exhibited no regrets. being able to have contact with the parents and with other gestational surrogates appear to be important valuables in their psychological resolution.

Discussion

Although gestational surrogacy is in its infancy as an alternative to infertile couples, it appears that with the proper protections and safeguards it is an extremely successful method of creating a family. Obviously, many infertile couples prefer a biologically related child, and the possibility of gestational surrogacy allows the chance for these couples to fulfill this important need in their lives.

It is important to note that the success of gestational surrogacy is based on a comprehensive program of protections for all parties. These involve a very thorough legal grounding, as well as independent legal representation. It is critical that the attorneys who are involved are well versed in the area of reproductive technology law. The Center for Surrogate Parenting has been successful in its petitioning of the California Courts to recognize that gestational surrogacy needs to be viewed differently than other third party solutions to childlessness. The need for thorough psychological screening is essential for any successful program. It is impossible to underestimate the need for a strong psychological base and well qualified psychological experts in the field of surrogacy.

It is this involvement of experienced professionals that minimizes the medical team’s responsibility and liability regarding the non-medical aspects of surrogacy. It is important that the medical community be protected by putting into place a comprehensive contract, appropriate insurance policies and a mutual understanding between the parties.
With all the professional in place (the legal, the psychological and the medical), the risks involved in gestational surrogacy are few and the potential is enormous.

It is clear that placing embryos in young women with unstimulated cycles results in a most favorable situation for pregnancy. The number of gestational surrogate procedures is increasing dramatically. With a conscientious team approach this alternative should be able to assist the infertile population as well as provide further medical understanding into the variables of In Vitro, ZIFT, and GIFT.

[1]The medical procedures reported were conducted by Jirair Konialian, M.D., Century City Hospital, Los Angeles, CA, Jaroslav Marik, M.D., Beverly Hills Medical Center, Beverly Hills, CA Richard Marrs, M.D., Hospital of the Good Samaritan, Los Angeles, CA.

[2] This legal procedure is quite different from the procedure involved when a surrogate is artificially inseminated. Under these circumstances, a suit for paternity is filed on behalf of the father and the infertile wife must subsequently adopt her husband's child. The surrogate relinquishes all parental rights to the adoptive mother, thus establishing a step-parent adoption procedure.