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ARTICLE

Avoiding legal pitfalls in surrogacy arrangements

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Abstract The goal of this article is to discuss the legal pitfalls that reproductive endocrinologists face when participating in gestational surrogacy contracts. This paper was composed using Westlaw and LexisNexis commercial legal search engines to perform a review of statutes and cases pertaining to gestational surrogacy. The search results demonstrated that in the absence of suitable preparation, there is significant potential for litigation while participating in gestational agreements. Providers caring for gestational carriers have been named as parties in lawsuits for failure to provide psychological screening, failure to screen for infectious disease and participation in gestational contracts that are not compliant with state law. There is great disparity in state laws and court rulings pertaining to gestational agreements. When legal disputes arise, individual state laws and court rulings are controlling over the Uniform Parentage Act. Likewise, recommendations by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine do not supersede state laws. The failure to abide by individual state laws unnecessarily exposes reproductive endocrinologists and their IVF facilities to potential litigation. In order to lessen exposure to litigation, an understanding of individual state legislation or historical court rulings is advised.

KEYWORDS: gestational carrier, gestational contract, law, litigation, surrogacy

Introduction

The number of children born pursuant to gestational surrogacy agreements is rapidly increasing. The most recent Centers for Disease Control assisted reproduction technology report documents that gestational carriers were utilized in 1012 assisted reproduction technology cycles performed in the USA in 2005 (Centers for Disease Control, 2005). In 2003, just 2 years earlier, only 72 cycles involved a gestational carrier (Chapter 15: IVF Surrogacy, 2007). As gestational surrogacy becomes more commonplace, it is essential for reproductive endocrinologists to understand legal issues pertaining to these arrangements.

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There are numerous legal pitfalls that may be encountered when participating in gestational agreements. Several lawsuits surrounding gestational contracts have named the physician and their IVF facility as parties for failure to provide psychological screening, failure to screen for infectious diseases and participation in gestational agreements that are not compliant with state laws (A.G.R. v. Brisman; Huddleston v. Infertility Center of America, 1997; Itskov v. N.Y. Fertility, 2004; Stiver v. Parker, 1992). In the event of a serious pregnancy complication, the gestational carrier may seek compensation from the reproductive endocrinologist for uncovered medical bills, lost wages and disability. Family members of a gestational carrier could file a wrongful death claim if the gestational carrier dies as a result of pregnancy. If a gestational carrier decides to seek custody of the child following embryo transfer, reproductive endocrinologists participating in gestational agreements that are not in compliance with state laws may be named as a party in an emotionally charged child custody dispute. Reproductive endocrinologists need to be cautious when participating in gestational contracts prepared by attorneys representing the intended parents, the gestational carrier or the surrogacy agency because these contracts may not adequately protect the physician or their IVF facility. The purpose of this article is not to discourage participation in gestational contracts, but to provide insight that may lessen exposure to litigation.

Types of surrogacy arrangements

There are two types of surrogacy arrangements. Gestational surrogacy involves IVF performed with the intended parents' gametes (or donor's gametes) and transfer of the selected embryo(s) to the uterus of a gestational carrier (Chapter 15: IVF Surrogacy, 2007). This is in contrast to traditional surrogacy in which the reproductive endocrinologist performs intrauterine insemination with the intended father's spermatozoa. The traditional surrogate not only supplies her uterus, but also her ovum, thereby contributing genetically to the resulting child. When parental rights are disputed in a traditional surrogacy arrangement, the courts have been far less willing to sever the relationship between birth mother and child on the basis of contractual obligation (In Re: Marriage of Moschetta, 1994; Larkey, 2003; Matter of Baby M, 1988). In some states, such as Texas, the gestational contract will not be validated if the gestational carrier's oocytes were used to create the embryo (Tex. Fam. Code Ann). For these reasons, it is wise for reproductive endocrinologists in most states to avoid participation in traditional surrogacy contracts.

Gestational contract and compliance with state laws

Before agreeing to participate in a gestational agreement, it is essential for reproductive endocrinologists to become familiar with their state's surrogacy laws because state laws are currently controlling over national guidelines. Likewise, recommendations by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine (ASRM) do not supersede state laws. Gestational agreements that are not in compliance with state laws may be deemed illegal, void or unenforceable. Despite good intentions and well-written contracts, parties cannot by contractual agreement obtain the power to act outside their state laws or against public policy (Bovard v. American Horse Enterprises, 1988). Facilitation of an illegal contract can potentially lead to both criminal and civil liabilities. For these reasons, reproductive endocrinologists should be sure that the attorneys preparing their gestational agreements are licensed in their state and familiar with their state's surrogacy laws or with the historical court rulings in their particular state for those practicing in states in which the legislature has yet to enact surrogacy laws.

Surrogacy laws differ widely from state to state. Some states, such as Arizona, prohibit both gestational and traditional surrogacy arrangements (A.R.S.). A few states such as Michigan and the District of Columbia even impose criminal penalties for the participants in any gestational agreement (D.C. Code; MCLS). North Dakota law voids traditional surrogacy contracts but recognizes gestational surrogacy contracts if the intended parents are genetically related to the child (N.D. Cent. Code). The state of Washington opposes gestational contracts that provide for compensation paid to the gestational carrier (Rev. Code Wash). States such as Texas and Utah permit gestational agreements and allow for reasonable compensation paid to the gestational carrier (Tex. Fam. Code Ann; Utah Code Ann). Many states do not have any legislature regarding gestational contracts. In such states, court rulings are more likely to vary depending on the case law in that state, the political environment and the ethical beliefs of the individual judge overseeing the case.

In states without legislation governing gestational contracts, the results of custody disputes for infants born to gestational carriers have varied in their outcomes and rationale. Before IVF, the birth mother was without a doubt the legal mother because gestation necessitated a genetic relationship. As reproductive technologies have advanced, the creation of new statutes defining legal parenthood has lagged behind. The best interest of the child standard is paramount in deciding custody disputes, but in the lack of explicit law, courts have also weighed the significance of gestation, genetics and intent. Some courts choose to emphasize the importance of gestational ties and grant legal maternity to the birth mother regardless of how conception occurred. In such courts, gestational carriers who attempt to fight for parental rights may prevail regardless of genetic relationships or contractual agreements (Matter of Baby M, 1988). Other courts have placed emphasis on the genetic link to the infant (Belsito v. Clark, 1994). In these courts, gestational agreements involving IVF of the intended parents' gametes with subsequent transfer of selected embryos to a gestational carrier are upheld. However, if the intended parents require donor gametes and a gestational carrier, the outcome of a custody dispute is not predictable when emphasis is placed on the genetic link. Some courts have looked beyond both gestation and genetic ties and instead, have placed importance on the intent to raise the child before conception occurred. Intention has been used as a 'tie breaker' in situations where two women claim parental rights, one based on gestation and the other based on a genetic relationship (Johnson v. Calvert, 1993).

In states lacking legislation, some courts will default to the statutes of adoption law. Gestational contracts notably

contrast with adoption in the timing of decision making. In a gestational contract, the gestational carrier relinquishes rights to the child before conception occurs. Some courts have required that the same time allowance for relinquishing parental rights after delivery be given to gestational carriers as given to a woman giving her child up for adoption (A.H.W. versus G.H.B.; N.J. Stat). Compensation paid to a gestational carrier also differs from adoption laws. In adoption statutes, no compensation beyond the provision for pregnancy-related costs is permitted. In gestational surrogacy, the gestational carrier is often provided a fee for her services as well as coverage of any pregnancy-related costs. If the gestational carrier contests parental status, the gestational agreement may be invalidated if the fee paid the gestational carrier is seen as contrary to public policy and an inducement to relinquish parental rights.

Further complicating the issue of differing state laws, many surrogacy agencies provide nationwide services. They may unintentionally request reproductive endocrinologists to participate in gestational agreements that are not in compliance with their state law. They may match a surrogate with intended parents who reside in different states. Due to a lack of clear legislation, jurisdiction over the contract is unpredictable and may reside in the state where the embryo transfer occurred, the state of residence of the intended parents, the state of residence of the gestational carrier or the state of birth of the child. In Hodas v. Morin (2004), a pre-birth order was upheld in Massachusetts where a child was born whose gestational mother resided in New York and whose intended parents lived in Connecticut. All three states had differing laws regarding gestational contracts.

State laws also have conflicting availability of the use of gestational agreements to same-sex couples. Texas requires the intended parents of a gestational agreement to be married, but state law forbids same-sex marriage (Tex. Fam. Code Ann; Tex. Fam. Code Section 2.001). Similarly, Florida state law, while allowing for both traditional and gestational surrogacy agreements, prohibits same-sex domestic partners from entering into such agreements (FLA. STAT). For lesbian couples, there is an increasing trend for both women to desire active contribution to the pregnancy. When one woman provides the egg, the other functions as gestational carrier and both together choose the sperm donor, a shared procreative participation can be achieved. In *K.M. v. E.G.*, a same-sex domestic couple registered in California, separated, and filed for joint custody of their twin girls (K.M. v. E.G.). The courts in California ruled that both women were mothers, one based on genetics and the other on gestation. However, most states have no precedent case or legislation regarding same-sex parental rights in surrogacy agreements. Therefore, until legislation advances to manage current technology, one cannot be too specific with regards to intended parentage and legal counsel should be recommended.

The Uniform Parentage Act does not supersede state laws

In an effort to promote national uniformity regarding surrogacy laws, the National Conference of Commissioners of Uniform State Law added Article 8 to the Uniform Parentage Act (UPA) which allows for validation and enforcement of gestational agreements (Uniform Parentage Act, 2002). The article is bracketed in order to allow states to omit the validation of gestational agreements if they so choose without weakening the remainder of the UPA. The UPA is advisory in nature, providing only federal guidelines from which states can draft their individual laws. Reproductive endocrinologists who participate in surrogacy arrangements must be mindful that these uniform laws do not supersede their individual states' laws.

Nevertheless, because state legislatures are gradually enacting gestational surrogacy statutes that follow some or the majority of these provisions, an overview of the UPA is worthwhile. Sections 801–809 of the UPA have specific provisions for gestational agreements. Section 801(a) allows for the creation of a gestational agreement in which all parties other than the intended parents are to relinquish parental rights and duties. Section 801(b) states that the intended parents, whether married or unmarried, must both be parties to the agreement. Section 801(c) requires that the gestational agreement be validated in court to become enforceable. Sections 801(e) and 803(b) provide for the coverage of reasonable health care expenses for the gestational carrier and permit reasonable compensation. The amount of payment that is considered reasonable is not explicitly defined. Section 801(f) provides that the gestational agreement may not limit the right of the gestational carrier to make decisions to safeguard her health or that of the fetus. Section 802 requires the gestational carrier or intended parents to be residents of the state in which the procedure occurs for at least 90 days. Section 803 requires medical evidence demonstrating that the intended mother is unable to bear a child or is unable to do so without unreasonable risk to her physical or mental health or to the unborn child. Section 803 also requires a home study of the intended parent unless waived by the court. Familiarity with these guidelines is useful with the understanding that each state may have adopted these statutes in part or in total, may have made surrogacy contracts void and unenforceable or may have no governing laws at all.

Avoid surrogacy contracts in which the gestational carrier is not covered for medical expenses, disability and death

It is essential that reproductive endocrinologists protect their legal interests by ensuring that the gestational contract has provisions to cover a pregnancy-related complication, disability or death. Even with contract provisions, intended parents may not have the financial resources to cover pregnancy-related medical and disability costs for the gestational carrier. It is prudent to require the intended parents to purchase additional medical, disability and life insurance to cover pregnancy-related complications. One should not rely on the gestational carrier's standard medical insurance carrier to cover pregnancy-related expenses because they often specifically exclude coverage related to a gestational carrier. Insurance for gestational carriers can be purchased directly by intended parents. Alternatively, fertility clinics can purchase coverage for the gestational carriers and pass costs on to the intended parents.

Disputes have arisen between insurance companies regarding coverage of a newborn resulting from a gestational agreement. In *Mid-South Ins. Co. v. John Doe, Frank Roe, Mary Roe, and Celtic Ins. Co.* (27), the insurance carrier of the intended parents and the insurance carrier for the gestational carrier each refused to pay for the neonatal care associated with the preterm infant. The court held that the insurance carrier for the intended parents should cover the cost related to the neonatal care.

Avoid gestational contracts in which the gestational carrier receives more than lawful financial compensation

Not including the cost of IVF, the cost of a gestational arrangement is estimated to be between US$75,000 and US$125,000 (Benardo and Benardo, 2007). According to a review of 25 agencies providing surrogacy services that have signed an agreement with the Society for Reproductive Technology (SART) to abide by ASRM ethics, the mean national compensation for the gestational carrier's services was US$20,000 and the mean national agency fee was US$10,892 in 2006 (Luk and Petrozza, 2008). Beyond covering all medical and legal fees, the intended parents should adhere to state law or local case law when considering the amount of payment that can or should be made to a gestational carrier. As an example, in the state of Washington, it is not legal to provide compensation to the gestational carrier over and above medical expenses (Rev. Code Wash). In some states such as Utah, legislation states that a gestational agreement may provide for payment of consideration but does not specify the amount (Utah Code Ann).

Avoid financial compensation from surrogacy agencies

It would be a conflict of interest and ethically suspect for reproductive endocrinologists to receive financial remuneration for their participation in a surrogacy arrangement. Section 289g-2 of 42 U.S.C.A. entitled 'Prohibitions regarding human fetal tissue' provides that 'it shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human fetal tissue for valuable consideration.' Although this law is primarily designed to deter sale of human embryos in interstate commerce, it could potentially be applied to receiving financial compensation from surrogacy agencies.

Provide proper informed consent

As with any medical procedure, proper informed consent is essential. Discussion should include the medical procedures of assisted reproduction technology involving the gametes, resultant embryo(s) and implanted fetus(es) and should highlight decisions pertaining to the assisted reproduction technology process. The surrogate and intended parents should be encouraged to obtain separate legal counsel to protect their individual interests (Committee on Ethics, 2008; Johnson and Clay, 2004). They should also understand the emotional, psychological, and legal risks of the arrangement (Johnson and Clay, 2004). Serious obstetric complications in gestational carriers have been reported and consultation with a perinatologist may help deter poor carrier candidates (Duffy et al., 2005).

In some states, there is legislature in place dictating what must be disclosed in the informed consent. For instance, in Texas, the physician is required to discuss the following: (i) the rate of successful conceptions and births; (ii) the risks associated with the implantation of multiple embryos; (iii) the nature of and expenses related to the procedure; (iv) the health risks associated with fertility drugs, egg retrieval and embryo transfer; and (v) reasonably foreseeable psychological effects (Committee on Ethics, ACOG Committee Opinion, 2008). It is also important for both the intended parents and the gestational carrier to understand the risks of chromosomal anomalies in the embryo. Reproductive endocrinologists should document that they informed the gestational carrier and the intended parents of the potential medical risks each may encounter. SART recently published a universal informed consent form that may be a useful adjunct to the informed consent process for gestational agreements (www.sart.org).

Screen ovum and sperm donors and gestational carriers for communicable diseases

Beyond screening each party's complete medical history including obstetric history, past medical history and risk of transmissible disease, all parties must also undergo laboratory testing for communicable diseases. The lack of screening of an intended father was the cause of litigation against the participating physicians in *Stiver v. Parker*, where a gestational carrier delivered an infant with active cytomegalovirus infection (Stiver v. Parker, 1992). During the same month of artificial insemination for traditional surrogacy, the gestational carrier was also exposed to her husband's semen and the infant born was genetically related to her husband rather than the intended father. The source of the infant's infection was ultimately not determined.

Although there are no specific Food and Drug Administration (FDA) provisions for testing individuals participating in gestational agreements for communicable diseases, the FDA requirements regarding the testing of human cells, tissues or cellular or tissue-based products refers to reproductive tissues. It therefore is applicable to treatments involving a gestational carrier. The current FDA donor screening and testing regulations became effective on 25 May 2005 (21 CFR Part 1271). These provisions mandate that all assisted reproductive technology programmes register with the federal government, screen donors for sexually transmitted infections, keep records of all donor cycles and make these records available to FDA inspectors upon request.

Other than FDA guidelines, there are infectious disease screening recommendations made by ASRM for the donation and receipt of embryos. According to the 2008 Guidelines for Gamete and Embryo Donation: a practice committee report (Practice Committee, 2008), ASRM recommends that donated embryos created from anonymous donors should meet all FDA screening and testing requirements, including quarantine of the semen sample for 6 months. In known or

directed semen donation, the 6-month quarantine of the semen sample may be foregone. The FDA does allow for the donation of cryopreserved embryos in instances in which the donors did not have the required testing. However, ASRM recommends against the transferring of embryos from untested donors (Practice Committee, 2008). ASRM recommends that all embryo recipients be willing to submit to the same testing performed for the donors.

Perform criminal background check and home study

Reproductive endocrinologists should verify whether or not state laws require a home study of the intended parents. States that follow the adoption model for surrogacy arrangements may require such a home study. Reproductive endocrinologists should be very hesitant to enter into a gestational agreement in which either the criminal history check or home study evaluation reveals information that would suggest a parental environment detrimental to a child.

Perform psychological assessment of surrogate

Prior to embryo transfer, all parties to a gestational agreement should undergo psychological screening. Factors investigated should include personal and family psychiatric history, legal history, interpersonal relationships, life stressors, coping skills and motivation for participation in a surrogacy arrangement, among others (Practice Committee, 2008). If the potential gestational carrier is married or has a partner, this individual should also be included in the psychological assessment.

In *Huddleston v. Infertility Centre of America, Inc.*, the gestational carrier brought action against the surrogacy centre and the participating physicians when the resulting child was killed by the intended father of the traditional surrogacy agreement (Huddleston v. Infertility, 1997). The gestational carrier claimed that the surrogacy centre was negligent in its omission of psychological screening of the intended father. Although the Infertility Centre of America was not found to be negligent because the court found that such an outcome was not foreseeable by the centre, this demonstrates the importance of psychological screening for both the surrogate and the intended parents.

Conclusion

Advances in reproductive technologies have outpaced the creation of legislation defining the privileges and duties of the relationships that are created with these new treatments. With the advent of third-party assisted reproductive technology, liabilities in patient care have expanded, not only encompassing medical issues, but also matters of ethical, legal and psychological concerns. In the absence of suitable preparation, there is significant potential for litigation while participating in gestational contracts. Providers caring for gestational carriers have been named in lawsuits for failure to provide psychological screening for all parties, failure to screen all parties for infectious disease and participation in gestational contracts that are not compliant with state law. In order to successfully care for patients involved in a gestational agreement while attempting to avoid litigation, an understanding of the state legislation or historical court rulings is advised. Reproductive endocrinologists should abide by the recommendations provided by the FDA regarding infectious disease screening and recommendations from ASRM regarding informed consent, infectious disease screening and psychological screening. The intended parents should be required to provide for the medical expenses, disability insurance and life insurance for the gestational carrier. With appropriate groundwork, participation in gestational contracts can be a rewarding experience for all parties involved.

References

21 CFR Part 1271, Subpart C.

A.G.R. v. Brisman, 08-cv-01716.

A.H.W. v. G.H.B. 772 A.2d 948.

A.R.S. § 25–218.

Belsito v. Clark, 1994. 67 Ohio Misc. 2d 54, 6, 644 N.E.2d 760.

Benardo, S.M., Benardo, K., 2007. Egg donation and surrogacy arrangements in law and practice. Bloomberg Corporate Law J. 2, 406–413.

Bovard v. American Horse Enterprises, 247 Cal. Rptr. 340, 1988.

Centers for Disease Control and Prevention, 2005. Assisted Reproductive Technology (ART) Report: Section 2-ART Cycles Using Fresh, Nondonor Eggs or Embryos. Available from: <http://www.cdc.gov/art/ART2005/section2c.htm>.

Chapter 15: IVF Surrogacy, 2007. Fertil. Steril. 87(Suppl. 1), S50–S51.

Committee on Ethics, 2008. ACOG Committee Opinion 2008 No. 397: Surrogate Motherhood, 111:465–470.

D.C. Code §§ 16–401 to –402.

Duffy, D.A., Nulsen, J.C., Maier, D.B., Engmann, L., Schmidt, D., Benadiva, C.A., 2005. Obstetrical complications in gestational carrier pregnancies. Fertil. Steril. 83, 749–754.

FLA. STAT §§ 742.11–15.

Hodas v. Morin, 422 Mass. 544, 814 N.E.2d 320, 2004.

Huddleston v. Infertility Center of America, 700 A.2d 453, Penn, 1997.

In Re: Marriage of Moschetta, 25 Cal. App. 1218, 1994.

Itskov v. N.Y. Fertility Inst., 782 N.Y.S.2d 584, 588–589, Civ. Ct., 2004.

Johnson v. Calvert, 1993. 5 Cal.4th 84, 851 P.2d 776, 19 Cal. Rptr. 2d 494.

Johnson, M.A., Clay, S.M., 2004. Managing legal risk in the assisted reproductive technologies environment: Part II. Keeping out of the sand traps in third party reproduction cases, February 2004. Available from: <http://www.surrogacylaw.com/biography.htm>.

K.M. v. E.G., 117 P.3d at 677.

Larkey, A.M., 2003. Redefining motherhood: determining legal maternity in gestational surrogacy arrangements. Drake Law Rev. 51, 605.

Luk, J., Petrozza, J.C., 2008. Evaluation of compliance and range of fees among American Society of Reproductive Medicine-listed egg donor and surrogacy agencies. J. Reprod. Med. 53, 847–852.

Matter of Baby M, 109 N.J. 396, 537 A.2d 1227, 77 A.L.R. 4th 1, 1988.

MCLS prec §§ 722.851–.863.

Mid-South Ins. Co. v. John Doe, Frank Roe, Mary Roe, and Celtic Ins. Co., 274 F.Supp.2d 757, 2003.

N.D. Cent. Code §§ 14–18–01 to –08; 14–19–01; 14–20–01 to –66.

N.J. STAT § 9:3–41.

Practice Committee of American Society for Reproductive Medicine; Practice Committee of Society for Assisted Reproductive Technology, 2008. Guidelines for gamete and embryo donation: a Practice Committee report. Fertil. Steril. 90(Suppl. 3), S30–S44.
Rev. Code Wash §§ 26.26.011 to .903.
Stiver v. Parker, 975 F.2d 261 C.A.6 (Mich.), 1992.
Tex. Fam. Code Ann § 160.753–756.
Tex. Fam. Code Section 2.001.
Uniform Parentage Act, 2002.
Utah Code Ann §§ 78–45g-801 to -809. www.sart.org.

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