Center for Reproductive Medicine • Advanced Reproductive Technologies
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September 13, 2016
Legislative Commission on Surrogacy

Dear Commission Members,

Paul Kuneck, M.D.
Bruce Campbell, M.D.
Lisa Erickson, M.D.
Colleen Casey, M.D.
Mark Damario, M.D.
Doug Carrell, PhD.

I am Dr. Bruce Campbell, M.D., president of the Center for Reproductive Medicine. We are a five physician infertility practice with offices in Minneapolis and St. Paul. Our clinic was started in 1987 and we are the largest clinic in Minnesota in terms of the number of IVF cycles performed annually.

It is my understanding that the Commission is looking specifically at Gestational Carrier (GC) treatment, and that today's session is primarily concerned with the business aspects of this particular treatment.

My preference would have been to attend the hearing in person to provide you with the information you seek, but put patient schedules precluded that possibility.

First, a definition is appropriate. A GC cycle is a cycle that involves an intended parent/s who supplies the egg, but is unable to carry the pregnancy and who uses a gestational carrier to carry the pregnancy. At delivery the GC presents the baby to the intended parent/s who is/are the genetic parents and the legal parents.

The word "surrogate" is frequently and incorrectly used in this context. A surrogate would supply both the egg and the uterus and give up a baby that was genetically hers to different intended parents. Traditional surrogacy is not condoned and not performed in our clinic nor in any clinics I am familiar with.

We performed our first GC cycle in 1993, and have performed 135 cycles since then. In 2014, the last year for complete data reporting to the CDC, we performed 1148 cycles of egg retrievals and frozen embryo transfers. GC cycles accounted for six of these 1148 cycles.

In 2011 we performed eight GC cycles, in 2012 18, in 2013 17 and in 2015 six. As you can see, GC cycles make up a very small part of our business.

What might be the concern of a legislative body about GC cycles? My concern would be the indication for the GC cycle. The potential is there for exploitation of poor women to carry pregnancies for wealthy women who simply don't want to be bothered with being pregnant.

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That is why in our clinics an intended parent must have a medical indication for the GC cycle. Such conditions would include being born without a uterus, having a hysterectomy during the reproductive years, having a medical condition such as severe hypertension where her physician has advised the woman it would be too dangerous for her to carry a pregnancy.

Both the intended parents and the gestational carrier and her partner meet with psychologists prior to arranging a cycle. The GC has to have delivered a baby before to qualify as a GC. She has to have a letter from her obstetrician saying she is healthy enough to carry a pregnancy. She has to have a legal agreement with the GC covering all aspects of the pregnancy. Usually additional legal work is done early in the pregnancy to make the intended parents the legal parents of the baby immediately after delivery.

We usually counsel a patient inquiring about a GC cycle it will most likely take 4-6 months before all the necessary arrangements are made to allow a cycle to start.

Although every case is different, most GC cases involve a relative or friend of the intended parent who consents to carry the pregnancy as an altruistic act for the intended parent.

Some patients do not have a relative or close friend to fulfill this role, and they utilize the services of a third party who facilitates the search for a GC. Even though a GC has been arranged by a third party, she still has to be screened as described above by the clinic involved in the cycle. These GCs will charge the intended parent for carrying and delivering the pregnancy. These arrangements are made outside of the IVF clinic performing the cycle.

While these cases are infrequent, when you are the infertile patient who could have a family only through a GC cycle, the ability to have this therapy available means everything. I see little chance for abuse of this therapy as long as the procedures currently in place to screen for abuse are followed by physicians in this field. These procedures are part of the American Society of Reproductive Medicine's guidelines outlining proper GC practice. In the 23 years we have been performing these cycles I cannot recall a situation which has caused me to question whether this therapy should be available.

Thank you for your interest in this matter, and please be assured that those of us in this field are appropriately concerned with the wellbeing of all the stakeholders involved including the infertile intended parent, the gestational carrier, and the resulting child.

Bruce F. Campbell, M.D.