Legal principles and essential surrogacy cases every practitioner should know

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Gestational surrogacy, made possible with the introduction of in vitro fertilization, has expanded family building options while introducing novel challenges to established legal principles involving constitutional, contract, and family law as well as duty of care and negligence. Both legislatures and courts have grappled with how to apply these sometimes-competing areas of law to protect participants and professionals, and to create legally secure families. This article explores the following: the Constitutionally protected rights of privacy and reproductive autonomy of gestational surrogates; Contract Law principles that govern surrogacy contracts; the varied ways states have extended Family Law to establish legally recognized parent–child relationships between intended parents and children born to gestational surrogates; and the legal duties of care medical professionals owe to their patients. (Fertil Steril® 2020;113:908–15. ©2020 by American Society for Reproductive Medicine.)

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Although the Book of Genesis is often cited to illustrate that surrogacy has been a part of family building since Sarah's servant Hagar carried and birthed a child for her and Abraham, gestational surrogacy—today's most prevalent form of surrogacy—became possible only with the advent of in vitro fertilization (IVF). By moving fertilization out of a woman's body and into a laboratory, genetics could be separated from gestation, challenging long-standing presumptions of motherhood based on pregnancy. Today, gestational surrogacy has expanded parentage options not only to women who cannot carry a pregnancy, but to single men and male couples, all accompanied by legal challenges for the individuals and professionals involved in—and the children resulting from—these arrangements. Most recent statistics report 6,291 gestational carrier cycles for 2017 (preliminary data) (1) and 5,526 in 2016, accounting for almost 4% of all transfers (2). Between 1999 and 2013, 16% of gestational surrogacy cycles reportedly involved international intended parents (3).

This article reviews the fundamental legal aspects and seminal case law that surround and guide gestational surrogacy practices today. Issues regarding ASRM's Ethics and Practice Committees' guidance, as well as international surrogacy practices, are addressed elsewhere in this volume and are largely beyond the scope of this article.

A SHARED VOCABULARY

As a starting point, lawyers know that words matter, and medical and legal professionals need a shared understanding of the meanings of a number of terms in this intertwined field of law and medicine. "Gestational surrogacy," or "gestational carrier arrangements," refers to a surrogate arrangement whereby a woman has agreed, in advance, to carry a pregnancy for intended parents that is not formed with her egg; any resulting child is neither her genetic nor her intended child. This pregnancy may result from the transfer of an embryo formed from the sperm and egg of two intended parents, any combination of donated and intended parent gametes, or a donated embryo. A "gestational carrier" (also referred to as a "gestational surrogate") may be compensated or noncompensated. Compensated surrogacies usually arise from arrangements made through surrogacy recruiting or coordinating programs (also referred to by some as "brokers" and "agencies") but may also be privately arranged between

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strangers, friends, or relatives, all ideally with the assistance of experienced legal and mental health professionals. In contrast, in "traditional" or, more recently termed, "genetic" surrogacy a woman is inseminated with a man's sperm with a prior agreement that she has no intent to parent the resulting child, regardless of her direct, genetic connection. The linguistic shift reflects that after 30 years of surrogacy arrangements, "gestational" and "genetic" more accurately describe the distinctions between the two types of practices. To avoid confusion, this article will use the term "traditional, genetic" surrogacy.

The language change comes from the 2017 revisions to the model Uniform Parentage Act ("UPA 2017"), a set of model rules to establish parentage drafted by the Uniform Conference of Commissioners of Uniform State Laws, a national legal commission formed in 1892 to provide guidance through model laws that state legislatures can adopt in whole or in part [4]. To date, UPA 2017 has been enacted in three states (California, Washington, and Vermont) and introduced in three others (Pennsylvania, Maine, and Massachusetts) [5]. On a substantive level, UPA 2017 also recognized that, as surrogacy flourished, the 2002 surrogacy provisions of the model act needed to be updated "to make them more consistent with current surrogacy practice" [4]. In the interim, a number of states had created legal frameworks for surrogacy through statutes or court decisions ("case law"), applicable only in that particular state. Although the drafters of UPA 2017 also chose to recognize the legality of traditional, genetic surrogacy as a more affordable and accessible option than gestational surrogacy, it "imposes additional requirements or safeguards on genetic surrogacy agreements. Among other things, UPA 2017 allows a genetic surrogate to withdraw her consent (to relinquish any legal parentage rights) up until 72 hours after birth" [4].

Legally, traditional, genetic surrogacy has long been seen to parallel adoption because, despite asserting her prior intent not to be a mother, a traditional, genetic surrogate and birth mother share the same biological relationship to the child. Thus, adoption laws and protections built into them to protect birth mothers—including, in virtually every state, the essential right to wait to decide whether to relinquish a child until a period of time after the birth, and prohibitions against paying birth parents as a form of baby buying, have frequently been applied and created a tension with the rising phenomenon of surrogacy. In contrast, as discussed below, the law has increasingly come to a consensus that gestational carriers or gestational surrogates—in almost all circumstances—are not legal mothers.

From a legal perspective, in any type of surrogacy arrangement, it is imperative to clarify in all consent forms and legal agreements that the surrogate does not intend to be a legal mother and that all intended, genetic parents are not "donors," as legally, gamete or embryo donors have no parental rights, responsibilities, or expectations.

FOUNDATIONAL AND EARLY LEGAL CASES

Surrogacy has always raised issues over maternity status, potential undue financial or other pressure, and women's constitutional rights over their reproductive choices and bodily autonomy, especially with respect to decisions regarding pregnancy management, termination, and selective reduction.

Surrogacy case law has addressed four key topics to date: balancing constitutional privacy and reproductive rights with state public policy interests; enforceability of surrogacy contracts; safeguards and professional duties of care owed in surrogacy arrangements; and establishment and disputed parentage issues of children born through surrogacy.

In Re Baby M (1988), the earliest reported traditional, genetic surrogacy dispute in the United States, has long been held up as a cautionary tale for surrogacy and has had a significant impact in restricting both traditional, genetic surrogacy in many states and compensated surrogacy of any type in a few states [6]. The case involved New Jersey residents. The intended parents were Elizabeth Stern, a pediatrician, and her husband, William Stern, a biochemist. The traditional, genetic surrogate, Mary Beth Whitehead, was a stay-at-home mother recruited by a surrogacy program run by Noel Keane. Whitehead received only minimal psychological counseling or screening, which nonetheless revealed concerns that were not passed on to her or the intended parents. In an attempt to avoid any New Jersey prohibitions on baby buying and selling and adoption laws that did not allow a birth mother to commit to placing her child prior to birth, the surrogacy contract was between only the intended father and Whitehead as the biological and legal mother (in gestational surrogacy cases, typically both intended parents are parties to the contract). When Whitehead ultimately changed her mind, offered to return the $10,000 payment, and attempted to keep the baby after the child's birth, the case ended up in court, raising then-novel legal questions of contract enforceability, maternity rights, and a custody determination.

The case reached the New Jersey Supreme Court, where the court ruled the contract illegal as a violation of public policy, rejecting the proposition that a surrogate could contractually agree in advance or be forced by contract to terminate her parental rights. Instead it applied a "best interest" standard to decide who should have legal and physical custody of the child. Class differences were noted throughout the litigation, with a guardian ad litem appointed to evaluate the parenting capabilities of each of the parties. Ultimately, the New Jersey court ruled that the Sterns would be the better parents and should have physical custody of the child, with Mary Beth Whitehead remaining as the legal mother with visitation rights [6]. Elizabeth Stern was ultimately allowed to adopt the child, a necessary step to secure her maternal rights.

Other early and more recent cases also reject the enforceability of contracts that require traditional, genetic surrogates to relinquish their maternity rights in advance. In a 1998 case from Massachusetts, *R.R. v. M.H.*, that state's highest court refused to enforce the contract against a traditional, genetic surrogate who did not want to hand over a child in exchange for $10,000, finding that she was essentially a birth mother, protected by adoption laws, and that any custody determination must be based on the child's best interest after birth [7]. The *R.R.* court explicitly acknowledged that gestational surrogacy presented "considerations different from those in the case before us...," accepting the arguments of "Amicus"

(Latin for "friend of the court") briefs (including one filed by this author) that, given the absence of a genetic connection, the adoption laws did not apply to gestational surrogates. In a 2013 traditional, genetic surrogacy dispute from Wisconsin, *Rosecky v. Schissel*, discussed in more detail below, that state's highest court also upheld a surrogacy contract with the significant exception of the legal maternity rights of the surrogate (8).

The legal uncertainty as to maternity status and the potential applicability of adoption and baby-selling laws identified in traditional, genetic surrogacy cases, coupled with the introduction of IVF, prompted an increase in gestational surrogacy arrangements whereby the surrogate's lack of a genetic connection makes her more easily distinguishable from a legal mother. In 2018, New Jersey enacted surrogacy legislation allowing compensated gestational (but not genetic) surrogacy (9), leaving only New York and Michigan currently disallowing the practice (10). Since 2007, New York has repeatedly introduced legislation supporting compensated gestational surrogacy; the bill came close to passage in 2019 and is being reintroduced in 2020 (11). In contrast, in February 2020, South Dakota introduced legislation to ban compensation to surrogates (12).

Although the New Jersey Supreme Court's decision in *Baby M* was a significant legal setback for surrogacy, with the advent of IVF, gestational surrogacy has flourished in many states, prompting new statutory and case law guidance as to parentage, contract enforceability, and professional duties and liabilities.

ESSENTIAL LEGAL PRINCIPLES AND CASES RELEVANT TO SURROGACY

Constitutional Right to Privacy and Reproductive Autonomy

Surrogacy arrangements involve balancing a woman's constitutional right to privacy and her right to contract away private reproductive choices. A foundational principle arising from the 1973 United States Supreme Court's seminal decision in *Roe v. Wade* is a woman's constitutional right to privacy and reproductive autonomy (13). Although not unlimited, *Roe's* protection of reproductive privacy and autonomy unequivocally supports the widely accepted view, also expressly incorporated into some state surrogacy laws, that intended parents cannot interfere with or overrule a surrogate's reproductive rights by the terms of a legal contract. This can become a critical issue if a surrogate—traditional, genetic or gestational—refuses to terminate or to selectively reduce at the request of the intended parents, even if she has previously agreed to do so in the contract. One state has recently introduced explicit legislation barring intended parents from forcing a surrogate to abort a pregnancy or to selectively reduce a multiple pregnancy (14). ASRM's 2018 Ethics Committee opinion also recognizes this legal principle ("[g]estational carriers are the sole source of consent regarding their medical care…") (15).

Contract Law

A contract between the intended parent(s) and gestational surrogate (and any spouse or partner) is an essential part of any surrogacy arrangement, and should be drafted and negotiated by separate, independent legal counsel experienced in reproductive law. Having separate, independent legal counsel protects each of the respective parties or couples, helps avoid conflicts of interest, and is not only a generally applicable ethical rule for legal representation but uniformly recommended or required for surrogacy arrangements by ASRM (16), the American College of Obstetricians and Gynecologists (17), the American Bar Association (18), and the Academy of Adoption & Assisted Reproductive Technology Attorneys (19). Albeit beyond the scope of this article, there also may be a question of conflict of interest or potential conflict of interest whereby an attorney simultaneously represents (or owns) a recruiting program and represents a participant to the surrogacy arrangement, as the *Striver* and *Huddleston* courts discuss (20).

Gestational carrier agreements should contain several essential elements. Although contract elements are beyond the scope of this article and too numerous to comprehensively list, among the major ones are: clearly setting out both the parties' parentage-related intentions and the legal process to establish legal parentage for the intended parents and not the gestational surrogate; setting out agreements on prenatal, pregnancy-related, labor, and delivery issues—including recognizing constitutional limits and reproductive autonomy; the consequences of various types of breaches of the agreement; escrowing all agreed upon compensations and fees prior to medical treatment; clarifying that compensation is for time, effort, and inconvenience (not for a live birth or transfer of legal custody); addressing both life and disability insurance; and addressing assumptions of the risks. There are many other important, if less central, issues, including restricting travel, alcohol, drugs, and social media postings; and addressing ancillary expenses including child-care, lost wages, and potential loss of reproductive organs.

Before any medical procedures can begin, the IVF physician and clinic will want to know that the negotiated legal agreement is in place and should require a written affirmation from legal counsel for one of the participants in the form of a legal clearance letter (Table 1). Clearance letters typically include representations as to the agreed-upon number of transfer attempts and timeframe, the maximum number of embryos per transfer, and an affirmation that the intended parents and gestational surrogate have each had separate legal representation. Without such a letter, the clinic should not begin any medical procedures. There is no legal requirement (unless a specific state should enact one), and likely no benefit, for an IVF physician or medical clinic to receive a copy of the actual legal agreement for their own files, as medical management of any planned pregnancy should follow standards of care for all patients and is not subject to any private contract between individuals seeking treatment.

As noted earlier, a central principle of contract law is that a contract (or part of a contract) that is found to be against "public policy" will not be upheld. Both the *Rosecky* and *Baby M* cases involving traditional, genetic surrogates highlight these