Hospital Care of Gestational Carriers and Intended Families: Issues and Discussion points

Susan Guest RN, MN
Clinical Nurse Specialist
Women’s and Infants Health Program, Mount Sinai Hospital, Toronto, Ontario.

Objectives

• Highlight the limitations of the Healthcare system in the provision of care to the Intended families of a Surrogate pregnancy.
• Describe some of the challenges in caring for surrogate carriers and intended families.
• Outline some proposed solutions to these challenges.
Hospital care of the surrogate and the intended family is bound by a number of legislative documents

Vital Statistics Act
- All births must be registered within 24 hours of the event.
- Specifies that the person who gives birth is the individual who must be named on the registration as mother.
- The VSA does not permit the intended mother, even if the intended mother is the biological mother, to be registered as the mother.

Care Focus on the Surrogate Mother
- The Canadian Charter of Rights and Freedoms provides all women with the right to integrity of both body and mind and the right to make personal decisions
  - The common law views the gestating fetus as part of the woman’s body
- The surrogate retains complete control to make medical decisions and retains the right to confidentiality
- The surrogate can determine what information about the pregnancy the health care provider can share with the Intended
Gestational Carrier Agreements

- The agreement speaks to areas such as: antenatal care and sharing of health information, transfer of care and decision making of infant, level of involvement of rearing parents
- This is a contract is written outside the hospital and therefore cannot be considered a binding contract within the hospital
- Mount Sinai Hospital will not review, comment on or enforce any external agreement between the surrogate and intended
- In addition, the hospital’s compliance with the wishes of the parties will be constrained by the provisions in the legislation

The challenge presented to us

- How do we respect and value the role of the intended parent(s), as well as the birth mother?
Why a policy?

- Created in response to increased frequency of Gestational Carriers as patients
- Effort to streamline care so there is consistency
- Requirement to clarify obligations of hospital and rights of all parties within hospital

Setting Expectations for all parties

A referral to Social Work
A referral to the Clinical Nurse Specialist
What works best-
  - The earlier, the better
  - The more clear and consistent in the message, the better
  - The more we can stick to the plan, the better- (unless we need to be flexible)
Consents:

Infant Care and Decision making-
• The Birth mother will make all decisions for baby until such time as she discharges infant into the care of the intended parents
  • (Munden et al, 2011,Risk Management in Canadian Health Care)

The Breastfeeding Issue

It is possible for the intended parent to be successful in inducing lactation-
• Generally find that breastfeeding has been discussed by the couples and there is agreement to a plan
• Intended see breastfeeding as the opportunity to bond that they missed out on during the pregnancy
• Always addressed antenatally to ensure safety of breastmilk for infant.
Hepatitis B Prophylaxis

If either of intended parents are carriers then vaccination is warranted as a contact precaution for infant(s)

Documentation nightmare!

Improved consistency and streamlined all documentation in infant’s legal health record and on registration and OHIP forms

It is now clear that:

• Birth mother’s name is on the Birth Registration
• OHIP forms signed by rearing parent, and can be given to intended as long as they are Ontario residents, or are committed to living in Ontario x 3 months.
• All discharge forms can be signed by intended

   If CONSENT is signed by all parties!
Accommodation of the Intended mother

- Birth mother = our patient = a bed = EASY
- Intended ≠ patient ≠ bed
  - Gap identified in provision of accommodation to the family receiving baby
  - Difficult to bridge given limitations of hospital and MD obligations to admitted patients

NOTE: Intended parent(s) may be genetic parents

Many options were proposed for Intended:

1. Visitors with infant boarding as Level 1 pediatric admit
2. Intended mother is a visitor - stays in birthing mother’s room
3. Accommodation outside of hospital
4. Payment for accommodation - has been considered
5. Admission for breastfeeding - has been considered
6. Care by Parent room-
When an intended parent lives out of province or country

• Many challenges with International intended parents
  • Governing Law and Jurisdiction Agreement (GLJA) form should be signed as early as possible in the pregnancy

• No health coverage is issued in either case and intended need to be aware of this early in the pregnancy so they can investigate health coverage prior to the birth of the infant(s)

Transfer of infant to another hospital

• Challenges with situation where infant is transferred to another hospital
• Rights of intended to care and decision making are unclear outside of hospital
• Many hospitals do not have a policy to follow and are uncertain of the intended parents rights in their setting
The policy continues to evolve

• With each new case, there is often a new situation

• The changes in the policy over the last year have reflected the address of various issues as they have presented themselves
  • Manage cases individually

• If the situation alter the policy