Gestational Surrogacy and the Health Care Provider: Put Part of the “IVF Genie” Back Into the Bottle

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Introduction

Medical advances in new reproductive technologies continue to raise complex legal and ethical issues. Last October, a California Superior Court judge issued his opinion on the first contested case in this country involving gestational surrogacy. Upholding the surrogacy contract as valid and declaring that the genetic parents had exclusive custody and parental rights, Judge Richard Parslow observed:

The IVF genie is out of the bottle and you’re not going to be able to put it back.

I contend that we must put part of the genie back into the bottle. Gestational surrogacy is not an acceptable option for the extension of in vitro fertilization (IVF). This is not a reaction to the facts of the California case, but rather a recognition that the medicalization of surrogacy as a reproductive technology attempts to legitimate a practice that professionals should not support.

Following a brief discussion of Johnson v. Calvert, the recent California case, I will summarize the status of U.S. and international laws and policies on surrogacy, with particular attention to gestational surrogacy. I will also discuss recent ethical positions on surrogacy issued by health professional organizations. With this background established, I will outline my position on why the ethical and legal risks inherent in gestational surrogacy require professionals to reject it as a reproductive alternative.

The Johnson v. Calvert Case

Crispina Calvert, who had had a hysterectomy, worked as a registered nurse in the same hospital as Anna Johnson, an ex-Marine, licensed vocational nurse. A mutual friend introduced them, believing that Anna had wanted to be a surrogate. Anna was black and a single parent of a three-year-old girl. She had had two prior miscarriages and two stillbirths. Crispina was Filipino and her husband, Mark, was white. The Calverts claimed that they could not afford to go to a surrogacy agency, but paid $3,500 for the agency’s standard contract and some legal advice. Johnson signed the contract.

It is unclear whether Anna was ever screened as an “appropriate” surrogate. Crispina and Anna both began hormonal therapy to have their ovulation cycles mesh. Crispina had a number of eggs removed and fertilized with Mark’s sperm and three were then transferred into Anna. Against the odds, one embryo implanted. For weeks, Anna received hormonal injections to maximize her chances of maintaining the pregnancy. Anna did have to be hospitalized more than once for complications during the pregnancy. She was also advised to seek psychiatric help for emotional problems.

The deal seemed to be working. Anna would receive $10,000 for her gestational services and for relinquishing the baby, the Calverts would have a genetic child, and the IVF program would contribute to another expansion of IVF for women who would otherwise not be able to benefit from such technology. But, Anna, for whatever reason, changed her mind and the deal began to fall apart. Seeking to invalidate the contract, she claimed among other things, that she had bonded with the fetus and sought the court’s protection of her future parental rights.

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Unwilling to recognize the possibility of three parents and Anna's role as the gestational mother (and appearing to doubt her claim that she had, in fact, bonded), the judge declared the contract valid and granted full and exclusive custody to the Calverts. Anna Johnson filed an appeal on October 25, 1990.6

U.S. and International Developments

Since the Baby M case made headlines a few years ago, policies on surrogacy have continued to evolve around the world.7 In the United States, legislation has been introduced in Congress and in 39 states, as well as the District of Columbia, to deal with various aspects of commercial surrogacy.8 To date, only 13 states have passed laws dealing with surrogate parenting contracts and their legality. Eleven states have either declared commercial surrogacy illegal and/or made it impossible to enforce a contract as contrary to public policy.9 A few of these states specifically include gestational surrogacy within their definitional sections.10 Arkansas allows for a birth certificate to be changed to recognize that the intended mother rather than the surrogate is the legal mother, but is vague about the parameters of the legality of surrogacy.11 New Hampshire's recent statute permits, but with extensive regulation and pre-approval by the court, both forms of surrogacy.12 No statute gives more rights to the surrogate with a genetic connection than to the gestational surrogate.13

Bioethical task forces in both New Jersey and New York have also recommended that surrogacy not be allowed, particularly in the commercial setting, and that the surrogate be given the right to keep the child.14 In fact, the New Jersey Task Force recommends that it be criminal for professionals to participate in commercial surrogacy. The prohibition can subject the professional to a charge of unprofessional conduct and prosecution. Such participation in surrogacy might include screening of candidates and performing artificial insemination and embryo transfer with a gestational surrogate.

Most recently, California's Joint Legislative Committee on Surrogate Parenting recommended that commercial surrogacy mother agreements be void and unenforceable. Furthermore, the Committee advised that California law should provide that "when ova or embryos have come from a woman other than the one who gives birth, the gestating woman is irrebuttably presumed to be the natural mother."15

Internationally, laws and policies clearly establish that surrogacy contracts, especially if commercial, are illegal, unenforceable, contrary to public policy and/or void.16 Furthermore, most laws establish that the birth mother is deemed the legal mother.17

Of particular interest, Bulgaria declares that motherhood is determined by birth, whether or not conception is with another's genetic material.18 Israeli regulations establish that a fertilized egg may only be implanted in the intended mother.19 In Norway and Sweden, a fertilized egg may only be placed back into the woman from whom the egg was removed.20 In Spain, surrogacy with or without money is null and void, but if there is a contract for gestation, it declares that the mother who gave birth is still the mother.21 The United Kingdom bans commercial surrogacy agencies from engaging women to act as surrogate mothers22 and the German Parliament just passed a law banning both surrogate motherhood and embryo transfer.23

The Council of Europe has declared that "maternity should be determined by the fact of giving birth, rather than genetics (origin of the ova), firstly because of the relationship between the child and the woman giving birth and, secondly, because of the necessity of giving the child a clear legal situation at birth.24 Furthermore, absent an exceptional case, surrogate motherhood should be banned and such contracts should be deemed null and void.25 The Council cautions that physicians should be prohibited from bringing together an infertile couple and a surrogate mother.26

Health professional organizations both in the United States and abroad have also taken positions. The American Medical Association in December of 1988 incorporated its earlier report on surrogacy into its official Opinions of its Council on Ethical and Judicial Affairs. The opinion states that surrogacy, whether genetic or gestational, "does not represent a satisfactory reproductive alternative for people who wish to become parents."27 This past June, the Ethics Committee of the American Fertility Society also reissued, with minor changes, its position recommending that surrogacy and gestational surrogacy be continued as only a "clinical experiment."28

The Committee on Ethics of the American College of Obstetrics and Gynecology (ACOG) just issued its revised opinion on "Ethical Issues in Surrogate Motherhood."29 The Committee found that the surrogate who both carries the fetus and delivers the infant should be the sole source of consent for all questions regarding prenatal care and delivery and that she should have a specified time after birth to decide whether or not to place the child for adoption with the commissioning couple. The opinion specifically addresses, in part, gestational surrogacy and recognizes that while the genetic link to the couple is important, it deems it "less weighty than the link between the surrogate mother and the fetus or infant that is created through gestation and birth."30 Thus, the opinion makes no ethical distinction between what it describes as "the usual pattern of surrogate parenting and surrogate gestational motherhood."31
The ACOG Committee further states that the physician, when approached, should assure all disclosure of medical and ethical risk and that the provider may justifiably decline to participate in a surrogacy arrangement. If the physician does agree to participate, strict ethical guidelines should be followed. Of particular interest is that the surrogate and the commissioning couple should be regarded as distinct parties and should be separately represented, both medically and legally.32

In August 1990, the Working Party on Human Infertility Services of the British Medical Association (BMA) adopted extensive ethical guidelines on surrogacy.33 These guidelines supersede a 1987 ruling that doctors should not take part in surrogacy arrangements until the BMA had agreed upon ethical controls.34 The BMA guidelines warn physicians that surrogacy arrangements are unenforceable in law and that either of the parties cannot be prevented from breach.35 The guidelines provide that surrogacy be a last resort, that doctors only consider as surrogates those women who have a partner and already have one child. Physicians should also warn both the commissioning couple and the surrogate and her partner of all risks (which the BMA outlines in great detail), including the possibility that the surrogate may refuse to relinquish the child and that the commissioning couple may refuse to accept a child born with any defects.36 The Working Party makes no ethical or legal distinction between genetic and gestational surrogacy. In fact, they note that “whatever the genetic origins of a child, and regardless of the wishes of the participants, the law regards the child as belonging to the mother who delivered it.”37

The Gestational Surrogacy Process: Ethical and Legal Problems

The American College of Obstetrics and Gynecology and the British Medical Association both have accepted the political reality that infertility specialists fear restrictions on their practice. In fact, some IVF programs are acting to create increasing demand for legalized surrogacy. Surrogacy in this medical context reduces gestation to a technological tool. This is understandable considering the increasing expectation of the couple believing that with enough technology anyone can have a baby.

At the same time this medicalization reduces the role played by the gestational mother in the creation of life. The surrogate is deemed to be making a healthy adjustment if she remains unconnected—the most unnatural of feelings. Reducing women to extensions of a medical process in this manner can lead to numerous dangerous consequences.

Furthermore, as an international matter, gestational surrogacy has the potential to exploit poor women from Third World countries, who may be desperate for money, and perhaps harbor the false hope of immigrating to the United States. Rich white couples, in turn desperate for a genetic connection, can use poor women to achieve their wishes. Health care professionals cannot condone using women in this way.

I would strongly urge health professionals to resist any support of the use of a gestational surrogate. Obviously we all want to satisfy the infertile couple with the option of IVF. But we have to set limits when another woman, also being treated as a unit by the IVF program, is involved. We are pitting mothers against each other and potentially the health care provider is in the middle of the conflict. The right law, the right contract, and the right counseling will not be able to correct the problems with gestational surrogacy.38

I do not make this argument in defense of Anna Johnson, or in reaction to that case. Although I am surprised that we have not see more cases yet, they will come and the health care provider will be in a no-win position.39 In the following sections this paper will highlight the specific issues that gestational surrogacy poses for the health care professional throughout the process.

Screening

Proponents of surrogacy believe that with enough screening by qualified professionals, surrogacy can be a success. The recent New Hampshire statute,40 in fact, provides for professional screening of both the couple and the surrogate to assure a court in a pre-approval process that the contract will work. Yet what are we screening for?

For example, how does a psychologist assess whether a gestational surrogate is a good risk?41 If she is less willing to want to bond because there is no genetic connection, will she remain this way throughout the gestational process? And what if she does continue to feel removed, because there is no genetic connection? Will this influence her prenatal behavior and make her a bad risk and a non-compliant patient? The data does not exist to develop the perfect profile of the surrogate and the commissioning couple who can cope with IVF and embryo transfer. What are the measures of motivation, self-esteem, family support, and experiences with coping with childbearing loss? What relationship will the genetic and the gestational mother have to each other? What perception does the surrogate have of the father and the future of a unit relationship? Certainly we do not have experience with genetic parents dealing with loss to the gestational mother.

We do have some experience that supports the motivation to deny or omit feelings and relevant medical information. And there may be even an unconscious
motivation not to hear or appreciate all the risks when the
motivation is so strong to achieve a pregnancy for the
couple, the IVF program, and for the surrogate to be
successful and to be paid.

In the first medical malpractice case filed that involved
the treatment of a surrogate, Mounce v. Hanson, the
surrogate did admit to the physician who took her medical
history that she had had two prior miscarriages and no
live births. She was not screened out. Perhaps more
importantly, she did not state that she had had a history
of heart trouble. She was desperate to serve as a surrogate,
perhaps as a way to deal with her prior losses, and to make
some money. In her eighth month of pregnancy, she died
of heart failure, following a number of warning signals,
and the baby died too. The sperm donor never came
forward, but her family has sued Genesearch, the surrogacy
program, the physician who screened and provided her
prenatal care, and the consulting cardiologist.

The Calverts also claimed that Anna Johnson failed
to provide them with important medical information. She
did not reveal that she had had two miscarriages and two
stillbirths. Clearly, she was not an ideal candidate, either
medically or psychologically, for a surrogacy deal. When
money is involved and when we all want something badly
enough, screening may be of limited use without all the
facts. And even if we think we have all the facts, we have
to decide which facts are the ones that matter.

Thus, in spite of the call for screening to assure that
the deal has the “Good Housekeeping seal of approval,”
the process is flawed. First of all, we have no consensus on
what we are screening for. Medically, what are the
standards for an acceptable surrogate? The existence of a
uterus and a willing carrier is not good enough. Rather,
I would argue that at the present time an infertile couple
is not a candidate for IVF if the woman is not able to be
the birth mother. As noted earlier, Norway, Sweden and
Israel require that IVF only be allowed if the woman is
implanted with her own genetic material.

Secondly, we do not know what the acceptable
psychological profile is for a low risk couple and surro-
gate. And finally, professionals are not qualified to deter-
mine what information is meaningful. The ethical and
legal, not to mention medical and psychological risks, are
not clear, and by definition, they may never be.

Informed Consent

Assuming that both the couple and the surrogate pass the
screening requirements, an elaborate informed consent
process is to follow. ACOG, for example, recommends
that the medical and ethical risks be carefully spelled out
to the couple and the surrogate. The New Hampshire
statute also requires an extensive evaluation, counseling,
and informed consent process. But are health care pro-
viders qualified to do the job? And do they have enough
information to make the process meaningful? How does
a gestational surrogate consent knowingly to relinquish-
mament of a future child? She may have experienced a birth,
but is it easier or harder to relinquish if you have no
genetic connection? Is the lack of a genetic connection
relevant at all? Obviously, genetics matter to the couple,
who may feel more strongly about losing their wholly
genetic child.

In fact, how does a provider describe the ethical and
legal risks? Legally, less than a quarter of the states have
laws that either hold surrogacy contracts unenforceable
or heavily regulate it. Under traditional family law,
rather than contract law, the birth mother is the mother.
Yet, in Johnson v. Calvert the lower court in California
found that genetics was all that mattered and the gesta-
tional mother had no rights.

Clearly, informed consent based on legal risks is
risky at best. There are no guarantees. Nor are there any
guarantees with respect to psychological risk for the
couple, the surrogate, or the surrogate’s family. Medi-
cally, there are unknown long-term risks associated with
fertility drugs, IVF procedures, risk to the child, and risks
to the gestational surrogate from multiple gestation.
Obviously, the medical risks are more significant for the
gestational surrogate than for the surrogate who is just
artificially inseminated and usually carries just a single
fetus to term. Again, it is one thing to risk your own body.
It is quite another to achieve “voluntary” consent to
experiment with another woman’s body for the couple’s
benefit.

Conflict of interest and the embryo transfer

Assuming some form of informed consent is attempted,
there still remain problems with the inherent conflict of
interest of the IVF program promoting embryo transfer
with a gestational surrogate. The couple and surrogate
are treated like a unit with the same interest—the achieve-
ment of a successful pregnancy. The client though, is not
the surrogate, but the paying couple. The surrogate is
needed to allow the provider to extend the potential of
IVF use into a “uterine carrier.” The surrogate is a means
to an end. How can the physician maintain a confidential
relationship with two women who both are potential
mothers of the same baby or babies?

Furthermore, the medical risks are significant for
both the genetic and gestational mother. First the ovula-
tion cycles must coincide. Drugs are necessary to manipu-
late their cycles. Fertility drugs also help stimulate the
production of eggs for the genetic mother-to-be so that a
number of eggs can be retrieved. This woman is clearly
risking a lot to make the process work. The egg is then fertilized with the husband’s sperm and any resulting embryos are transferred into the gestational surrogate. The surrogate continues on hormonal injection for a number of weeks to maximize the chances of a successful implantation and pregnancy. The IVF program has a responsibility to the well-being of all members of this unit.

This is a risky business. Once the IVF process is finished, the IVF program may think its job is over. A pregnancy (or pregnancies) has been achieved, yet there is potential for future maternal morbidity and mortality for both mothers-to-be. It is one thing to assume these risks when the genetic mother is to also be the host uterus. It is different however, when there is potential for conflict within the unit. In fact, all the parties cannot be treated as a unit. They are individual patients, with individual needs, and the provider must avoid all appearances of any conflict of interest. By its very definition, IVF and embryo transfer with a gestational surrogate is a case of potential conflict of interest. The ACOG Committee Opinion states conflict of interest must be avoided by the use of separate medical providers for infertility and care to the surrogate.50

For the process to work, will we tolerate inherent conflict which clearly favors the interests of the consumers of the IVF technology over the surrogate? Does the IVF provider have, in fact, a physician-patient relationship with the surrogate, or does the provider take the surrogate as a mere extension of the procedure? How much responsibility will the IVF program take for screening a surrogate? If the surrogate is good enough for the couple, is the surrogate good enough for the IVF provider? It is the responsibility of the provider to warn the surrogate of all risks, but is not this then in conflict with the couple’s goals and interests?

The ACOG Committee Opinion provides that the surrogate is the source of all medical decisions with respect to the pregnancy.51 For in fact, once the transfer is complete, all biological connections are made by the gestational mother-to-be. She is more than a uterine container.52 She provides all the nutrients and bodily functions necessary to make this embryo grow into a fetus and then a baby. Clearly the interest of all is in her physical and emotional well-being. And any psychological counseling necessary during pregnancy must be directed to doing what is best for the pregnant woman.

Multiple embryo transfer

It is common IVF practice to transfer at least three fertilized embryos. Some IVF programs transfer up to six.53 Obviously, this practice attempts to maximize the chances of achieving a pregnancy. However, the chances of twins, triplets and maybe more are not remote. A recent World Health Organization study on IVF found that with the potential for multiple birth, maternal morbidity and mortality as well as infant morbidity and mortality significantly increase.54 If the genetic mother chooses to take this risk with her body, it is one thing. But health care professionals should not be imposing such risks on the gestational surrogate whose body is being used for the couple’s benefit.

Multiple gestation and its risks raise problems for gestational surrogacy that were not considered with genetic surrogacy in which single gestation is the norm. The risks to all parties, including the liability of the IVF physician, increase. It is more likely that the gestational surrogate will become a high risk pregnancy, will require a cesarean section delivery, will have more complications, more monitoring, and be unable to continue working throughout the pregnancy. And how do we then fairly compensate for this additional burden of gestational service and relinquishing more than one baby?

The potential conflict of interest for the IVF provider appears again. Just how many embryos are right to transfer? On the one hand, selective termination of the “extras” might be the answer for the genetic couple.55 This way they can choose two and let the rest go. But what about the surrogate’s view? Perhaps she will not want to abort and will risk carrying all three or four to term. Of course, this decision also raises the risk to her and the fetuses.

Ultimately, if the gestational surrogate is the decision-maker for medical care, she and not the genetic couple must decide what is best for her health and the health of the fetuses, including selective termination of pregnancy. This is not to say that the couple and provider will not exert a lot of pressure on her.

Prenatal diagnosis and genetic testing

A standard surrogate contract will require the surrogate to undergo genetic testing, including amniocentesis to establish whether or not there are any genetic or chromosomal abnormalities. Yet is not this a strange requirement for the gestational surrogate? The gestational surrogate is being asked to undergo such procedures, when she is not the genetic carrier of the problems being screened for. Obviously genetic counseling has no function for her. Such counseling is relevant to the genetic couple, but it is the surrogate who is subjecting herself to the testing. Once again she would have the right not to abort a defective fetus, but if the couple then rejects the fetus, who gets the child? Unless the surrogate chooses to keep the child with no genetic link to her, the child may become a ward of the state. What if she does choose to abort the fetus, because
she does not want to carry a “defective” pregnancy, and
the couple still wants the pregnancy to continue? It is the
couple’s genetic material and they are willing to accept the
result. Yet, if they desire the surrogate to have genetic
testing, it would seem that the couple would have to
accept her decision to abort. Regardless of the result, the
use of genetic testing with gestational surrogates raises
unique ethical and legal challenges for the provider.

Control of behavioral lifestyle and work environment

In addition to genetic testing, surrogate contracts often
require that surrogates do not drink, smoke, or take illicit
drugs. Enforcement of such provisions is problematic.
They require that the physician take on the role of spy,
rather than the fiduciary role to the patient. In fact, the
ACOG Committee Opinion clearly provides that the
confidential relationship remains with the surrogate.56

However, with gestational surrogacy, it would seem
that the couple, and perhaps the physician, will feel more
need to control the gestational surrogate. If she is less
attached, since she has no genetic connection, they may
fear she will be less concerned with taking care of herself
and the fetus. There have been cases in which health care
providers have gone to court to try to force certain
treatments, or cesarean section deliveries.57 Although it
may seem unlikely, the couple, with the support of the
provider, after investing so much time, emotional energy,
and money in achieving a pregnancy, may feel they have
no other recourse than to go to court to attempt to protect
their genetic material from any negative behaviors of the
surrogate. The couple might try to argue that their intention
to rear the child, as well as the force of the contract, gives
them legal standing to seek an injunction to get the
surrogate to undergo a medical procedure or to stop
smoking, drinking, or taking drugs during the pregnancy.
It is not clear whether the court would be more or less
concerned about the autonomy of the pregnant woman to
tool control her own body when she does not have the
intention to bear the child and accept the consequences of
her actions. One also wonders what the psychological
impact of not carrying a genetic fetus has on the acts and
behavior of the surrogate, as well as on the health of the
uterine environment. If in fact, it is easier to separate, is it
easier to ignore other concerns for the fetus?

Furthermore, what will be the implications for
employment of the surrogate? Is gestating her only job?
Does she have the right to continue any other
employment? If she works in a lead factory, must she be forced
to be transferred or fired?58 What if she is having twins
and is told “to get off her feet?” If she stops working, will
the couple pay her lost earnings? Will she be barred from
disability payments if pregnancy resulted from an embryo

transfer for hire? What role will the provider play in
helping her to obtain disability coverage? With the in-
crease in medical risk comes increasing economic risk.

Birth defects and causation

Unfortunately, no one can guarantee the birth of a healthy
child. With gestational surrogacy, it may be more difficult
to determine the cause of a problem at birth. Was it a
genetic problem? Was it the work environment that the
surrogate worked in? Was it the one drink? Was it caused
by a sexually transmitted disease that she caught during
relations with her husband? Gestational surrogacy takes
genetics out of the picture, but it may be difficult to pin the
problem on a particular cause. In the end, will the couple
and/or the surrogate, if she retains custody, look to the
physician for a financial solution through a liability
claim? With so much that cannot be controlled in the birth
process, and with such high expectations and expenses
generated from IVF and embryo transfer, a liability threat
from both the surrogate59 and commissioning couple
should not be minimized.

Conclusion

State courts and legislatures, health professional
organizations, and policymakers throughout the world are
struggling to develop laws and guidelines to address the
complex questions raised by the expansion of new repro-
ductive technologies. Clearly, infertility specialists are
sincerely devoted to trying to help couples have their own
babies. But health care professionals must resist the
temptation to expand the use of IVF and embryo transfer
with gestational surrogacy. The medical, ethical and legal
risks of using another woman to serve the interests of the
infertile couple cannot be minimized. Gestational
surrogacy is not a cure for infertility, but rather a course
to be avoided.

References

used in combination with in vitro fertilization. The fertilized egg
of the genetic mother with the sperm of the genetic father or a
sperm donor in vitro is transferred into the uterus of the surro-
gate, who is the birth mother. This differs from what I will term
“genetic surrogacy” in which both the egg and gestation are
provided by the surrogate, as was the case with Mary Beth
Whitehead. Since the first birth in 1986, there have been about
80-100 births by gestational surrogates in this country. (cite)
Non-commercial gestational surrogacy is also practiced at Bourn

2. Id.


4. Additional facts about the case provided through personal interviews with the lawyers for Anna Johnson and the Calverts (October 1990).


10. Louisiana and Kentucky just discuss surrogacy by insemination, with no discussion of gestational services and/or surrogacy by embryo transfer.


13. The Uniform Status of Children of Assisted Conception Act, drafted by the National Conference of Commissioners on Uniform State Laws (1988), provides for one alternative that declares surrogacy contracts unenforceable (the alternative adopted by North Dakota) and it establishes that the birth mother is the legal mother. The other alternative, not adopted by any legislature, does provide that a surrogate who also provides the egg can change her mind within 180 days after the last insemination, but makes no similar provision for the gestational surrogate. There is no discussion on why the distinction was made, but this provision was a major political compromise.


15. The Committee did conclude that voluntary, unpaid, surrogate parenting arrangements should be allowed and should proceed consistent with other adoption practices. “Commercial and Noncommercial Surrogate Parenting,” Report of the Joint Legislative Committee on Surrogate Parenting to the California State Legislature 22 (Nov. 1990).


17. See Survey, supra note 16.


26. Id.


28. Ethics Committee of the American Fertility Society, Ethical Considerations of the New Reproductive Technologies, “Surrogate Gestational Mothers” (Chapter 21 at 645-675) & “Surrogate Mothers” (Chapter 22 at 685-735), 53 Fertility and Sterility (1990).


30. Id. at 2.

31. Id.

32. Id. at 4-5.


34. In fact, the Swiss Academy of Medicine continues to express general hostility to the use of IVF and embryo transfer in conjunction with surrogacy.


36. BMA, supra note 16 at 28-30.

37. Id. at 41.

38. Many of the problems are inherent in noncommercial, as well as commercial surrogacy. For an outstanding discussion on why noncommercial surrogacy cannot be treated as a “mere act of altruism” and why reproductive gift-giving

39. There are at least five other cases pending in lower and appellate courts around the country, according to Sharon DeAngelo, co-founder of the Washington, D.C.-based National Coalition Against Surrogacy. The National Law Journal, Oct. 8, 1990. See also, infra note 59 for discussion of tort actions by Anna Johnson and Mary Beth Whitehead.


42. No. 89-045388 (Harris Cty. Tex. 1990).

43. Id. Follow up discussions with the attorneys representing the estate of Ms. Mounce and Dr. Hanson (October 1990).

44. Numerous newspaper accounts of the testimony and discussions with the lawyers state that this information was not shared. In fact, the court opinion notes that "the Calverts were relying on Anna's representations, and arguably omissions, because there are some things she didn't tell them about her experience." The National Law Journal, Nov. 5, 1990, p.36.

45. See supra notes 19-20 and accompanying text.

46. ACOG Committee Opinion, supra note 29 at 4-5.


48. See supra note 9 and accompanying text.

49. See supra note 1. The appeal was filed to the 4th District Court of Appeals on October 25, 1990.

50. See ACOG Committee Opinion, supra note 29 at 5. The Committee did not specifically address the inherent conflict of interest of the IVF program provider at the time of embryo transfer. Discussion with Elaine Locke, staff to ACOG Committee on Ethics (October 1990).

51. Id.

52. The more we view her as a container, the more we also separate her interests from those of the fetus, rather than seeing them as a union growing together.


54. Id.

55. For a discussion on the difficult issues raised by selective termination, see Overall, "Selective Termination of Pregnancy and Women's Reproductive Autonomy," Hastings Center Report 6 (May/June 1990).

56. ACOG Committee Opinion, supra note 29 at 4-5.


59. In fact, Anna Johnson filed a complaint last December against the physician who performed the IVF procedure, the IVF program, and the attorney who drafted the surrogacy contract. The claims against the physician, for example, include allegations of medical malpractice, failure to provide informed consent, battery, and negligent and intentional infliction of emotional distress (discussion with Richard Gilbert, attorney for Anna Johnson, January 8, 1991). A few years earlier, Mary Beth Whitehead settled out of court her action against Noel Keane and the Infertility Center of New York for fraud in the Baby M contract and for their failure to properly counsel her on the risks of surrogacy.