

Defending Gestational Surrogacy

Addressing Misconceptions and Criticisms

BY VANESSA BROWN CALDER

This study outlines the case for gestational surrogacy, which is by far the most common form of surrogacy today.¹ In this type of surrogacy, the gestational carrier (GC) is not related to the child, and in-vitro fertilization (IVF) is used to produce embryos using the intended parent's (IP's) genetic material or donor material that is subsequently transferred to the GC.

Gestational surrogacy has become more common as the technology has improved, with GC embryo transfer cycles comprising 4.7 percent of all embryo transfer cycles in 2020, up from 2.2 percent in 2011.² Still, given that only 2 percent of births per year result from IVF, and that GC cycles constitute less than 5 percent of embryo transfer cycles, gestational surrogacy produces a small number of births, perhaps around 4,000 annually.³ Even so, surrogacy has allowed some couples with major fertility challenges to have their own genetically related children.

Despite surrogacy's enormous value to these couples, critics often focus on unusual examples and describe gestational

surrogacy as exploitative and risky to the GC and child.⁴ These accounts frequently highlight individual stories that fit dated stereotypes but do not reflect the current research.

Critics also minimize the substantial benefits associated with giving and receiving the gift of life itself. Moreover, attempts to limit women's ability to choose to be a GC indicate that critics believe women cannot make important personal and medical decisions for themselves, even following counseling and informed consent.

A HEALTH PROFILE OF INTENDED PARENTS

The American Society for Reproductive Medicine (ASRM) recommends surrogacy in cases where "a true medical condition precludes the IP from carrying a pregnancy or would pose a significant risk of death or harm to the woman or the fetus."⁵ According to ASRM guidelines, indications for the use of a GC include absence of a uterus or a significant uterine abnormality; psychological or



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medical contraindication to pregnancy; biologic inability to conceive or bear a child; or unidentified endometrial factors resulting in multiple IVF failures.⁶ For instance, where patient diagnosis is reported, uterine factor infertility diagnosis is five times more common in parents who use gestational carriers than in typical in-vitro fertilization patients.⁷

Options for childbearing are limited for intended parents with those and other medical challenges. In these cases, gestational surrogacy can provide the gift of life: gestational carriers have higher rates of implantation, pregnancy, and live births compared to IVF cycles undertaken by the intended mother.

CRITIQUES OF SURROGACY

This section details the critiques of surrogacy and examines the facts supporting each claim. The criticisms either contradict or exaggerate the facts or display an unfamiliarity with the reality of surrogacy.

Are Gestational Carriers Exploited?

Critics sometimes argue that GCs are exploited during the surrogacy process.⁸ Yet surrogacy is voluntary, with ASRM guidance stating that GCs must be of legal age and preferably 21 or older, have a stable home environment and social support, and ideally have experienced at least one straightforward pregnancy and delivery.⁹ In a study of GC embryo transfer cycles occurring between 2009–2013, 51 percent of GCs reporting age information were 30–34 years old.¹⁰

Although surrogacy laws vary by state, it is possible to make some generalizations about the process. Intended parents and would-be GCs agree to move forward with a gestational surrogacy agreement only after matching on various stated preferences and requirements. Gestational carriers' preferences and requirements frequently range from the character of the GC-IP relationship to the number of embryos the surrogate would be willing to transfer to whether, and under what circumstances, the surrogate would be willing to terminate a pregnancy, if any.

If, after meeting, IPs and GCs decide to move forward, requirements are outlined in legal contracts that describe the

GC's rights, obligations, and protections.¹¹ The majority of GCs surveyed use their own lawyer during this part of the process, whether they are working with a surrogacy agency or not.¹²

About 97.1 percent of GCs who used agencies, and those who pursued an agreement with IPs either independently or privately, had a complete medical evaluation and 94.6 percent received counseling or an evaluation by a mental health professional.¹³ As part of this process, GCs report being informed of the medical and psychological risks of moving forward with a transfer cycle, with 93.8 percent stating that they were advised of one or more medical risks and 91 percent stating that they were advised of one or more psychosocial risks.¹⁴ Fertility clinics also routinely advise patients of potential risks attendant to fertility treatment as part of the consent process.

Interviews, research, and nonscientific surveys indicate that the most common motivations for becoming a GC are altruistic rather than financial. A 2023 survey by a Los Angeles surrogacy agency found that the most important factor in deciding to be a surrogate was “the desire to help a couple have a family,” at 72 percent.¹⁵ The second most important factor was the “calling to help others in need,” at 59 percent. Reportedly, financial need frequently disqualifies would-be GCs.¹⁶

Although their motivations are broadly altruistic, in the United States GCs are also typically financially compensated. Intended parents pay GCs somewhere between \$30,000 to \$60,000 personally, along with covering the cost of agency fees, legal fees, IVF, health insurance, and other miscellaneous expenses related to the pregnancy (clothing, travel, lodging for the GC, and more) for a total cost of between \$100,000 to \$225,000.¹⁷ Compensating a GC is arguably superior to insisting that they rely on altruistic motivations alone because compensation helps offset the time and opportunity costs of pregnancy.

If GCs believed that they were being exploited they would report that the experience was negative or that they do not plan to be a surrogate again. Instead, long-term follow-up indicates that surrogacy is a positive and meaningful experience for GCs. Research finds that “the majority of gestational carriers report feeling a sense of self-worth and achievement after the process, which in turn generates a sense of self-efficacy and leads to a notable increase in their self-esteem.”¹⁸ A longitudinal study of both gestational and genetic surrogates in the

UK found that no surrogates expressed regret about their involvement 10 years following the birth of a child.¹⁹ In an online survey of California GCs, 83 percent stated that they would consider becoming a GC again.²⁰

Finally, although there are no federal laws expressly regulating surrogacy, there are state and local limitations.²¹ In addition, professional medical societies such as the ASRM provide surrogacy standards for fertility clinics, and reproductive treatment generally is subject to regulation by the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medicare and Medicaid Services.²²

In summary, there is little evidence of exploitation of GCs because they voluntarily enter surrogacy contracts after being informed of risks; there is little evidence of post-surrogacy regret; surrogates are well compensated; and many would consider becoming GCs again.²³

Outcomes for Gestational Carriers and Children

There are medical and psychological risks attendant to all pregnancies, whether they are conventionally conceived or assisted by reproductive technology, and women are generally not discouraged or prevented from getting pregnant due to those risks, except in extreme cases. Yet much is made by critics of the possible health risks associated with gestational surrogacy.

Unlike a typical pregnancy, GCs' physical and mental health histories are carefully screened to limit the risks that GCs take on and to ensure a smooth pregnancy, delivery, and recovery. Professional medical experts at the ASRM have developed screening guidelines for GCs designed to reduce adverse outcomes, and medical providers have incorporated these guidelines into practice.²⁴

Psychological Outcomes for Gestational Carriers

Critics are concerned about the psychological consequences of GCs delivering and transferring a baby to the intended parents following birth. Some of these concerns no doubt stem from historical examples of surrogacy disputes, for example, that of Baby M, the subject

of an early surrogacy custody dispute and the product of genetic surrogacy. However, as the product of genetic surrogacy, the Baby M case is categorically different from most surrogate pregnancies today.

Indeed, multiple research reviews find that GCs generally have positive long-term psychological outcomes. A review of the research finds that

in the long term, gestational surrogates have good emotional stability and psychosocial adjustment, their scores for self-esteem and depressive symptomatology falling in the normal range, as well as good marital and family relationships . . . no studies have found significant differences between scores of surrogates and those of the general population, confirming the conclusion based on gestational carriers' self-reports, that they are well adjusted, emotionally and psychologically.²⁵

A Cornell study submitted to the New York state legislature concludes that "the scientific literature review demonstrates that there are in fact no significant adverse medical or psychological outcomes for women who are gestational carriers nor the children they give birth to."²⁶

Research in Western countries indicates that the transfer of the baby from a GC to the parents is generally a smooth process; that GCs typically viewed their surrogacy experiences and their relationships with the resulting child positively; and that GCs typically have ongoing relationships with IP families.²⁷

Moreover, critics overlook the psychological rewards to GCs. As previously noted, research finds that GCs frequently report feeling an increased sense of self-worth and achievement, which produces a sense of self-efficacy and bolsters self-esteem.²⁸

Medical Outcomes for Gestational Carriers

Both conventional and assisted reproductive technology (ART)-assisted pregnancies include risks because pregnancy is inherently riskier than nonpregnancy, all else being equal. As noted, would-be GCs are regularly informed of medical risks during screening and treatment.

However, certain factors can increase the risk of GC

pregnancies. For instance, GCs are more likely than other women to transfer multiple embryos, and pregnancies of multiples are well known to elevate risks for both the carrier and children. As a result, the European Society of Human Reproduction and Embryology (ESHRE) and the ASRM strongly recommend that a single embryo is transferred per GC cycle. Recent data suggests that clinics are adopting this recommendation, as more GC cycles involve the transfer of a single embryo. Society for Assisted Reproductive Technology (SART) data indicates that GC single embryo transfer cycles increased from 45.1 percent to 62 percent from 2015 to 2017.²⁹

Moreover, for various reasons, IVF pregnancies may have higher complication rates than conventional pregnancies. One study finds that medical risks are elevated for GCs using IVF compared with conventional conception.³⁰ This is likely due, in part, to differences in the embryos that are produced by IPs compared with the fertile population. In line with this, risks for issues like preterm labor decline when donated embryos are used.³¹

It is also possible that some of the higher risks involved in ART versus non-ART pregnancies result from some aspect of the ART process itself. For example, subchorionic hematomas (bleeding between the embryo's membrane and the uterine wall) are more common in IVF pregnancies, perhaps because of the embryo transfer process.³² These often resolve spontaneously.

Although medical risks for IVF pregnancies are elevated compared with conventionally conceived pregnancies, medical issues, including preeclampsia (a hypertensive disorder); gestational diabetes; and placental complications (such as placenta previa, where the placenta covers the cervix) are still the exception. Moreover, ART-related risks are not specific to GCs: in a systematic review of the literature, GCs experienced hypertensive disorders and placental complications at the same rate as non-GC IVF pregnancies.³³

Innumerable choices in life produce risks, and a GCs' willingness to accept pregnancy-related risks should be respected, like the choices of other consenting adults.

Outcomes for Children Produced via Surrogacy

Surrogacy critics also worry about how the child will fare following delivery and transfer to the intended

parents. However, research finds that children resulting from surrogacy arrangements develop normally from a psychosocial, cognitive, and emotional perspective, with no differences between these children and conventionally conceived children.³⁴ A Cornell review found that at 10 years old "there were no major psychological differences between children born after surrogacy and children born after other types of assisted reproductive technology (ART) or after natural conception."³⁵

A small study of UK teens who were conceived through gestational or genetic surrogacy found that their feelings toward their conception were positive (6 of 22); indifferent (15 of 22); or ambivalent (1 of 22); with teens produced through surrogacy in no case reporting negative feelings towards their conception.³⁶ For those teens who were in contact with their surrogate, their feelings toward the surrogate were positive in most cases.

In summary, although small sample size and geographic differences limit the strength and generalizability of studies—including some noted above—medical research nonetheless constitutes an improvement on extrapolating from individual cases. Based on available research, GCs and children resulting from GC arrangements do well from a psychological and medical perspective in the years following their birth and do no worse than children resulting from nonsurrogacy pregnancies.

TERMINATION OF GESTATIONAL CARRIER PREGNANCIES

Although critics highlight stories where surrogate pregnancies ended in early termination, these are unusual exceptions.³⁷ For various reasons, the termination of a surrogate pregnancy will always be rarer than the termination of a conventional pregnancy conceived without the help of a surrogate.

First, by their very nature, surrogate pregnancies are planned and desired rather than accidental or unwanted. Many reasons that women cite for having an abortion during a typical pregnancy would be issues that the intended parents had already considered before deciding to proceed with surrogacy. For instance, financial issues, timing issues, partner-related issues, and the need to focus on other children are some of the top reasons provided by

women for having an abortion.³⁸ But these are all issues that would be considered and set aside or resolved before moving forward with surrogacy.

Second, embryos created via IVF are commonly genetically tested for major chromosomal abnormalities through PGT-A testing and sometimes tested for inherited genetic diseases through PGD testing.³⁹ Testing for genetic conditions is almost three times more common in GC cycles as compared with non-GC IVF cycles.⁴⁰ Selecting chromosomally normal embryos through PGT-A testing or genetic screening eliminates one cause of spontaneous or elective abortion that conventional pregnancies cannot eliminate. As a result, GCs are less likely to have a medical abortion than pregnant mothers in conventional pregnancies.

Given the high costs of surrogacy for IPs and the way that GC contracts are commonly structured (often GCs are paid in monthly installments after pregnancy is confirmed), both parties are incentivized to opt for the most likely path to a healthy and successful pregnancy.

Third, the time and resource investment necessary for a surrogate pregnancy is much higher than for a conventional pregnancy. A surrogate pregnancy requires all parties to clear various health, legal, and financial requirements. From the intended parents' perspective, finding a gestational surrogate is time-consuming and intended parents are often quoted a search process duration of 12 months or more. Most IPs would feel that they have much to lose by terminating a successful GC pregnancy.

Not only are there many reasons that IPs would be unlikely to terminate a GC pregnancy, but agency polling indicates that surrogates are loath to terminate pregnancies. A California surrogacy agency found that 50 percent of surveyed GCs would terminate for major life-threatening medical conditions only; 13 percent of surrogates said that they would not terminate under any circumstance; and only 3 percent of surrogates were willing to terminate a pregnancy for a cosmetic reason, such as a minor deformity.⁴¹ The remaining third of respondents indicated that they would terminate

based on IPs' discretion. These views likely result from religious beliefs, with an outsized number of surveyed GCs identifying as evangelical Christians.

In line with the fact that surrogate pregnancies are planned rather than accidental, the product of significant time and financial investment, and typically prescreened for major medical abnormalities—so for many reasons unlikely to be terminated—a nonscientific and informal Cato survey of surrogacy agencies suggests that the abortion rate for surrogacy agencies is a fraction of the abortion rate for US pregnancies overall.

While the abortion rate across the United States is between 1.1 and 1.4 percent of pregnancies, the abortion rate for surrogate pregnancies is less than 0.15 percent in our sample of agencies, meaning that abortion is approximately one-tenth as likely.⁴² Although the sample is subject to nonresponse since many agencies were unwilling to share information that they deemed private, the evidence is suggestive and fits the logic indicating that GC pregnancies are rarely terminated.

CONCLUSION

Like many areas of reproductive technology, surrogacy is subject to various ethical debates. However, analysts should strive to inform those debates with a clear picture of surrogacy's risks and rewards. Given that gestational surrogacy results in the creation of a new person, any suggestion to restrict or limit gestational surrogacy should not be undertaken lightly.

For some parents, surrogacy makes having a child possible. Whether or not a couple utilizes surrogacy, US access to the practice keeps hope alive for both domestic and international couples pursuing fertility treatment.

Of course, creating new life has never been a risk-free endeavor. However, despite concerns raised by critics, evidence supports the idea that long-term outcomes for both gestational carriers and resulting children are predominantly positive.

NOTES

1. Genetic surrogacy, where the surrogate and unborn child share genetic material, is relatively uncommon. Gestational surrogacy has several advantages over genetic surrogacy, including that the legal relationship of the resulting child to the IPs is clearer.
2. An embryo transfer cycle occurs when the embryo is transferred to the patient's uterus during the IVF process. "2020 National ART Summary," CDC, 2020.
3. A back-of-the-envelope calculation indicates 4,000 live births resulted from GC pregnancies in 2020. "ART Success Rates," CDC, 2020.
4. Commentary at a major think tank states that "the risks for both [the surrogate], and the baby, are significant." Grace Melton and Melanie Israel, "How Surrogacy Harms Women and Children," Heritage Foundation, May 5, 2021.
5. American Society for Reproductive Medicine, "Recommendations for Practices Using Gestational Carriers: A Committee Opinion," *Fertility and Sterility* 118, no. 1 (July 1, 2022): 65–74.
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7. Note that diagnoses are not mutually exclusive. Kiran M. Perkins et al., "Trends and Outcomes of Gestational Surrogacy in the United States," *Fertility and Sterility* 106, no. 2 (August 1, 2016): 435–42.e2.
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