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5 pages

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Our services at Pennsylvania Reproductive Associates (PRA) include an In Vitro Fertilization program (IVF) and other methods of assisted reproduction which have arisen from this accepted technology. Some examples of this are: Gamete Intra-Fallopian Tube transfer (GIFT), donor egg program, and the gestational carrier program.

Ladies and Gentlemen, as I testify today, a woman who was born without a uterus is having eggs removed from her ovaries which will be fertilized by her husbands' sperm. Once embryo development has occurred, these embryos will be replaced into her carrier, who will hopefully become pregnant and carry this baby to term for her.

Our gestational carrier program was initiated about a year ago, and on March 2, 1989 our first baby conceived in this fashion was born. You will be hearing from this mother and her carrier today.

My main purpose today is to distinguish for you the difference between surrogacy and gestational carrier.

In the instance of a woman who is serving as a surrogate, that woman agrees to be inseminated with the semen from the husband of an infertile woman. The surrogate not only carries the pregnancy and delivers the child, but also has a genetic input into the pregnancy.

On the other hand, a gestational carrier is a woman in whom an embryo is implanted in order to complete a pregnancy. That embryo has the genetic make-up of its biologic parents. Thus, the gestational carrier who voluntarily becomes pregnant does so with an embryo derived from the egg and sperm of an infertile couple.

The principle indication for a gestational carrier program is to provide a treatment option for women who can not otherwise carry a pregnancy and wish to have a biologic child. Medical indications include:

1. The absence of the uterus from surgical or genetic causes. Such examples include women who have been severely DES exposed, those born with either an absent uterus, or a severely deformed uterus, and women who may have had their uterus removed for disease at a young age.
2. Medical conditions which make the occurrence of pregnancy unacceptably hazardous to the mother. Examples of this include previous eclampsia, uncontrolled or brittle diabetes, chronic renal disease, congenital or acquired heart disease, or Sustemic Lupus Erythematosis (SLE) with renal involvement.

The carrier agrees to provide these services for the infertile couple on a contractual basis completely defined before treatment is begun, psychology screening of all parties is mandatory in our program.

What this means is that we must redefine the term mother. Is the mother the woman who delivers the child, or could the term mother also be applied to the genetic source of the child? Please let me remind you that the American Fertility Society has enthusiastically endorsed the egg donor program which is reserved for women who have a uterus but non-functioning ovaries. In other words, these women may have premature menopause which occurs naturally, they may have been born without ovaries, or they may not have ovaries due to a surgically induced menopause as a result of treatment for various diseases. The egg donor program is parallel to the use of donor sperm which has been done in this country for over a hundred years.

I might mention at this time that my concern is that the bill, in its present format, would most probably prohibit infertile couples from exercising the option of using a gestational carrier, should the bill be passed. The bill is very broad in the way it is written and does not allow those women for whom it is medically necessary to use a gestational carrier to have their genetic child. I might also mention at this time that the gestational carrier program is only utilized when it is medically necessary for a couple to utilize this means to achieve a pregnancy. Indications for inclusion into the gestational carrier program are strictly medical and it can not be utilized for social reasons or convenience. Therefore, I am asking you to compromise on the language of this bill so that it may address our concerns.

Thus, you can see it becomes increasingly difficult to legislate these definitions and therefore I suggest to you that doctors and patients work this out without the complications of legislation, particularly in the area where technology changes so quickly and for which there is no legal precedent.

At Pennsylvania Hospital, we have elected not to become involved in surrogate parenting, and I wish to reemphasize that you word the bill to exclude carriers from possible legislation prohibiting surrogacy, since the two are vastly different in respect to genetics, ethics, and psychological and emotional implications.

Finally please note that the reason why some couples may pursue a gestational carrier to have a biologic child versus adopting a child, is because adoption is a very arduous process in which only one out of ten couples ever receive a child. Lists are often over subscribed by the time our patients reach us their age prohibits them from being eligible candidates for adoptive parents. Therefore, adoption is not a viable alternative.

Gestational carrier and egg donor programs of assisted reproduction are not without legal, ethical, moral and psychological overtones. We certainly are very aware of this, and know we are sailing on uncharted waters. These programs are under the constant scrutiny of the American Fertiltiy Society and local hospital boards who demand, as in our program, extensive psychological testing prior to initiation of treatment. With proper screening and selection criteria, we are able to offer a very special service to our infertile couples and that is the gift of life.