

Surrogacy in Advanced Chronic Kidney Disease: Between Constitutional Protection, Legal Constraints, and the Responsibilities of Health Care Management

Joana Rocha^{1*}, Círia Sousa²

1. Nephrology Department, Unidade Local de Saúde de Braga, Braga, Portugal

2. Nephrology Department, Unidade Local de Saúde Tâmega e Sousa, Penafiel, Portugal

<https://doi.org/10.71749/pkj.149>

Keywords: Gestational Carriers; Jurisprudence; Renal Insufficiency, Chronic; Reproductive Rights; Surrogacy; Women's Health

INTRODUCTION

This critical reflection analyzes the intersection between health law, bioethics, and health unit management, focusing on the admissibility and operationalization of surrogacy in the context of advanced chronic kidney disease (CKD).

The relevance of the topic stems from a growing epidemiological reality: it is estimated that approximately 6% of women of childbearing age have CKD – a fact that presents particularly clinical, legal, and ethical challenges in advanced CKD. Under these circumstances, pregnancy may represent a life-threatening event for the mother, as well as for fetal development.¹

This analysis will develop around five fundamental axes: constitutional, normative-legal, comparative, ethical, and managerial in health.

CONSTITUTIONAL FOUNDATION: CONFLICTING RIGHTS AND PRACTICAL CONCORDANCE

The starting point lies in the structuring principle of the dignity of the human person defined in article 1 of the Portuguese Republic Constitution (PRC), which radiates effects on a set of fundamental rights relevant to the case under analysis. Among these, the following stand out: the right to life (Article 24), the right to personal integrity (Article 25), the right to the development of personality and the privacy of private and family life (Article 26) and the right to form a family and to filiation (Article 36), together with the right to the development of personality and the protection of family life enshrined in Article 26.²

Article 26 of the PRC assumes particular relevance in this context, due as it protects personality rights, including the development of personality, personal identity, and the privacy of private and family life, functioning as a constitutional basis for reproductive self-determination.²

A woman with advanced CKD remains fully entitled to these rights. The pathology cannot, in itself, translate into an implicit material limitation of her reproductive capacity, under penalty of constituting a form of structural inequality not expressly recognized by the legal system.

The constitutional protection of family life is not limited to the negative dimension of non-interference by the State, but also encompasses its positive dimension of protection the conditions necessary for the realization of the family and parental project.

Furthermore, we should consider the general protection of personality provided for in Article 70 of the Portuguese Civil Code, which protects individuals against any unlawful offenses or threats to their physical or moral personality, and may also form the basis for eventual civil liability arising from unjustified limitations on the exercise of reproductive rights.³

However, this core of rights potentially clashes with Article 64 of the PRC, which enshrines the right to health protection and imposes on the State the duty to guarantee adequate, safe and quality care.² In the case of advanced CKD, pregnancy is associated with severe clinical risks—worsening renal function, need for daily dialysis, pre-eclampsia and high maternal-fetal morbidity and mortality.⁴ Thus, a classic situation of conflict between fundamental rights arises: on the one hand, reproductive self-determination;

Received: 05/06/2026 **Accepted:** 18/10/2026 **Published Online:** 29/10/2026 **Published:** -

* **Corresponding Author:** Joana Rocha | joana.francisca.rocha@ulsb.min-saude.pt | Hospital de Baraga, Rua das Sete Fontes, São Victor, 4710-243 Braga, Portugal

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on the other hand, there is the obligation to protect health and the principle of non-maleficence.⁵ The solution cannot lie in absolute exclusion, but rather in a practical harmonization that allows for the maximum possible realization of both values. In this context, surrogacy can present as a constitutionally adequate instrument for practical agreement between these interests.

It is also important to consider Article 67, number 2, subparagraph e) of the CRP, which entrusts the State with regulating Medically Assisted Procreation in terms that safeguard the dignity of the human person.² This precept assumes special relevance in the context of Surrogacy and Medically Assisted Reproduction, requiring that the legislator's intervention simultaneously ensure protection, proportionality, and respect for the fundamental rights involved.⁶

As highlighted by the National Ethics Council for the Life Sciences, “the decision on the use of Medically Assisted Procreation techniques must be subordinated to the primacy of the human being,” rejecting any instrumentalization of the human person and demanding the protection of dignity and fundamental rights in the face of the applications of science and medical technologies.⁷ This guidance is particularly relevant in the context of surrogacy in women with advanced CKD, where the protection of human dignity must coexist with respect for reproductive autonomy.

At the level of European law, it is also important to bear in mind Article 3 of the Charter of Fundamental Rights of the European Union, which enshrines the right to the integrity of the human being, including, in the field of medicine and biology, respect for free and informed consent and the prohibition of eugenic practices.⁸ In addition, there is the jurisprudence of the European Court of Human Rights, notably the judgments in *Mennesson v. France* (2014) and *Paradiso and Campanelli v. Italy* (2017), which, although focused on the issue of filiation, reinforce the need for States to weigh the rights of the child and the family in the context of surrogacy, avoiding disproportionate restrictions on the exercise of the right to respect for private and family life (Article 8 of the European Convention on Human Rights).⁸

REGULATORY FRAMEWORK: LIMITATIONS OF LAW NO. 32/2006 AND JURISPRUDENTIAL INSTABILITY

Law No. 32/2006, in its current wording (amended, among others, by Law No. 90/2021), regulates Medically Assisted Procreation (MAR), admitting surrogacy only in exceptional circumstances and free of charge.⁹

However, our legal system restricts the admissibility of surrogacy to situations of absence of a uterus or uterine injury that absolutely preclude pregnancy. This formulation raises a central question in the case of patients with CKD: gestational inability does not stem from a uterine cause, but rather from a renal or systemic nature.

If the *ratio legis* is to allow access to biological parenthood when pregnancy is objectively impossible or medically contraindicated, there is no material basis for excluding gestational incapacity of systemic/renal origin. Therefore, a teleological interpretation of the rule is required. Indeed, such a distinction — of a merely formal nature — can lead to materially unjustified discrimination, in violation of the principle of equality (article 13 of the PRC).² From the point of view of severity and risk, the impossibility of a safe pregnancy in the context of advanced CKD is no less relevant, and could be substantially more serious.

At the same time, the practical application of surrogacy in Portugal is weakened by a context of normative and jurisprudential instability. Our Constitutional Court declared the unconstitutionality of several rules relating to surrogacy, in particular due to insufficient protection of the surrogate mother's right to change her mind.

Despite subsequent legislative revisions, a perception of legal uncertainty persists, exacerbated by delays in administrative regulation and the cautious actions of the National Council for Medically Assisted Reproduction.

In practice, this combination of legal restriction and interpretative uncertainty transforms a formally recognized right into a right that is difficult to implement.

COMPARATIVE LAW: BETWEEN NORMATIVE RIGIDITY AND PRACTICAL EFFECTIVENESS

Comparative analysis reveals weaknesses in the Portuguese model. In the United Kingdom, the legal framework for surrogacy is based on the Surrogacy Arrangements Act 1985, subsequently strengthened by legislative and jurisprudential interventions.¹⁰

Although it maintains the prohibition of commercialization, the British system is distinguished by greater legal predictability, clear mechanisms for assigning parenthood (Parental Orders) and a consolidated institutional practice.¹¹ Thus, the British model prioritizes controlled and supervised operation. In contrast, in Portugal, normative uncertainty often leads to inaction, resulting in recourse to so-called “reproductive tourism,” with displacement to jurisdictions with more permissive, possibly less regulated, regimes.¹² This phenomenon exacerbates socioeconomic inequalities and can expose the parties involved to increased ethical and legal risks.

ETHICAL PERSPECTIVE: BETWEEN AUTONOMY AND PROTECTION

Legal analysis cannot be separated from the fundamental principles of bioethics⁵:

- **Autonomy:** This must be recognized for both women with advanced CKD and surrogate mothers, implying free, informed, and accompanied consent.

- Beneficence: Surrogacy can represent the best overall clinical solution, avoiding serious risks associated with direct pregnancy.
- Non-maleficence: Refusal of access to surrogacy in high-risk cases can, paradoxically, lead to greater harm by encouraging high-risk pregnancies.
- Justice: The current limitation can translate into an unequal distribution of reproductive opportunities, penalizing women with systemic pathologies compared to those with uterine pathologies.

In this sense, the absence of safe alternatives can constitute a form of indirect institutional violence, by restricting ethically acceptable medical solutions.

HEALTH MANAGEMENT PERSPECTIVE: EFFICIENCY, RISK, AND RESPONSIBILITY

From the perspective of managing Health Units, the issue takes on a relevant operational dimension:

Efficiency and Resource Allocation

Enabling MAR can, in certain cases, represent a more efficient strategy for the National Health Service, avoiding prolonged hospital stays, intensive treatments (hemodialysis during pregnancy) and highly specialized neonatal care.

Clinical Governance

The lack of clear protocols compromises the uniformity of clinical decisions and increases the variability of treatment between institutions.

Civil Accountability

The unjustified refusal of access to reproductive solutions may give rise to legal liability, particularly within the

framework of the doctrine of loss of chance (*perde d'une chance*), applied to the reproductive context—that is, the deprivation of the opportunity to realize the parental project under safe conditions. This concept has been progressively accepted by Portuguese legal doctrine and case law, with particular relevance in the area of medical and hospital responsibility.

CONCLUSION

In the context of advanced CKD, surrogacy should be understood not as a marginal exception, but as a therapeutic necessity in certain clinical cases.

The Portuguese legal framework, although formally permissive, proves to be materially restrictive, due to a combination of normative rigidity, regulatory gaps, and jurisprudential instability.

Therefore, a reform is urgently needed to broaden the admissibility criteria for gestational incapacity of systemic origin, strengthen the mechanisms of legal security, and promote the integration of this reality into clinical practice in a structured way.

Medicine has already made possible what was previously unfeasible. It is now up to Law and Health Management to ensure that this possibility translates into an accessible, equitable, and ethically sound reality.

More than an exclusively biomedical discussion, surrogacy in the context of advanced chronic kidney disease constitutes a true problem of realizing fundamental rights, requiring proportional, constitutionally adequate, and materially egalitarian responses from legislators and health institutions.

Ethical Disclosures

Conflicts of Interest: The authors have no conflicts of interest to declare.

Financial Support: This work has not received any contribution grant or scholarship.

Provenance and Peer Review: Not commissioned; externally peer-reviewed.

Consent for Publication: Not applicable.

Contributorship Statement

JR and CS: All authors contributed to this work, approved the final version of the manuscript for publication, and agree to be accountable for all aspects of the work, ensuring the accuracy and integrity of the data presented.

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