

Organizational selection and assessment of women entering a surrogacy agreement in the UK*

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In the UK, surrogacy procedures are unregulated and not monitored. Information concerning the selection and assessment of intended (the mother commissioning) and surrogate mothers (the mother carrying and delivering the baby) is therefore not generally available (BMA, 1996). It is important to determine what type of assessment is used, and how selection takes place within the organizations dealing with surrogate motherhood arrangements. The present survey enquired about the incidence, selection and assessment procedures of all registered surrogate and commissioning couples, and aimed to find out what advice and support is given. Eight organizations took part in the survey, six were clinics and two agencies dealing with surrogate arrangements. Two voluntary organizations/helplines were also surveyed, but their data are not relevant to the results presented here. An interview and questionnaire approach was used. Psychosocial assessment was minimally addressed by all organizations, and no fixed procedures for assessment and selection were employed. Despite this, few incidences of controversial cases were reported. Confidence in this practice could be increased in the future if both parties embarking on a surrogacy arrangement knew they were properly selected and assessed. A regulatory body could monitor consistent use of professional evidence-based criteria prior to arrangements.

Key words: psychosocial assessment/selection/surrogacy arrangements

Introduction

The public profile of surrogacy in the UK was brought about by Kim Cotton (1985) and the advancement in medical technology. These demonstrated the problems involved in meeting the needs of a proportion of infertile couples for whom no alternative options are available. Surrogacy is referred to in two broad terms: full or partial surrogacy. In full surrogacy, the surrogate mother carries a couple's embryo; in partial surrogacy she uses her own egg. Up to 8000 infertile

women and 600 surrogates are known to make serious enquiries regarding this practice, suggesting the numbers are large enough to warrant careful screening for an arrangement which can have devastating immediate and long term effects (van den Akker, 1998a).

Within the UK, two agencies deal with partial surrogacy, a straightforward process requiring artificial insemination (AI). Many AI procedures are carried out within the couples' homes, and do not require medical intervention (van den Akker, 1998b). Both agencies have demonstrated high success rates. A large number of clinics hold an Human Fertilisation and Embryology Authority (HFEA) licence; however, only six have experience of in-vitro fertilization-surrogacy (IVF-S) (Balen, 1998; van den Akker, 1998a). IVF-S can only be achieved through medical intervention, and requires a considerable amount of testing and treatment accompanied by discomfort. Virtually all British clinics offering IVF-S rely on the two agencies to help their infertile couples find a suitable surrogate. Unlike partial surrogacy, IVF-S is a comparatively new practice. Since the UK does not have any enforceable legislation regarding surrogacy, the practice is largely unmonitored and unregulated, and relies entirely on the guidelines laid out by individual clinics and agencies (van den Akker, 1998a).

The 1985 Surrogacy Arrangements Act legalized surrogacy, provided it is non-commercial, although a subsequent act rendered any arrangements and contracts unenforceable in law (HFEA Act, 1990). Nevertheless, those using IVF-S have the protection of the HFEA's licence, which, according to Blyth (1994), provides them with more support than those undergoing straight surrogacy. However, no act or legislation has drawn on psychosocial aspects of surrogacy. Ideally, evidence-based criteria for good outcome should be part of the surrogacy process, particularly since IVF poses its own stress (Freeman *et al.*, 1987). Furthermore, when controversial cases are brought before the courts, professionals are asked to provide expert opinions. It is therefore essential that expertise is based on the same evidence used to select cases for good outcome (Taub, 1992).

Although numerous women are treated relatively easily with IVF-S, (Ben-Rafael *et al.*, 1998; Brinsden, 1998), the success rates of IVF surrogacy tend to be more limited than IVF in the biological mother (Brinsden, 1998). Consequently, psychological distress of failure of IVF-S is likely to be more common in IVF-S than is reported for other IVF (Braverman and Corson, 1992; Domar *et al.*, 1992). Since this practice is increasing, it is necessary to evaluate the mechanisms used to assess prospective commissioning and surrogate women's psychological status, in an attempt to avoid post-treatment psychological ill health. In the USA selection procedures are

*The views expressed in this paper are those of the author and not the NHS.

stringent, probably because their practice is more regulated and commercial. The companies play a major role in negotiating between the parties and acting as advocates and go-betweens (Ragone, 1994). Ince (1984) describes her account as an applicant to the 'surrogate industry', where rigid application processes take place. The company controlled both parties, but the surrogate in particular was contracted and therefore under full control of the company.

Unlike the USA, the UK organizations do not screen for parental fitness in surrogacy. This may be because we do not have the socio-cultural experience of this unorthodox route to parenting (McGee, 1997; Johnson, 1997; Sureau, 1997); we do not possess the language to accommodate these reproductive liberties; and we know too little about the psychological importance of the 'genetic link'. Consequently, at present, arrangements are often based on trust between people who are complete strangers. Because there has been no official requirement for monitoring the parties' well-being, the emphasis is on the couples to support each other. However, since money is exchanged and contracts are drawn up, we are not simply dealing with 'donations' or altruistic carriers, but with a 'market' for surrogacy (Johnson, 1997). The present paper therefore investigated the assessment and selection procedures employed in surrogate motherhood.

Materials and methods

A standardized interview and questionnaire design was used. The questionnaire obtained largely closed (yes/no) responses; for example; 'Do you deal with the wider family/social network of the surrogate? Y/N'. Each question was followed by open-ended questions relating to when, why and how this was asked. The last page of the questionnaire asked open-ended information about their organization in relation to surrogacy, and asked respondents to elaborate on their own feelings regarding surrogacy. The interview was designed upon return of the questionnaires and focused on areas where elaboration of responses were needed, and on areas which required in depth open-ended responses on selection and assessment, and perceived knowledge and understanding of surrogacy arrangements by the couples involved. The occurrence and method of psychosocial, familial medical and health assessment was also investigated.

Sample

All organizations known to have experience ($n > 2$ in last year) of surrogacy were approached individually. Many clinics are known to hold HFEA licences for IVF-S, but only a fraction have completed more than two cases in the last year (Balen, 1998). Since the majority of clinics had no successful IVF-S cases yet, or only one, they were not deemed experienced. The six most successful clinics in terms of numbers of completed surrogacy cases per year were accepted as experienced. Ten organizations took part in the survey, six were clinics, the rest surrogacy agencies ($n = 2$) or voluntary organizations/helplines ($n = 2$). The clinics dealt virtually exclusively with full surrogacy, the agencies with full and partial surrogacy. All those interviewed and completing the questionnaires were: directors for agencies and helplines; medical directors ($n = 2$), consultants ($n = 1$), and a senior sonographer/egg donation and surrogacy coordinator ($n = 1$) for clinics.

Procedure

After initial telephone contacts, letters were sent out, and the organization's co-operation was obtained. The questionnaire was sent,

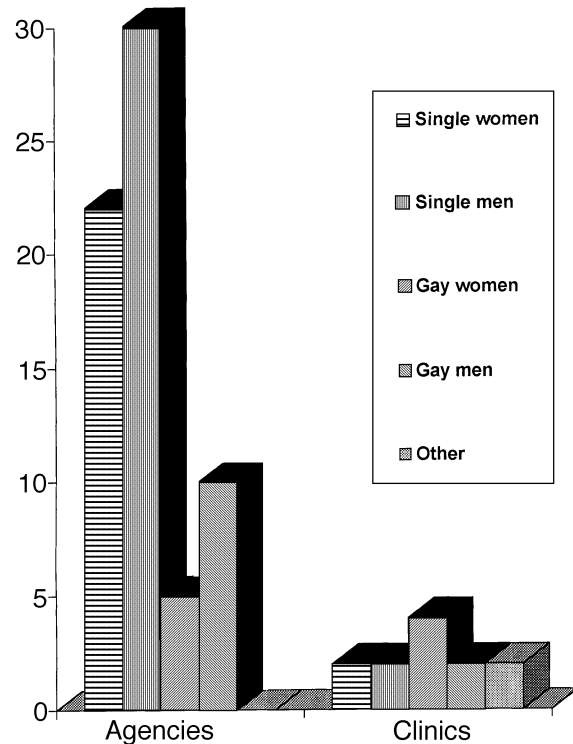


Figure 1. Total numbers of non-traditional people ever approaching agencies and clinics for surrogacy arrangements.

followed by the semi-structured telephone ($n = 1$) or face to face ($n = 7$) interview. The survey was conducted approximately between November 1997 and March 1998.

Results

All organizations were experienced in surrogacy ($n > 2$ in the last year) and showed a high degree of compassion in dealing with the couples involved. The majority of approaches came from heterosexual couples, with few reports of non-traditional individuals seeking surrogate arrangements. Both agencies and one clinic were approached by non-traditional individuals. Figure 1 shows the type of non-traditional individuals enquiring about surrogacy. In five out of eight cases they would give these individuals equal treatment because, as one agency said, they support individual freedom. The other two clinics and remaining agency said they did not, because it was considered illegal or unethical. Five organizations had been approached by up to 20 foreign couples.

All organizations were asked to give their opinion of their clients' knowledge of their condition and treatment. Four organizations considered commissioning couples' knowledge of infertility to be adequate, and only two believed surrogates had adequate knowledge of infertility. Knowledge of surrogacy by both commissioning couples and surrogates was generally seen as poor by 75% of organizations (Figure 2). Similarly, both parties' expectations of surrogacy arrangements and of the success of IVF-S were seen as unrealistic by 50% of the organizations. The perceived lack of knowledge was seen as a major cause of drop outs, particularly for surrogates. Virtually all organizations said they used some form of screening, but

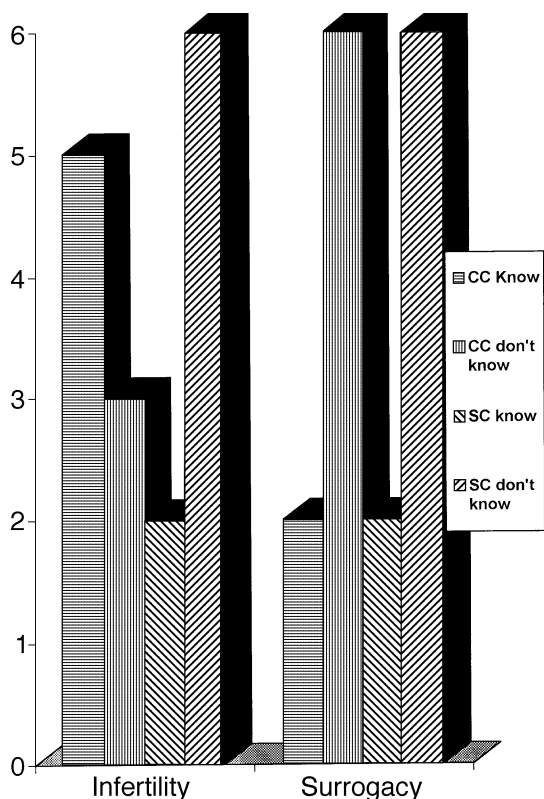


Figure 2. Organizations' perceptions of commissioning (CC) and surrogate mothers' (SC) knowledge of infertility and surrogacy.

criteria for suitability were relatively vague. However, most organizations agreed that a surrogate requirement was parity, and a requirement for both surrogate and commissioning mothers was good health. Age was said to be important by 25% of clinics, particularly for the selection of a surrogate. No other factors were noted as important in the selection process. No other consistent criteria were used, but the opinion of the counsellor or gynaecologist (sometimes other health care professional), or their experience, determined the assessment. Some organizations provided their prospective clients with a list of counsellors' telephone numbers within their home area. These counsellors were not always experienced in dealing with surrogacy arrangements. Three clinics employed their own counsellors, and one of these had extensive experience of surrogacy which followed a professional assessment protocol. In 37.5% of organizations no charge for counselling provision was made, and counsellor visits were voluntary in 62.5% of organizations.

In 62.5% cases, commissioning couples were asked why they had chosen surrogacy, to assure cases of social surrogacy were excluded, and alternatives to surrogacy were discussed by all but one clinic. The importance of a biological link was discussed by 33% of clinics and both agencies. Furthermore, surrogate and commissioning family issues were addressed by seven out of eight organizations. Some organizations (6/8) asked their couples how their relatives felt about surrogate children, others (2/8) interviewed the relatives alongside the couples, but this was only done on an 'if deemed necessary' basis. Numbers of rejections were marginal. Two organizations had rejected up to 15 commissioning women. One organization

Table I. Mean numbers (range) of all commissioning and surrogate mothers ever actually entering an agreement between agencies and clinics

	Commissioning	Surrogate
Agencies	470 (40–900)	223 (50–396)
Clinics	24 (6–54)	30 (19–54)

rejected up to 30 surrogates. Reasons why commissioning and surrogate women were rejected included their age, poor health or general unsuitability. In seven out of eight cases no psychological issues such as possible bonding problems, personality factors or social behavioural issues were explored in the assessment procedures.

All organizations sought medical, legal, psychiatric and ethical committee advice when necessary. Despite the overwhelming reports of serious enquiries by commissioning couples, significantly fewer commissioning and surrogate couples were ever involved in actual arrangements. The mean numbers and ranges of actual arrangements started for clinics and agencies are shown separately in Table I. The difference in numbers between commissioning and surrogate mothers is due to the fact that many more commissioning couples' attempts fail, whereas surrogates are known to offer themselves more than once for different couples, whether previous attempts failed or not. Numbers of successful pregnancies resulting in relinquishments by surrogates and adoptions by commissioning mothers range from 2–210. Only one agency reported a 4.5% refusal to relinquish rate, which is surprising considering the assessment procedures reported. No commissioning couple has been known to refuse to adopt a baby following the arrangement.

Due to what is and is not enforceable in law, both agencies and three clinics encourage commissioning couples to have faith in the surrogate's behaviour during pregnancy, and in her wish to relinquish the baby. The surrogate is asked to have faith in payment by the commissioning mother, and in her wish to adopt the baby by the same number of organizations. Unfortunately, ongoing support is not offered. Despite the legal position in the UK, most organizations expected couples to sign their organization's agreement form, (one clinic, one agency), to seek legal advice (two clinics, one agency), or to sign a consent form (three clinics).

Discussion

The fact that most enquiries about surrogacy arrangements came from heterosexual couples is not surprising, because strictly speaking non-traditional couples are unlikely to be infertile as a result of their non-traditional status. The BMA (1996) is clear about the discouragement of surrogacy for social reasons, and the non heterosexual population could be considered social approaches. However, the data obtained from these organizations do not allow a clear interpretation of the non-traditional individual's fertility status, since only one clinic specified that some of their non-traditional individuals suffered fertility problems. Furthermore, considering the lack of oppor-

tunities for surrogacy in mainland Europe, it was surprising to discover how few foreign couples attempted surrogacy in the UK.

Screening was carried out by nearly all organizations, however undefined this was. This lack of uniform screening does not necessarily constitute bad practice, because few non relinquishments of babies were documented. However, with an inevitable increase in this practice, in line with the predicted growth in infertility figures, we may need to err on the side of caution by using some form of consistent selection criteria. There is no reason why one individual, whether commissioning or surrogate, rejected by one organization, should not try another. Discussions with the organizations reveal this is already taking place.

Furthermore, although the experience of the organization's appointed selector is important, it also opens the system to individual bias and preferences. These are not always based on good or fair judgement, and should play no part in the selection of people into such an important arrangement. Only one clinic used the same counsellor, who had extensive experience of the surrogacy process, and who considered the outcome phase as equally important within a professional assessment format, for all its clients. Interestingly, the purported age criteria for selection into the arrangements were not always adhered to. It is possible that this is a direct result of the lack of evidence indicating age to be a major detrimental factor to motherhood in modern family units (van den Akker, 1994). Alternatively, the organizations follow HFEA guidelines, which do not stipulate a limit (Dimond, 1995). The organizations also confirmed that the wider family concerns were addressed to some extent. The manner of address varied, however, from simply enquiring about relatives' opinions of surrogate children, to interviewing close family members. Golombok *et al.*'s (1990) research has shown that the wider local network can also have damaging effects on those involved in surrogacy, suggesting this area should also be explored further.

The lack of standardized psychological assessment precludes this practice from the benefits of predicting emotional response during and post-agreement, as was found by Newton *et al.* (1990) in infertile couples going for IVF. Thus from a psychosocial point of view, related research suggests it could be beneficial to implement a standard protocol of assessment for both parties in the surrogacy agreement, although this needs to be carried out with caution (Parker, 1982). Media reports tend to broadcast impossible people in impossible surrogacy situations, yet in practice, the successes far exceed the disasters. Apart from anxiety and depression, personality factors could also be part of the assessment protocol. According to Appleton (1993) it is unlikely that commissioning couples are in a real position to exploit the surrogate, and certainly his own work suggests this may be a rare occurrence. Similarly, from the surrogate's point of view, altruism is seen as commendable, but even if they embark on an agreement for financial reasons (Blythe, 1994), this is unlikely to damage the infertile couple emotionally. Although these cases are extremely rare, they could be avoided with increased assessment.

Similarly, issues of bonding are either not assessed or not

considered fully and systematically in current practice with surrogacy. These issues need to be addressed in the assessment process, because as Smith (1998) points out, it is the unprepared midwifery practitioners who deal with the unpredictable reactions of the surrogate and commissioning mothers. Following clinical care, it becomes a problem for the wider family network, including that of existing children.

Faith in others is unlikely to be a sufficient criteria of success for the future of surrogate motherhood. Since both parties knowledge of infertility, and particularly surrogacy, was perceived as less than adequate by many organizations, an arrangement based on faith in the unknown may be unacceptable. It is, on the other hand, equally debatable whether we want the American approach (Ragone, 1994). Appleton (1993) advocates we aim for 'an independent body to provide a proper level of support, counselling, and follow up monitoring within surrogacy'. This body could also regulate assessment and selection of those involved in surrogacy, with the specific aim of evaluating suitability of both parties in the surrogacy arrangement, for their immediate and long-term benefit.

In conclusion, this study investigated the assessment and selection procedures currently employed in British organizations dealing with surrogacy. The results of related research and the information obtained from the organizations taking part in this study demonstrates areas of selection and assessment for psychological health which are not addressed systematically. It is expected that standardized screening will direct areas where counselling may be indicated. Nevertheless, it is worthy to note that 'the social consequences of a relatively new biomedical technique cannot be predicted in great detail or with total accuracy' (Walters, 1983).

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