Current issues on a standard for surrogate pregnancy procedures

Jung-Ok Ha

Institute for Gender Research, Seoul National University Social Science College, Seoul, Korea

While Korea does not have any legal statement on surrogacy, treatments are carried out in practice. As a result, every Institutional Review Board (IRB) of each fertility clinic faces an ethical predicament in reviewing each case. There is a need to arrange the institutions' own standards of surrogate pregnancy procedures before the establishment of national or professional regulation. This article examines the legal, social, and medical issues of surrogacy to help IRBs to judge their cases.

Keywords: Surrogacy; Institutional Review Board; Standard for surrogate pregnancy procedures

Introduction

[An issue to be filed with an Institutional Review Board (IRB) in December 2009]: A 47-year-old woman inquired whether she would be able to benefit from surrogacy treatment at the corresponding institution. The woman whom the client had designated as the potential surrogate mother was 28 years old, and had given birth once. The client wanted an IUI with sperm from her husband to be used in the pregnancy.

The above case was actually discussed at the IRB meeting of an Obstetrics and Gynecology Hospital ("Embryo Producing Medical Institution" in legal terminology) located in Seoul. It is likely that similar cases have been discussed in the IRBs of other institutions, although the ages and operation types vary according to the case. As no law or regulation have been established in the Republic of Korea, the IRB of each institution needs to refer each matter to discussion and decide upon these cases individually whenever requests are made.

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Corresponding author: **Jung-Ok Ha**

Institute for Gender Research, Seoul National University Social Science College,
16-350 Gwanak-ro, Gwanak-gu, Seoul 151-742, Korea

Tel: +82-70-4189-3480 Fax: +82-2-882-6287 E-mail: jungok@snu.ac.kr

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This article aims to address what needs to be considered when an IRB deliberates over each issue concerning surrogacy procedures. As there is no legal statement on surrogacy, but treatments are actually carried out, each institution faces an ethical predicament [1]. Therefore, principles on surrogate pregnancy procedures must be established at the institutional level instead of deliberating and discussing every issue from scratch for every case. This article presents the essential issues to be considered in the establishment of such principles.

The weight of non-regulation

Some may doubt the need to establish principles at the institutional level because there is no statutory law on surrogacy in Korea. It may seem unnecessary to consider how to establish the range of permission or subjects of medical treatment since there is no legal provision to ban surrogate procedures, nor will anyone be punished for conducting these procedures. However, the fact that there is no surrogacy-related written law or guidelines also means that each institution shoulders a heavier responsibility when it comes to surrogacy.

Since the Bioethics and Safety Act (hereinafter referred to as the Bioethics Act) of Korea bans private intermediation concerning gametes or embryos for the purpose of generating profits, writing surrogacy-related contracts may not be allowed nor can the efficacy of the contracts be recognized. Article 13 of the Bioethics Act states that

"No one shall provide or utilize sperm or oocytes, or induce or assist in providing or utilizing them for the purpose of receiving monetary benefits, property interests, or other personal benefits in return." Thus, it is difficult to invoke such contracts in a court when a dispute breaks out because the contract will be considered invalid. Under this situation, such documents such as written consent from the medical institution [1], after the entire parties concerned have recognized the surrogate pregnancy and delivery, may be recognized as the sole standard in a court as an "innominate contract."

Since around 2010, the Department of State in the US has requested additional DNA tests for US citizens when they give birth to their children overseas and register their births. In these cases, private test reports are not accepted. Instead, this involves the supervised taking of saliva samples from the parties involved by an accredited laboratory. If the DNA test result shows no genetic linkage between the US citizens and the babies, the babies are denied US citizenship. This policy reflects the US's negative perspective on the transaction of reproductive cells and the so-called 'reproductive tourism' for overseas delivery or surrogacy often conducted in India and other Asian countries. Recently, the Department of State ordered every US embassy located in other countries to investigate the status of assisted reproductive technology (ART) and the procedures for recognizing a parent and child relationship stipulated in the civil laws of the corresponding nation and to collect related data [2,3].

In this situation, if a certificate of birth issued by medical institutions in Korea, or a pregnancy diary, or the medical records are proven to be false (for example, the name of the surrogate mother is replaced with that of the client), the external public confidence in medical institutions will be in danger globally.

Therefore, the IRBs of medical institutions that function as "Embryo Producing Medical Institutions" should make careful decisions when discussing surrogacy even though there are no actual written laws in Korea governing this. This article aims to examine legal, ethical, and medical issues to be considered in setting up such principles.

Surrogacy-related laws in foreign countries

1. Statutory laws and provisions

When referring to foreign legislation concerning surrogacy, few countries have expressly stipulated regulations, most have no laws or regulations, and if they have any, only a few permit surrogacy.

Korea and Japan also have no regulations affecting surrogacy. However, when a dispute around surrogacy takes place and is brought to court, many legal scholars interpret a surrogacy arrangement as a justice act contrary to social order, invoking article 103 of the Korean Civil Act: "A justice act which has for its object such matters as are contrary to good morals and other social order shall be null and void."

Some scholars, however, have recently raised the opinion that the effect of the previous agreement between the parents in determining custody should be recognized, invoking article 999.4 ("Custodian: If a child born out of wedlock is legally recognized and his parents are to be divorced, the custodian shall be determined by an agreement between the parents, and, if such agreement cannot or would not be made, the Family Court shall designate the custodian upon the request of the parties or ex officio: Provided that if the agreement between the parents harms the children's welfare, the Family Court shall order to correct it or ex officio decide the custodian.") and article 138 ("Conversion of Null Act") [4].

Meanwhile, France and Germany stipulate that a surrogacy arrangement shall be null and void in any case. On the other hand, Israel and Greece have enacted laws that legalize surrogacy in 1996 and 2002, respectively [5,6].

In the case of the US, where family relations are regulated by state laws, half of the US's states have statutory laws and some allow surrogacy while others forbid it [5]. For example, New York State legally allows surrogacy but nullifies contracts concerning surrogacy. In other words, it is legal to be a surrogate mother (one can list her name on the surrogate mother lists in a hospital) but it is illegal to pay money to a broker, or to give extra money to a surrogate mother other than for medical fees. This aims to prohibit the generating of profits from surrogacy arrangements and to restrict commercial transactions in surrogacy. New York State is known to have about 40 percent of births from surrogate pregnancies. The 'Baby M' case, a very famous custody case that became the first American court ruling on the validity of surrogacy, also came about in New York State [7].

The UK, which enacted the world's first law on ART (Human Fertilisation and Embryology [HFE] Act 1990) and established a competent authority (HFE Authority) based on the Act, allows the delivery of babies and their parentage from "the woman who carried the child (surrogate mother)" to the "gamete donors (client couple)" through a very special procedure named 'Parental Orders,' which comes in a very similar form to adoption [8].

The client couple ("intended parents" [9] or just "applicants" [10] in official terminology) must apply for the Parental Order within 6 months after the child's birth, and the surrogate couple must consent to the Parental Order 6 weeks after the child's birth. The applicants for the Parental Order should be two people over 18 years old and remain in a stable relationship including putative marriage regardless of their genders. And at least one of the oocytes and sperm of the client couple must be used in creating the embryos. The child born through surrogacy must live with the client couple who are domiciled in the UK. No extra money can be given to the surrogate mother other than actual medical fees. Though the Parental Orders and birth registries written during this procedure are not open to the pu-

blic, the information on the carrying mother and surrogacy must not be deleted so that the babies born through surrogacy can be able to gain access to the information later as adults.

The UK introduced this apparently complicated procedure in order to protect the parentage of the client couples while sticking to the common principles of the traditional civil acts—"The woman who gives birth to the child is the mother." The regulation on the parent-child relationship is deserving of scholarly attention in relation to legislation on surrogacy.

2. Parent-child relationship: Whose child is the baby born through surrogacy?

Most of the national and international civil acts regulating the parent-child relationship are oriented to defining, recognizing, or the denying the father's identity rather than the mother's. This is obviously affected by the core principle of the Roman law, "*mater semper certa est, pater semper incertus est*," which reflects that childbirth itself is enough to define who is the mother. This is true of the Korean Civil Acts: there is no provision on the mother. Instead, article 844.1 stipulates that "A child conceived by a wife during marriage shall be presumed to be the child of the wife's husband." Similarly, Japan, France, and Germany regard a child-carrying woman as the mother, and presume her husband as the father in their statutory laws.

What is to be remembered here is that they place the greatest consideration on the marital relations with the child-carrying woman from the husband's perspective in determining legal fatherhood. Genetic connection is not stipulated by the law. Therefore, the father of the babies carried by a surrogate mother shall be the husband of the surrogate mother regardless of the genetic link, unless stated otherwise and unless the legal validity of the surrogate arrangement is recognized.

Most of these laws were enacted before ART existed. However, even after genetic linkage and childbirth became separated from each other through the donation of oocytes or surrogacy after ART was introduced, most of the judicial precedents presume the carrying woman, or surrogate woman, to be the baby's mother. For example, if a surrogate woman who carries a baby from the genetic embryo from a client couple changes her mind and rejects transferring the baby to the client couple, most countries consider the surrogate mother with no genetic linkage with the baby as the legal mother and give parentage to the surrogate mother.

Basically, the UK's Parental Orders procedure mentioned above is also based on the principle that the carrying mother—i.e., surrogate mother—is the baby's mother, and parentage may be handed over from the carrying mother to the client couple through the Parental Orders procedure. According to the related law, the mother of the baby is defined as "the woman who is carrying or has carried a child,"

and even when "the intended parents" apply for a Parental Order, the legal mother is the surrogate mother [9,10]. The birth registry, which is not open to the public but can be read by a child born through surrogacy when he/she has reached adulthood, also indicates the surrogate mother to be the legal mother [5]. In other words, the principle of "The woman who gives birth to the child is the mother" is sustained in the UK.

On the other hand, Israel and Greece have legalized surrogacy, enacted in a separate law that defines the client parents as the legal parents. In this case, parentage is originally held by the client parents. In the case of the US, which shows various regulations and enactments on surrogacy according to each state, regulations on the parent-child relationship also vary according to the individual state.

Issues to be considered

1. Permission by ART type

Each institution may decide whether to permit surrogacy or not according to the ART type used in the pregnancy. For example, they can set a genetic linkage between a child and one of the client couples as a minimum condition for having parentage connections like the UK's Parental Orders.

The first type is the IUI-type pregnancy with the sperm of the client's husband. This is the oldest type that was being used before the introduction of IVF. However, some criticize that this is no more than the permission of traditional surrogacy without any sexual relationship although there is a genetic linkage with the biological father. A man has requested IUI-related surrogacy from the institution that I belong to; however, the IRB denied the application as it could not confirm whether his wife, who resided overseas, had consented to the surrogacy.

The second type is to transfer IVF embryos from the reproductive cells of the client parents to the uterus of the surrogate mother. The baby born through this method has genetic linkage with both the client mother and father. The surrogate mother only acts in the physical pregnancy. This will be the most acceptable type of surrogacy in most countries: some countries named this type of surrogate mother as the "gestational mother" in order to distinguish her from traditional surrogate mothers [5,11].

The third type is to transfer the embryo from the IVF egg with donated sperm and the oocyte of the client woman into the uterus of the surrogate woman. This method, however, is feasible in theory, but has not been found in the discussion of IRBs. There could conceivably be a case in which a client parent has laid claim to the sperm donated by another person, which was used for an IVF embryo when they applied for surrogacy at a medical institution. To handle a case like this, it would be important to decide whether a DNA test should

be carried out when an embryo was not generated in a certain institution.

The fourth type is to transfer the IVF embryo with the sperm of the client husband and donated oocyte to the uterus of the surrogate mother. In the deliberation of the IRB that I belong to, an opinion was raised that the future mother of the IVF baby, or the client woman, should necessarily provide at least one of the two elements—oocyte or uterus.

The fifth type is to transfer embryos that were fertilized *in vitro* with donated sperm and a donated oocyte into the uterus of the surrogate mother. Since the client parent has no genetic linkage with the baby, there is a strong possibility that this case will be rejected in IRB deliberations. However, it is also groundless to ban this one type since other types of surrogate pregnancies are allowed.

2. Qualifications of clients

The requirements and qualifications of the client couple who are to become the potential parents of the baby need to be carefully considered in the deliberations of the IRBs.

The first consideration is the legal marital status.

Here is an issue that must be decided on—whether or not to give priority to the welfare of babies from the traditional perspective or to refuse clients and discriminate against marital status and heterosexual centrism. In the UK, prior to 2004, only married couples could apply for the Parental Order for babies born through surrogacy. However, civil partners and couples in putative marriages gained the ability to make an application after the enactment of the Civil Partnership Act in 2004. In this case, the applicants for the Parental Order must simply be two people who are domiciled in the UK [10].

Increasing numbers of countries that add legitimacy to surrogacy do not require legal marriage as a condition for surrogacy. Israel, for example, which in 1996 was the first in the world to legalize surrogacy, allows single people to apply for surrogacy regardless of their sexual orientation [6]. In the US, some states allow male gay couples to have babies through surrogacy.

If Korea requires the legal marriage of client couples as a condition for surrogacy, each institution will have to ask the client couple to submit an official document (“Family Relations Register”). However, it may arouse a question of equality as such documents are not required for other IVF cases.

The second consideration is the age of the client couple.

Particularly, the age of the client could be a major issue in parenting. In the case that was introduced at the beginning of this article, the rather mature age of the client woman (47) became an obstacle in the deliberation of the IRB. However, males in their 60s and 70s who have babies tend to be envied in most cultures around the world. As such, some point out that an age limit imposed on just women

might be a form of sexual discrimination [7]. Similarly, age limits for surrogacy may cause controversy, as there is no age limit on general IVF treatment.

It is also an issue of whether both legal marriage and biological age are conditions for being a good parent. This would raise the issue of discrimination if more stringent conditions were applied to surrogate pregnancies as no condition or screening procedure is applied to those who wish to become pregnant or become parents through other ways including IVF.

3. Qualifications of surrogate mothers

The first consideration is whether the surrogate mother is married or has experienced conception and delivery.

Perhaps, those who are married or have experienced conception and delivery may be preferred both by the surrogate mother and client couples for the reason of health. In Israel, single mothers who have children are most preferred as surrogate mothers as few disputes are provoked since most of them suffer from economic destitution while also having the experience of conception and delivery [6].

According to the Bioethics Act of Korea, marriage or experience of delivery is not an explicit condition for donating oocytes. Instead, it regulates the frequency and interval of extracting oocytes and requires a medical checkup to become a donor.

Thus it would raise criticism as excessive paternalism if the voluntary intention of becoming a surrogate mother was blocked by the condition of marriage or having the experience of having delivered a baby.

If marriage becomes a condition for being a surrogate mother, the written consent of her husband would be needed. As pointed out earlier, a man who is married to a woman who carries a child becomes the father of the child according to the Korean Civil Act and thus the husband of the surrogate mother must be aware of the attempt of his wife to become a surrogate mother.

In addition, the limitation on the frequency of being a surrogate mother based on oocyte donation regulation might be an issue. If the frequencies are to be set, how to confirm and control these should be also considered.

The second consideration is whether the surrogate mother is related to the client couple.

In the UK, a surrogacy arrangement, advertising, and private brokerage are banned according to the Surrogacy Arrangement Act 1985. When discussing the bill, Kenneth Clarke (Minister for Health) suggested, “An agreement between sisters [is] the least harmful of all [12].” As such, surrogacy between sisters is most preferred in Korea. In Japan and Italy, mothers were reported to have become surrogate mothers for their daughters [7]. However, even the legal scholars who

insist on allowing surrogacy recommend that relatives should not be surrogate mothers as then kinship might become complicated.

The third consideration is the age of the surrogate mother.

Some raise the opinion that an upper limit and lower limit of the age of a surrogate mother should be set. Others are opposed to that opinion because biological ages and physical conditions largely vary according to the individual and it is not possible to ignore the differences and to stick to a single age bracket.

4. Compensation and actual cost

Article 13.3 of the Bioethics Act bans the acquirement of pecuniary gains and article 15.4 provides for the compensation of actual cost for oocyte donors.

For surrogate mothers, each institution needs to confirm that a surrogacy arrangement is not made for the purpose of acquiring pecuniary or property gains or other considerations in written form. Some also recommend that pregnancy should not be treated like the donation of gametes since pregnancy requires a long period of time and considerable physical effort unlike egg donation.

5. Medical checkups and physical restraints during pregnancy

Whether it is possible to require or enforce antenatal checks, diverse surgical procedures, injections, or medicines to keep the pregnancy safe would also be an issue, particularly with tests intrusive to the surrogate mother. In reality, surrogate mothers are not in a position to reject the requirement of clients or doctors to be injected or medicated from the time of becoming pregnant. Moreover, they are reluctant to ask if the injections or medicines might be harmful to their bodies [13]. It could also be an issue whether clients might try to enforce certain living environments or habits on surrogate mothers for the purpose of maintaining the pregnancy and protecting the baby: For example, clients might ask surrogate mothers to move from their own living space and move elsewhere for prenatal education [13].

Another issue is whether client couples also stop surrogate mothers from undergoing medical treatment for religious reasons. The issue is also related to whether surrogate mothers can be restrained for the reason of the baby's safety or other reasons. The issue includes whether clients can enforce artificial abortion late in the pregnancy, which may cause physical harm to the pregnant woman when the fetus has an abnormality, or whether they can enforce the maintenance of pregnancy if the maintenance of the pregnancy might cause physical harm to the pregnant woman.

It should also be considered who should determine the range of inconvenience or risk and based on which standard. For example, in the case of artificial abortion due to the abnormality of a fetus, it should be considered who should determine which range of abnormality this might be allowed under. Whether or not an institution should

accept the request for an abortion by client couple (otherwise they would refuse the transfer of a baby) over a very minor abnormality of the baby from medical doctors' perspective would also be an issue.

When the client couples are allowed to consider such a thing, the institution will have to explain this to the surrogate mother and gain her consent.

Surrogacy-related requirements for institutions in the UK

The issues concerning surrogacy as well as the parent-child relationship are primarily legal matters. However, the role and duties of the medical institutions should also be considered. In this section, I present what should be the basic duties of medical institutions in Korea based on the regulations from the UK, which has neither explicitly legalized nor banned surrogacy, but does forbid pecuniary transactions, as is the case in Korea.

1. Assessment on the welfare of the child

In the UK, the primary principle or legitimacy in the ART-related laws or guidelines is "The Welfare of the Child," and the release of the identity of donors is an extreme form of reflecting this principle [9]. Originally, the UK had thoroughly protected the identifying information of donors under the condition of anonymity. Then, since 1993 when the HFE (Disclosure of Information) Act 1992 was passed, a child born through surrogacy secured the right to know, and could gain access to the identity information of donors when he/she reached 18 years of age [14]. This legislation gives preferential importance to the welfare of the child, although a survey did reveal that gamete donors were most worried about a possible encounter with their genetic child when making a decision about possible donation.

The UK's HFE Act and Code of Practice requires every institution to generally assess the welfare of the child in relation to ART, especially any surrogacy arrangement: "If the child is not to be raised by the carrying mother (i.e., in a surrogacy arrangement), the centre should assess both those commissioning the surrogacy arrangement and the surrogate (and the surrogate's partner, if she has one) in case there is a breakdown in the surrogacy arrangement [9]." Of course, the assessment should be documented and inspected.

2. Provision of information and consultation to client couples and surrogate couples

In the deliberation of a Parental Order, the courts review whether the carrying mother (surrogate mother) and her partner "have freely, and with full understanding of what is involved, agreed unconditionally to the making of the order" [10]. Since the documents of evidence are written by medical institutions, they must guarantee such inform-

ed consent. However, an agreement concluded within six weeks after a child is born is ineffective [9].

Institutions should give the “information about the effect of the Parental Orders provisions in the HFE Act 2008” and advise that “surrogacy arrangements are unenforceable” both to client couples and surrogate couples.

Discussion

I have reviewed what issues are to be considered in the surrogacy-related deliberations of IRBs from the legal, social, and medical perspectives. It is not easy to judge what are the most right and ideal standards, as situations differ by nation and state.

When setting up surrogate-related principles, each institution needs to establish what its primary values will be—in other words, legitimacy should be established for principles to be built on. The values could be the composition of the ‘normal’ family, hope for infertile couples, welfare of the babies, or the birth of many children. After identifying these primary values, detailed standards must then be established.

The next thing to be considered is the need for the positive approach of experts towards social responsibility. Even if there is no statutory law or guidelines for surrogacy, the experts working in medical institutions need to have a high sense of social responsibility in establishing principles to brace for the future enactment of surrogacy-related laws.

Conflict of interest

No potential conflict of interest relevant to this article was reported.

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