A Case of Surrogate Pregnancy

Kathleen Marie Dixon, PhD; Robert B. Kelly, MD, MS; J. Bradley Moritz, MD; and Margaret Bailey, MSSA
Bowling Green and Cleveland, Ohio

DR ROBERT KELLY *(Faculty, Fairview General Hospital Residency Program in Family Practice; Clinical Assistant Professor, Department of Family Medicine, Case Western Reserve University [CWRU]):* I would like to welcome the audience to City-Wide Family Medicine Grand Rounds. Today's topic of surrogate pregnancy is one that presents many ethical and practical dilemmas for health providers, patients, and legislators. Dr Moritz will begin with a case presentation from our practice. Margaret Bailey will then briefly discuss some of the psychosocial aspects of this case that came to our attention during interviews with the patient and her husband. Dr Dixon will follow with a discussion of ethical issues raised by this and similar cases, followed by an opportunity for open discussion with audience participation.

CASE PRESENTATION

DR J. BRADLEY MORITZ *(Second-Year Resident in Family Practice, Fairview General Hospital):* Mrs H. came to me as a new patient for prenatal care. She was a 30-year-old gravida 4 para 3 woman who was 13 weeks' gravid by dates and uterine size. Her previous pregnancies had been uncomplicated with uneventful labor and deliveries. She explained that this pregnancy was the product of artificial insemination as part of a surrogate pregnancy contract. The sperm donor was the husband of an infertile wife; all arrangements had been made through an organization specifically established to handle surrogate pregnancies.

Mrs H. lives with her husband and three children in a middle-class neighborhood. She described herself as "close" to her sister, mother, and stepfather, who live nearby. The relationship with her husband's family was more distant. They are both high school graduates; he works as a pipefitter and she raises the children.

The results of her physical examination and prenatal screening laboratory studies were all unremarkable. The pregnancy progressed uneventfully to 23 weeks' gestation. Mrs H. expressed that it was her preference to have a natural childbirth, to see the baby once in the delivery room, then never again. She wanted to avoid an episiotomy and requested an early discharge. Two sessions with Mr and Mrs H. were held to explore their feelings about the pregnancy and the surrogate contract process.

Despite a medically benign course, our regular obstetric consultants felt that her pregnancy care was high-risk because of its surrogate nature. There had been no prior cases of this type at our community hospital. When we were unable to find consultant physicians to agree to provide backup, her care was transferred at approximately 24 weeks to an obstetrician at the county hospital who was willing to assume it.

Following this transfer, contact with Mr and Mrs H. was maintained; they and their three children remain as patients in our practice. They were offered, but chose not to take advantage of, continued supportive counseling during the later months of pregnancy and following the delivery. A healthy baby girl was delivered at term at the county hospital. Mrs H., by her own preference, saw the baby only briefly in the delivery room, and was discharged from the hospital within 48 hours. The baby was immediately given over to the care of the adoptive parents, who live in another state.

Mrs H. has stated that she is glad the "whole thing is over with" and that she was very happy with the care she received from both her family physician and the county hospital obstetrician. Initially, Mr and Mrs H. planned not to have any communication with the adoptive parents after the birth. Nevertheless, Mrs H. recently told me that she calls the adoptive parents occasionally to check on the baby's progress and has made two visits to see the baby with the adoptive parents' permission. The adoptive parents would like another child and have asked Mrs H. whether she would be a surrogate mother a second time; she adamantly refuses.

Submitted, revised, September 8, 1989.

From the Center for Biomedical Ethics and the Department of Family Medicine, Case Western Reserve University School of Medicine, and the Department of Family Practice, Fairview General Hospital, Cleveland, Ohio. Requests for reprints should be addressed to Robert B. Kelly, MD, The Hassler Center for Family Medicine, Fairview General Hospital, 18200 Lorain Ave, Cleveland, OH 44111.

MARGARET A. BAILEY *(Family Therapist, Fairview General Hospital Residency Program in Family Practice; Senior Clinical Instructor, Department of Family Medicine, CWRU):* In addition to the visits that Mrs H. had with Dr Moritz for prenatal care, he and I met with the couple on several occasions to explore their experiences and feelings relating to the pregnancy and the surrogacy arrangements. In these interviews, it became clear that Mr and Mrs H. became involved in interpersonal and intrapersonal dynamics they had not expected. These dynamics included the rather traumatic effect that the insemination procedure had on the surrogate mother, the meaning the pregnancy had within the marital relationship, and finally the lack of boundaries between the biological father, the adoptive mother, and Mr and Mrs H. Despite psychological testing and a screening interview for the surrogate pregnancy program prior to entrance, the couple were quite unprepared for what happened to them.

In terms of past psychosocial history, Mrs H. and her husband seemed to lack effective communication and emotional intimacy in their marriage. For example, they disclosed that they had not really worked through any of the financial or relationship difficulties they experienced before entering into the surrogacy program. When Mrs H. thought she wanted to back out of the program after the insemination procedures had begun, she did not share her misgivings with her husband. On further exploration of motives, Mrs H. disclosed that at one time she had wanted to have another child, but by then her husband had undergone a vasectomy. The result was that an unconscious wish for pregnancy may have played a role in the decision to enter the program. Mrs H. also felt that she could ease the couple's financial problems and resulting tensions with the $10,000 surrogacy fee.

As they described it to us, both Mr and Mrs H. saw the insemination process in very negative terms. It even had overtones of an "affair" in the way it was conducted by the surrogacy program. Mrs H. would travel to another city, meet the adopting couple at the physician's office, eat dinner with them, and stay at the same hotel. It was during these meetings she found she did not like the biological father or carrying his baby. She felt "dirty" following the sperm inseminations, would immediately bathe numerous times, and described other behaviors and feelings more typical of a rape victim. There was also a clear overinvolvement between the adoptive mother and Mrs H. The adoptive mother confided to Mrs H. many of her own marital and infertility problems, and made weekly telephone calls to check on the progress of the pregnancy. Mrs H. felt sorry for her but was made very uncomfortable by these revelations and constant scrutiny. Mr H. was less forthcoming about his feelings, but did seem to resent his wife having become pregnant by another man; these concerns seemed to have been exacerbated by the frequent contacts with the biological father and adoptive mother.

Generalizing from this case, the family physician's role can be to explore with a couple their thoughts, feelings, and motivation for decisions such as surrogate pregnancy. The physician can also assess the marital communication pattern and the emotional capacity for intimacy in the couple's life while gathering such information. This intervention can potentially be a major benefit to the health of the family system and could have been useful for this couple had they presented for care before entering the surrogacy program.

RESIDENT: Can you tell us more about the screening interviews or psychological testing that Mrs H. had before entering the surrogate program?

DR MORITZ: She described one or two sessions in which she saw a psychologist, but I don't know what else was done. She did say she thought the sessions were totally inadequate.

DR LINDA POST *(Assistant Professor, Department of Family Medicine, CWRU):* What explanations have been given to their children?

DR MORITZ: At the time of the pregnancy, their oldest child was 6 years of age. Mrs H. has told me that she was able to hide the pregnancy from the children by wearing loose, bulky clothing. She is considering telling them about their "surrogate" sister at some point in the future but has not made a definite decision to do so. Her own parents, in-laws, and close friends were told about the nature of the pregnancy.

MS BAILEY: I think not telling the children reflects her own attempt to deny the pregnancy at this point. For the same reasons, she did not want to continue counseling and did not want to be asked questions that would lead her to think about it.

ETHICAL ISSUES

DR KATHLEEN DIXON *(Center for Biomedical Ethics, CWRU School of Medicine):* Any treatment of the ethics of surrogate motherhood must begin with a frank acknowledgment of the tremendous sensitivity of the issues surrogacy represents. Indeed, the term *surrogate mother* is itself the subject of controversy. The phrase has been criticized as a misrepresentation of the relationships obtaining between the contracting parties. A woman, such as Mrs H., who supplies both ova and uterine space for the fetus might be more aptly called a *surrogate wife.*[1] While I will continue to use the more familiar *surrogate mother* to refer to women who are genetic or gestational mothers, I encourage careful reflection on the connotations of the term.

continued on page 22

continued from page 20

Surrogate motherhood forces professionals and policy makers to confront problems created when infertility is combined with a profound need to obtain and nurture biologically related children. Surrogate motherhood brings individuals' interests in procreation into direct competition with state interests in maintaining the integrity of important social institutions, and with professional interests in the physical and mental well-being of the parties to surrogate contracts. We should not be surprised at the furor surrogacy creates, for as George Annas[2] said, "[surrogacy] evokes both the emotional and rational aspects of life; from the right to reproduce to severing the mother-child bond, from the right to contract to visions of slavery, from the greed of the baby-brokers to the love of parents for their children. . . ."

Rather than add to the heat of the discussions of surrogacy, I will try to illuminate some of the central ethical issues involved in surrogate motherhood. I do so, however, with some humility, recognizing that I cannot share the anguish or need that prompts infertile couples to enter into contracts with surrogate mothers. Nor can I share the complex psychological and social factors that induce women to act as surrogate mothers. Finally, I recognize that I am not on the firing line in the same way as physicians who have an obligation to protect the physical and mental health of contracting parties.

Is There a Moral Right to Reproduce?

When we ask about existence of rights, we need to describe the type of right we're thinking about. There are two possibilities: a negative right or a positive right. A negative right is a right to noninterference in an attempt to achieve some good or engage in some activity. When one has a negative right to a thing, one's actual or eventual attainment of it is not ensured; however, no one may legitimately prevent you from trying to obtain that thing. A positive right is a right to the secured enjoyment of some good. It is a justified claim to receive some good or engage in some activity.

Most people would want to argue that there is a prima facie negative right to procreation. That means that there is a right to noninterference in reproductive efforts, all things being equal. If, therefore, a couple wishes to conceive a child, in the normal course of events others do not have a moral right to interfere. Recognition of a prima facie negative right to procreation can be seen in arguments that assert the moral impermissibility of forcible sterilization of the mildly mentally retarded.

I have said that there is a prima facie negative right to reproduce, that there is ordinarily a right to noninterference in procreative efforts. Yet we can easily recognize that surrogacy is not an ordinary or normal occurrence; it is an exceptional circumstance. Typically, procreation involves the cooperative sexual efforts of only two persons. In surrogacy we have an instance of technologically facilitated "reproductive collaboration." Surrogate procreation requires the cooperative involvement of a third party—the surrogate—who will provide the ovum for fertilization, the womb to gestate the embryo, or both. Most surrogate pregnancies are also realized with the technical assistance of a physician who artificially inseminates the surrogate with the sperm of the contracting man.

One of the essential questions in surrogacy is whether the negative right to procreate extends to reproductive collaboration. I believe that the most reasonable answer is a qualified no. Individuals involved in reproductive collaboration may be entitled to freedom from restriction if two important conditions are met. Freedom from intervention holds only if the collaborative context, or surrogate contract, is itself morally acceptable. Second, individual collaborators are free from restriction only if all parties involved contract freely in contexts of full disclosure and adequate consent.

Is the Surrogate Contract a Morally Acceptable One?

This question is extremely difficult and complex, and I will attempt only to outline a response. The morality of surrogate contracts depends on their fundamental acknowledgment of the surrogate as an autonomous individual, who is owed the same dignity and respect as any other person. If surrogate contracts reduce surrogates to the status of "mother machines"[3] or rented wombs, then the contracts violate a fundamental moral canon: the principle of respect for persons.

Surrogate contracts formalize parties' agreement to reproductive collaboration. The surrogate mother agrees to submit to artificial insemination, to carry the fetus to term, and to relinquish all parental rights to the child.[1] In return, the contracting male or nurturing parents agree to pay all pregnancy-related medical and living expenses. The would-be parents may also agree to deposit a given sum in an escrow account.[4] These funds will be released to the surrogate when she surrenders the child to the nurturing parents after birth. Compensation for surrogates is determined by the contracting parties. Although some women forgo fees entirely, most surrogates require compensation. While contracts typically fix the award at $10,000, surrogates' fees can range from $5,000 to $50,000.[4]

Surrogate contracts may contain many other provisions. The surrogate may have to submit to genetic screening before insemination. The contract may also require her to undergo an amniocentesis. In some contracts the surrogate agrees either to accept an abortion in the event of fetal abnormality or to assume all burdens associated with raising the handicapped infant herself.

Other contracts stipulate that the nurturing parents are responsible for any and all burdens of child care as long as the surrogate fulfills her contractual obligations to obtain prenatal medical care and to abstain from certain high-risk health practices.

Contracts that leave women no control over the course of their pregnancy reduce them to the status of mere means to obtain healthy, biologically related infants. It is important to note that the immorality of these contracts is not mitigated by the surrogate's informed acceptance of contractual terms. The principle of respect for persons prohibits any treatment of persons as mere means to ends. Thus, we are not permitted to sell ourselves into slavery. We may not submit to any contract implying that we possess only instrumental and not intrinsic value. Surrogate contracts need not violate the principle of respect for persons. Contracts can respect the autonomy and dignity of the surrogate.

Another factor complicating assessments of the morality of the surrogate contract is the matter of financial compensation of surrogates. Is surrogacy immoral if its motivation is financial reward? An objective response to this question would require a thorough analysis of the impact of motivation on the morality of action. Completion of this task would take us well beyond the scope of the present project. Consequently, I will merely state rather than argue for my conclusion: individuals' intentions or motivations have no bearing on the morality of action. They do, however, speak to the moral value of persons' characters.[5] Unfortunately, we cannot reason from an assessment of character to the morality of any act. Virtuous individuals will, at times, act immorally just as those of vicious character occasionally perform good deeds. Thus, the rectitude of surrogacy does not hang on the motivations of the surrogates.

Let me say a few words to those who differ on this score. Your response to the matter of financial compensation is best when it issues from a thorough consideration of certain social realities. We live in a context of profound socioeconomic inequalities. Our culture has an obsessive fascination with material goods and wealth. The domestic policies of recent political administrations achieved the feminization of poverty. We must decide if in the face of these facts we will prohibit individuals from pursuing this avenue for redressing social inequities. Surrogacy for financial reward is merely a symptom of a broader educational, social, and financial disease. To treat the disease, we must address the cultural contexts that limit the educational opportunities of women, the social contexts that build female occupational ghettos, and then compensate the individuals within these "pink collar ghettos" at substandard rates. Until women achieve social and economic parity, many will agree with Mrs H. They will believe surrogacy is a rational or perhaps even the only way for them to make a substantial financial contribution to their families.

Surrogacy can reveal some of the darker aspects of human nature. It forces us to maintain a precarious balance between our commitments to the exercise of human freedom and the promotion of the good. While surrogate contracts are not necessarily immoral, they are so problematic that if gross exploitation and abuse is to be prevented, regulative oversight and restriction is required. Consequently, there is no negative right to reproductive collaboration.

Let's take a moment to consider whether the second condition for a negative right to collaborative reproduction has been met. Is it true that all parties contract freely in contexts of full disclosure and adequate consent? Libertarians support surrogacy on the grounds that the ability of free individuals to contract is absolute and inviolable. This view sounds appealing as a theory but, as we can see in the present case study, can be disastrous when given practical application. If a reasonable approach to surrogacy is to be had, we must realize that in this arena reason wars with affect for control over the individual who bargains. Surrogate arrangements are not situations where neutral, dispassionate, and paradigmatically rational consideration necessarily holds sway.

We face a variety of practical features that may well limit the adequacy of consent and in some instances preclude a free and informed consent. Nurturing parents are driven by a profound, almost obsessive need for biologically related children. Surrogates are frequently plagued by feelings of personal inadequacy that make them unable or unwilling to defend their own interests and rights. Many women view surrogate contracts as atonements for earlier decisions to abort or surrender a child to adoption.[6] Surrogacy is undoubtedly a context in which parties contract with partial and uncertain knowledge about the risks and benefits of the exchange. What kinds of psychological hazards face the surrogates who relinquish their children or the parents who raise them in the miasma of family secrets or tarnished dreams of enjoyment of the perfect child? These concerns may not make an informed and voluntary consent to surrogate contracts impossible. They certainly do add, however, to the difficulty involved in obtaining a valid consent.

Reasonable requirements protecting the quality of consent will limit the numbers of individuals entering into surrogate contracts. Perhaps only women who have successfully coped with earlier decisions to relinquish custody of a biological child should be surrogates. First-time mothers should be prevented from entering into surrogate contracts. They can have no knowledge of the kind of rights they are alienating or the strength and difficulty of the emotions they may experience. Because of the difficulties in obtaining an informed and voluntary consent,

regulation of the surrogacy is required. Thus, there is no right on the part of individuals engaged in reproductive collaboration to be free from external restriction or oversight.

Sale of Service or Product?

Surrogate contracts currently in vogue make it clear that contracting parties are exchanging a product rather than purchasing a service. In a surrogate relationship, the biological father and nurturing mother contract with a surrogate to acquire a commodity—a healthy infant. They are not purchasing a personal service, namely, egg donation and womb rental. Most contracts allow the surrogate no compensation if a spontaneous miscarriage occurs before the fifth month of pregnancy, and provide only minimal compensation in the event of a miscarriage or stillbirth after this time.[7,8] In comparison, surrogates are usually paid $10,000 for relinquishing a live infant to the biological father and his spouse. If nurturing parents were paying for a service—rent-a-womb—payment would be made regardless of outcome for the period the service was provided.

While surrogacy as currently constituted involves the sale of a commodity, surrogate contracts could easily be restructured to reflect an exchange of personal services. It is important to note that a commodity orientation does not itself establish the immorality of surrogacy. The moral impermissibility of baby selling would have to be demonstrated. One could argue that baby selling is incompatible with the dignity and respect due to persons. This argument succeeds only if neonates and infants are considered moral persons. Baby selling could also be attacked on utilitarian grounds. We could argue that the sale of neonates and infants would promote a context in which children would be bereft of the social and familial security that assists in identity formation. We could point to psychological harms caused by familial disruption. It is not clear, however, that the practice of surrogacy will result in these harms. Children acquired through surrogacy may not feel unwanted. In fact, they may experience an embarrassment of riches—too many individuals want to love and nurture them. Therefore, we may do best to argue that surrogacy should not be prohibited outright, but should instead be closely monitored.

The Potential Role of Family Physicians in Surrogate Arrangements

Although I do not pretend to have exhausted moral consideration on the theme of surrogate motherhood, our discussion of ethical issues allows us to consider the role of the physician, especially the family physician, in surrogate arrangements. I see three possible roles for the family physician: technical expert, counselor, and societal agent. As technical expert the family physician could screen the nurturing couple or surrogate or both prior to insemination. The physician could also test the woman of the nurturing couple for infertility or presence of factors that would create a substantial medical risk for her were she to become pregnant.* Contracting parties could be referred for competent professional assistance in the detection of genetic disorders. The family physician could help them appreciate the kinds and levels of risk they would assume in any pregnancy. The family physician could also screen the biological father for sexually transmissible diseases. This would reduce the risk of injury or disease to the surrogate.

The family physician would be a valuable part of a larger team assessing the psychological suitability of both nurturing parents and surrogate mother. Commercial surrogate contracts are usually brokered by profit-oriented agencies that maintain a pool of women willing to serve as surrogates. Surrogate agencies maximize their short-term interests by obtaining the broadest possible pool of surrogate candidates. Some forgo psychological evaluation entirely, accepting all medically suitable women.[1] Other agencies, such as the one that handled Mrs H.'s pregnancy, have abbreviated, inadequate screening programs. These shortcuts subject all parties to increased risks. Family physicians' expertise and appreciation of psychosocial contributions to medical care would enable them to assess parties' comprehension of data essential for informed consent. While brokers provide dossiers on surrogates for nurturing couples to review, surrogates may receive little or no information about the nurturing parents.[1] Surrogates and nurturing parents frequently rely on the risk-benefit assessments and educational materials prepared and presented by surrogate agencies. The profit orientation of the agencies and absence of uniform legislation governing surrogate contracts makes these materials suspect.† Family physicians can offer an objective, independent channel and review of information.

Family physicians can also offer important counseling to those considering surrogate contracts. In the eyes of

*Legislation proposed in New York, S. 1429-A (Feb 3, 1987) (Dunne, Goodhue), restricts access to surrogates to infertile married couples. Their right to enter into surrogate contracts is thought to rest on constitutional guarantees of equal protection. Physicians may be pressed into service as gatekeepers through requirements to obtain certificates of medical need. (See The New York State Task Force on Life and the Law,[1] pp 64, 68, note 33.)

†Avi Katz[4] describes a number of bills governing surrogacy that have been introduced in state legislatures. The range of information and services that brokers are required to provide to contracting parties is alarming. An Alaska bill has no provisions for psychological counseling or special education. Bills introduced in Connecticut, South Carolina, and Hawaii require psychiatric evaluation of the surrogate. Legislation proposed in the District of Columbia, Michigan, and New York requires psychiatric evaluation of the surrogate, counseling for the nurturing parents, and independent representation for the surrogate and infertile couple.

many patients, the advice of the family physician carries special weight and authority. This professional power can be wielded in ways that help contracting parties reflect on their options, motivations, and goals. Individuals should be encouraged to scrutinize their reasons for pursuing surrogacy and reality-test their hopes. If biological children are seen as a way to attain personal immortality, family physicians should advise that these needs will probably not be met in surrogate arrangements or indeed in any parenting context. As counselors, family physicians could provide a much needed perspective on surrogate motherhood. There has been so much interest in the welfare of the child produced in the surrogate arrangement, and in the rights of the biological parents, that the welfare of existing children in the surrogate's family has been ignored. Indeed, most have forgotten that surrogates have a family whose well-being ought to be considered.

Finally, family physicians could function as agents for broader social interests. Surrogacy forces us to face enormously difficult moral, social, and professional questions. There is no absolute authority in this area, and practical ramifications of existing or proposed policies are not always clear. We could be greatly benefited by broader exposure to the insights of family physicians. If the American Academy of Family Physicians were to issue well-considered analyses and recommendations for professional and social responses to surrogacy, they would undoubtedly be welcomed and utilized. In the interim there is a quieter social service that family physicians could perform. You could encourage adults to respond to the profound need for loving homes for older or handicapped children. Perhaps we need the family physician to remind us that if our love and tolerance is extended only to those who are "perfect"or blood kin, ours will be a narrow and lonely world indeed.

DISCUSSION

STUDENT: Do you think it's possible to have a surrogacy contract in which the rights of the individual are respected?

DR DIXON: I think it is possible to have a contract that will respect the autonomy of the surrogate. Unfortunately, brokers and nurturing couples don't always have incentives to write contracts in this way. Typically, certain behaviors are proscribed and others prescribed very specifically.[3,9] I have reviewed pending legislation that gives surrogates total control of the pregnancy. I am especially pleased with the language of one bill presented in the California Assembly. It reads, "The surrogate is the source of consent with respect to the clinical intervention in and management of the pregnancy, including termination of the pregnancy."*

RESIDENT: Dr Moritz, what did you know about the contract that the patient made and how she felt about it?

DR MORITZ: I asked for and received a copy of the contract from Mrs H. If we had been able to continue her care, we could have had some help from our hospital's legal department in anticipating problems raised by the nature of the agreement. I was particularly interested in what was specified to happen during the peripartum period, how adoption procedures were going to be held, how the insurance was going to be handled, and what options Mrs H. had. Because of rather involved legal terminology, I don't feel in retrospect that seeing the contract was in fact helpful.

DR KELLY: Imagining the role of primary physician for Mr and Mrs H., I was wondering what it would have been like if both the families were here in town and in contact with me. Occasionally, as family physicians, we get into a problem within a single family: Who is our patient, for whom should we be the advocate? Here we have two families and the fetus; what is our proper role? What should I tell the adoptive couple if they ask about the pregnancy? Should I get involved with them in some way? The ethical and medicolegal waters seem very muddy. These are difficult issues to struggle with, and yet, who to do that better than a family physician?

DR MORITZ: Maybe this is from lack of experience, but I was operating on the assumption that Mrs H. was my patient, and her husband, although not the biological father, the main support for my patient. I never even considered making contact with the natural father or his wife. When I think about it, though, up until at least the time of the delivery and the adoption, I am also the baby's physician and the baby's advocate. The adoptive parents could reasonably have some things to ask me about.

STUDENT: What happens typically in the event the child is born deformed or retarded, in terms of the contract?

DR DIXON: Many contracts stipulate that the surrogate must undergo amniocentesis early in the pregnancy and obtain an abortion if the fetus is handicapped. Such provisions are probably unenforceable infringements of Fourteenth Amendment privacy rights.† Some contracts don't clearly define rights and obligations of parties when infants are born handicapped. If the baby is handicapped and the adoptive parents refuse to assume custody of the child, the surrogate mother could provide care for the

Cal. Assembly 1707, 1985–86 Reg. Sess. Sec. 2(1985) (as cited by Katz,[4] p 46 note 229)

†The Supreme Court's recent decision in Webster v Reproductive Health Services *opens the door to state regulation of abortion. This new legal climate presents additional challenges to contractual requirements related to abortion. (See Katz,[4] p 46, note 229.)*

child and require the biological father to provide financial support. The surrogate could also renounce her parental rights to the child, turning it over to an adoption agency. The media circus surrounding *Malahoff v Stiver* reveals the inadequacies of many surrogate contracts. None of the parties wanted the microcephalic child born to Judy Stiver. The contracting man requested that the hospital withhold treatment from the child and allow it to die.[10] Bills presented in Connecticut, Hawaii, and South Carolina require biological fathers to adopt any child resulting from the surrogate pregnancy.[4]

DR SIM GALAZKA *(Associate Professor, Department of Family Medicine, CWRU):* What is known about the long-term effects on the two families involved in surrogacy arrangements and on the children arising from these arrangements?

DR DIXON: Analyses of the outcomes of surrogate contracts are contradictory.[11–17] Many of those who study the impact on surrogate mothers indicate that they experience no serious psychological complaints. Others describe serious psychological sequelae. Data addressing the surrogate or adoptive family as a unit are quite scarce. Surrogacy is still too new a phenomenon in our society. Much work in this area remains to be done if we are to establish sound rationales for social policy.

DR J. CHRISTOPHER SHANK *(Chairman, Family Practice Department, and Residency Director, Fairview General Hospital; Associate Clinical Professor, Department of Family Medicine, CWRU):* I would like to congratulate our presenters for an interesting and thought-provoking Grand Rounds, and thank those of you in the audience who participated in the discussion as well.

References

1. The New York State Task Force on Life and the Law: Surrogate Parenting: Analysis and Recommendations for Public Policy. Albany, NY, 1988, pp 1, 23, 26, 64, 68
2. Annas G: Baby M: Babies (and justice) for sale. Hastings Cent Rep 1987; 17:104–110
3. Corea G: The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs. New York, Harper & Row, 1985
4. Katz A: Surrogate motherhood and the baby-selling laws. Columbia J Law Soc Policy 1986; 20:1–53
5. Rachels J: Active and passive euthanasia. N Engl J Med 1975; 292:78–80
6. Goleman G: Motivations of surrogate mothers. New York Times, Jan 20, 1987, Sec C, p 1. In The New York State Task Force on Life and the Law: Surrogate Parenting: Analysis and Recommendations for Public Policy, Albany, NY, 1988, pp 25, 29
7. Andrews L: The aftermath of Baby M: Proposed state laws on surrogate motherhood. Hastings Cent Rep 1987; 17:98–101
8. Holder A: Surrogate motherhood: Babies for fun and profit. Law Med Health Care 1984; 12:115–117
9. Gersz S: The contract in surrogate motherhood: A review of the issues. Law Med Health Care 1984; 12:107–114
10. Andrews L: The stork market: The law of the new reproduction technologies. Am Bar Assoc J 1984; 70:50–56
11. Parker PJ: The psychology of the pregnant surrogate mother: A newly updated report of a longitudinal pilot study. Presented to the American Orthopsychiatric Association Meeting, Toronto, April 9, 1984
12. Keane N: Legal problems of surrogate motherhood. South Ill Univ Law J, 1980, pp 174, 152
13. Rynearson E: Relinquishment and its maternal complications: A preliminary study. Am J Psychiatry 1982; 189:338, 339
14. Deykin E, Campbell P: The postadoption experience of surrendering parents. Am J Orthopsychiatry 1984; 54:271, 273
15. Harrison M: Social construction of Mary Beth Whitehead. Gender Society 1987; 1:300–311
16. Sokoloff B: Alternative methods of reproduction: Effects on the child. Clin Pediatr 1987; 26:11–16
17. Karpel M: Family secrets: Conceptual and ethical issues in the relational context. Fam Process 1980; 19:295–306