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

TABLE 1

A legal clearance letter should typically include:

- Confirmation that intended parents (IPs) and gestational carrier (GC) and her spouse, if married, each have independent legal representation, including the names of each attorney.
- Confirmation that the final legal agreement has been negotiated, signed by each of the participants, and returned to each attorney.
  - If there is applicable statutory law, affirm compliance with that statute and include any specific information required by it.
- The maximum number of embryos agreed to be transferred per cycle (typically one embryo, there may be some exceptions for two), subject to both the in vitro fertilization physician's recommendation and approval by GC and IPs.
- The maximum number of embryo transfer attempts, typically three (excluding cancelled cycles) if needed for GC to become pregnant.
  - May be subject to any of the following:
    - Necessity for IPs to create additional embryos
    - Any decision by IPs or GC to discontinue and terminate legal agreement after any transfer that did not result in a viable pregnancy
    - If no pregnancy results after agreed number of transfers, IPs and GC may mutually agree to additional transfer attempts
- Any relevant time period for all agreed transfers to occur within (typically 12 or 18 months).

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contract principles. Although the *Baby M* court found the entire surrogacy agreement void as against public policy, the *Rosecky* court voided the agreement to sever maternal rights by contract as against public policy and upheld the rest of the contract as enforceable. Both cases yielded the same result: the traditional, genetic surrogate could not be required to terminate her parental rights despite a contractual agreement to do so, but the surrogacy-born child was placed in the custody of the intended parents under a best interest of the child test determination. Elizabeth Stern was ultimately able to adopt her child, whereas Marcia Rosecky was not, nor was she ever recognized as the legal mother before her death.

In addition, under contract law, breaches of certain types of contractual terms cannot be enforced through "specific performance" (forcing someone to physically perform a contractually agreed-upon action or nonaction). Contractual terms involving pregnancy management, termination, and selective reduction—whether for a traditional, genetic or gestational surrogate—will all fall within those types of breaches. Instead, money or "liquidated" damages may be allowed for such breaches as long as the breached term is not found to be against "public policy." Independent experienced legal counsel for each of the participants will increase the likelihood that a contract will be found equitable and enforceable.

Duty of Care and Professional Liability

Legal liability in negligence or malpractice cases depends on whether a recognized "duty of care" has been breached. Given the multiple participants and potential child (or children) involved, surrogacy presents unique issues and obligations for professionals. Two significant cases from the 1990s each identified a heightened duty of care owed by both medical and nonmedical professionals to all of the participants, and to the anticipated child, in surrogacy arrangements. Two additional, more recent, cases discussed here also raise issues of responsibility or liability for medical, legal, and mental health professionals' screening, representation, and care of a prospective surrogate.

In *Stiver v. Parker*, Judith Stiver, a traditional, genetic surrogate and her husband sued surrogacy broker Noel Keane, her assigned lawyer, and the four participating doctors for negligence after the child she delivered was born with cytomegalovirus, presumably contracted from Alexander Malahoff, the intended father whose semen was not tested (20, 21). Keane, a lawyer, ran a surrogacy business in which he recruited surrogates, acted as the prospective father's lawyer, drafted the surrogacy agreement, and organized the rest of the surrogacy program including arranging the psychiatrist and doctors, and providing a lawyer for the surrogate whom she first met at the time that she was shown and signed the agreement (21).

The court held that Keane and each of the other professionals owed an affirmative duty of protection and heightened diligence (21):

> ...Keane assumed a task and role as a surrogacy broker, and the other professionals participated in the program Keane designed. The group were in this sense joint venturers ... They are entrepreneurs pioneering in a new field. Keane, as well as the doctors and the lawyer, expected to profit from their roles in the program ...
>
> We conclude that Keane, the surrogacy business designer and broker, and the other defendant professionals who profited from the program, owed affirmative duties to the Stivers and to Malahoff, the surrogacy program beneficiaries. This duty, an affirmative duty of protection, marked by a heightened diligence, arises out of a special relationship because the defendants engaged in the surrogacy business and expected to profit thereby. Keane owed a duty to design and administer a program to protect the parties, including a requirement for appropriate testing (21).

The second case identifying this same heightened duty of care involved another surrogacy arranged by Noel Keane, *Huddleston v. Infertility Center of America* (22). As operator of the Infertility Center of America (ICA), Keane matched Phyllis Huddleston as a traditional, genetic surrogate with a single, intended father, James Austin. After being artificially inseminated with Austin's sperm, Huddleston gave birth to a baby boy and gave physical custody to Austin. The baby died at 5 weeks of age, after Austin repeatedly abused the baby, resulting in severe head and brain injuries (22). Reportedly, Austin had no childcare experience, no psychological counseling, and his mother had died shortly before the surrogacy (23). In Huddleston's civil suit against the ICA for wrongful death and survival actions, Keane attempted to argue that his program had no duty to the surrogate over harm to the baby, since she had relinquished legal custody. The court, citing *Stiver*, disagreed and held that the ICA "must be held accountable for the foreseeable risks of the surrogacy

undertaking" because of the special relationship between the surrogacy business, parties to the surrogacy, and the resulting child (22). Austin was also criminally charged and convicted in his infant son's death.

Stiver and *Huddleston* strongly support an affirmative duty of care owed by surrogacy recruiters, physicians, and other involved professionals to the surrogate, the intended parents, and the resulting child. For reproductive endocrinologists (REIs), duty of care over screening and pregnancy management issues will include reviewing a prospective surrogate's medical records and using their independent medical judgment in assessing the prospective surrogate's suitability as well as issues such as the number of embryos to implant. Later pregnancy management issues for obstetrician/gynecologists are beyond the scope of this article, but they as well as REIs may face the need to respect patient confidentiality issues, to obtain and understand the limits of Health Insurance Portability and Accountability Act releases, and to have a keen awareness of the relevant constitutional rights of reproductive autonomy should any issues of testing, termination, or selective reduction arise, as well as the clear potential for conflicts of interest.

The obligations that various professionals have in screening potential surrogates remains a somewhat open question. Although many recruiting programs gather some records and do some preliminary screening, medical professionals should recognize their nondelegable duty of care owed to any patient. ASRM guidance also makes clear that all physicians should "strongly recommend," and that participants should receive, "psychological evaluation before, and access to counseling during and after participation" (15).

Two more recent cases illustrate novel legal issues that REIs and obstetrician/gynecologists may confront in medically screening prospective surrogates and managing surrogate pregnancies. A 2016 trial court level case from Maryland, *Ng-Wagner v. Hotchkiss*, highlights the challenges of screening prospective gestational surrogates (24). In that case, a couple sued their REI for negligence after their surrogate delivered at 25 weeks due to preeclampsia and their baby died 3 weeks later. The couple argued that their physician had been negligent in only taking a medical history from their prospective surrogate instead of obtaining and reviewing either her medical records or a letter from her obstetrician/gynecologist. The woman had reported four normal pregnancies; in fact, she had delivered six children, the most recent of whom was born premature due to preeclampsia. The defense argued, unsuccessfully, that it was within the standard of care to ask the prospective surrogate about her medical history and to rely on it. A jury verdict in the amount of $44.1 million was later reduced to $887,500 under that state's statutory cap for medical malpractice, with the appellate court upholding the jury's decision favoring the intended parents.

A 2018 case from Iowa, *P.M. v. T.B.*, is also notable (25). Although the Iowa Supreme Court ruled that compensated gestational surrogacy agreements do not violate Iowa's public policy, and granted custody to the intended father (Iowa law required a nongenetic, intended mother to adopt), the case also highlights—without resolving—several significant duty of care and liability concerns for professionals. The case involved two married infertile couples and an imbalanced gestational surrogacy agreement prepared solely by the intended parents' lawyer. The intended mother, "nearing age fifty," needed an egg donor and gestational surrogate; she and her husband had six children from their prior marriages. They found their surrogate, T.B., through Craigslist. She was seeking to cover the costs of her own future IVF with her current husband after a tubal pregnancy and ligation; she had four children from a prior marriage.

According to the court, the gestational carrier and her husband "elected to waive" legal counsel, and there is no mention of any mental health screening or counseling for any of the parties. The agreement included provisions for transfer of two embryos, despite ASRM guidelines recommending elective single embryo transfer; conditional compensation on a live birth (inconsistent with both professional standards that payments are for inconvenience and efforts, and laws in virtually every state that prohibit buying or selling a baby), and the conditionally agreed-upon payment of $13,000 (to be paid directly to the intended mother's IVF program) was a third or less than prevailing fees for singletons, without a standard provision for additional compensation for carrying multiples. It is unlikely that a gestational carrier represented by legal counsel would have agreed to any of these provisions.

The couples' relationship began to break down within weeks after the agreed upon transfer of two embryos, and ultimately direct communication between them ended. Twins were born prematurely, and one died 8 days later. The intended parents went to court almost 2 months later, unaware of the births or death, seeking custody of the twins. After two months of litigation, the trial court awarded the biological father both legal and physical custody of the surviving twin.

On appeal, the gestational carrier T.B. was represented by Howard Cassidy, the attorney who represented Mary Beth Whitehead in the 1986 *Baby M* case. A steadfast opponent of all forms of surrogacy, he argued that a surrogate should be the presumed legal mother, that enforceable surrogacy agreements "embody deviant societal pressures," and that surrogacy exploits women by using them much like a "breeding animal." The court's ruling suggests that his appeal was not based on specific troubling facts or aspects of the case: "[W]e emphasize that TB's legal attack is on surrogacy agreements in general. We do not foreclose the possibility that a surrogacy agreement in a particular case could be subject to specific contract defenses, such as fraud, duress or unconscionability" (25).

Thus, the court did not address whether the circumstances of the case violated duties of care owed to TB, nor was there any mention of whether the IVF program requested or required a representation in the Clearance Letter that the parties had had separate legal counsel in reaching their legal agreement or had undergone any mental health evaluation, psychoeducation, or counseling before any medical procedures or during the pregnancy.

Establishing Parentage (and Non-parentage)

A mantra well worth remembering is that doctors may make babies but only the law can make a legally secure family. Thus, in addition to issues surrounding duty of care, creation of contracts, bodily autonomy, and decision-making for any surrogate, establishing parentage for children born from surrogacy is a critical legal component of any surrogacy arrangement. Because Family Law is the domain of states, how legal parentage is established in surrogacy arrangements varies depending on applicable state law. Surrogacy cases involving participants from different states or countries can exponentially complicate this issue. Medical professionals should have a general understanding of the relevant issues, as outlined here, but it cannot be emphasized enough that pursuant to general legal ethics principles and professional guidelines, each patient or patient couple—intended parents and surrogates and their partners—should have independent legal advice and representation from legal professionals experienced in reproductive and surrogacy law in the relevant jurisdictions. Representation "throughout the surrogacy arrangement," including the parentage as well as contract stages, may be critical (4), and such ongoing representation is recommended by ASRM Practice Guidelines (16).

From a legal perspective, maternity has historically been determined through either pregnancy or adoption, whereas paternity has been presumed by marriage to the mother, established by a man's voluntary acknowledgment of paternity, or proved in some circumstances through state-approved parentage tests including DNA testing. With the advent of IVF, donor gametes or embryos, surrogacy, and same-sex couples, the three central elements of parentage—genetics, gestation, and intent—can now be divided among more than one individual. Parentage law has had to catch up with these medical and social advances, a process that has generated numerous legal cases and legislation throughout the country. Although traditional, genetic surrogacy typically still requires an adoption to legally transfer maternity to the intended mother, most states have recognized the nonmaternal distinction for a gestational carrier and have developed alternative pathways to establishing legal parentage in many—but not all—gestational surrogacy arrangements. This section outlines the basic methods of determining (establishing) parentage in gestational surrogacy arrangements, highlights some of the conflicts that have arisen and how they have been addressed and provides insight into how medical professionals should best approach these thorny issues.

Two of the earliest cases involving parentage of a child born through gestational surrogacy, both during the 1990s and from California, illustrate the ways in which the law has responded to this separation of genetics, gestation, and intent as elements of parentage. In 1993, in *Johnson v. Calvert* (26), a married couple, Mark and Crispina Calvert, using their own eggs and sperm, contracted with a colleague of the wife's to carry their child as a gestational carrier. During the pregnancy, the gestational carrier, Anna Johnson, attempted to challenge the arrangement for a number of reasons, and at one point filed a maternity claim. The California Supreme Court was faced with the then-novel question of who was the legal mother of the child. Reviewing its existing maternity statutes, the court found that under California law, both genetics and gestation can be determinants of legal maternity and ruled that when those elements were found in two different women, the "tie-breaker" should be intent. Since Crispina Calvert was the genetic mother and had always been the intended mother, the court ruled that she, not the gestational carrier, was the legal mother.

Five years later, California courts had to revisit the question of maternity when a married couple had used both donor sperm and donor egg and separated during their gestational carrier's pregnancy. In *In re Buzzanca* (27), the ex-husband claimed that because he was neither the genetic father nor married to the woman carrying the pregnancy, he could not be found to be the child's legal father. Initially, lower courts somewhat infamously concluded that the child had no legal parents, but the California Court of Appeals ultimately ruled that the ex-husband's intent to be the father, evidenced by the legal surrogacy agreement he had entered into, was enough to determine that he was the legal father (27). Similarly, in 2015, a Pennsylvania court enforced a surrogacy contract and thus legal maternity rights and responsibilities against actress Sherri Shepherd after her divorce, whereby the former couple had used a donor egg, on a similar intent-based theory (28). Shepherd was ordered to pay child support but has chosen to have no contact with the child who is being raised by his father in California (29).

Since that time, a growing number of states have recognized legal parentage not only for intended, genetic parents but also in many jurisdictions for their different or same-sex spouses as well as for partners without any genetic link to the child. A warning is important, however: what is considered a sufficient link, including marriage, and the methods for establishing parentage, vary considerably from state to state.

Several states by statute or case law have determined that legal parentage can be established for intended parents either prior to the birth of the child (through a "pre-birth order" effective upon birth) or at, or shortly after, the birth of the child. State laws vary considerably as to both the protocols and criteria (such as marital status, same-sex couples, genetic connections to the child) for establishing parentage. Illinois, for example, enacted legislation that allows parentage to be established outside of court so long as one intended parent is a genetic parent (30). In Massachusetts, as in many states, parentage protocols have been established by case law instead of statute. The author was involved in some of the earliest cases in Massachusetts that established first the principle that genetic intended parents should be recognized as legal parents upon the birth of the child without the necessity of an adoption, and subsequently that those protocols should apply to cases involving donor egg (including multiple trial-level, unreported cases) (31). In a later case, the Massachusetts Supreme Judicial Court provided guidance on how to establish pre-birth orders, including mandatory notice to its Registry of Vital Records and Statistics (32). Currently, some states require one of the intended parents to be genetically related to the child or require additional steps in the parentage process if there is no genetic connection; some states require a perfunctory or comprehensive court hearing

with witnesses; still others streamline the process for a court or out-of-court filing. Experienced legal counsel will be essential in assessing who can acquire legal parentage, and how it must be accomplished, thus ensuring that a reliable plan to establish legal parentage is in place prior to any pregnancy. Ideally, the most protective protocol is to establish legal parentage at the earliest opportunity to ensure the child's legal status, as well as parental rights and responsibility for the intended parents and not the gestational carrier, and insurance coverage for the child through the intended parents from the moment of birth.

Parentage-related risks and vulnerabilities still remain for some surrogacy-created families. With multiple jurisdictions and international surrogacy arrangements, obtaining or relying solely on parentage orders can be challenging. For same-sex couples, notwithstanding the U.S. Supreme Court's recognition of same-sex marriage in *Obergefell v. Hodges* in 2015 (33), some state laws still do not fully recognize a nongenetic parent's legal status, and there is a strong consensus by reproductive law experts that virtually all same-sex couples should undergo a formal co-parent adoption after the birth of their child (34). In addition, anecdotal stories of birth orders delayed—at times intentionally—to obtain insurance coverage under the gestational surrogate's policy or to assist international parents in returning to their home countries without parentage orders that are inconsistent with that country's laws, may have the unfortunate consequence of leaving a gestational surrogate and her spouse/partner legally and financially responsible for a child and birth-related expenses. This is, again, an area in which independent experienced legal guidance for each of the participants is essential.

CONCLUSION

Gestational surrogacy is not only here to stay but signifies an expanding family-building option for myriad potential intended parents. In many respects, surrogacy remains a challenging and somewhat uncharted, if flourishing, interprofessional practice. For medical professionals providing services to intended parents, gestational surrogates, and gamete donors, a better understanding of the parameters and limits of the law through the cases reviewed here should be helpful. Recognizing a surrogate's constitutionally protected bodily autonomy and reproductive rights, as well as the likely heightened duty of care owed to her, should help guide decision making over issues such as the number of embryos to transfer, what prenatal tests to perform, and how to respect any other decisions around pregnancy management, including termination or selective reduction. Relatedly, a general understanding of the contours and limits of surrogacy contracts, variability in applicable laws, the critical role and complexity involved in establishing legal parentage, and a recognition that these issues are magnified for interstate or cross-border surrogacy and international intended parents, are hopefully all helpful to those involved in providing medical services to the participants in gestational surrogacy arrangements. Finally, recognizing the myriad complexities and nuances that fall outside the role of the medical professional should be helpful in requiring as best practice that patients seek independent, experienced legal representation with the nonmedical aspects of their family-building efforts.

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