

When people first ask, what is a surrogate, they are often using one familiar word for two very different arrangements. That difference matters. It affects the medical process, the relationship to the child, and the ethical and legal questions that come with the pregnancy.

In current U.S. Fertility practice, the arrangement most people mean is **gestational surrogacy**. In that model, a **gestational carrier** becomes pregnant through IVF and carries an embryo created outside the body. The embryo may be created using the intended parent's egg and sperm, donor egg or donor sperm, or some combination of intended parent and donor gametes. The key point is simple and important: the gestational carrier is not genetically related to the baby she carries.

That is not the same as traditional surrogacy. In a traditional arrangement, the surrogate uses her own egg. She is the person who carries the pregnancy and the genetic mother of the child. That genetic link changes the nature of the arrangement in ways that fertility professionals do not treat lightly.

If you are trying to understand how does surrogacy work, the first step is to separate these two models clearly. Once that distinction is in focus, the rest of the conversation becomes much easier to follow.

The core distinction most people miss

The phrase "surrogate" gets used casually, but in medical settings words are chosen more carefully. A **gestational carrier** is not just another term for any surrogate. It refers specifically to a person who carries a pregnancy created through IVF from an embryo that is not made with her own egg.

That distinction exists because IVF made gestational-carrier arrangements possible. Without IVF, there is no embryo transfer into another person's uterus. With IVF, an embryo can be created outside the body and then transferred to the person who will carry the pregnancy.

Traditional surrogacy works differently. Because the surrogate's own egg is used, she is not only carrying the pregnancy, she also has a genetic connection to the child. That single fact explains why traditional surrogacy is treated as a separate category rather than a variation on the same theme.

In practical conversation, people often say "surrogate" when they mean "gestational carrier." That shorthand is common, but it can muddy discussions quickly. Couples, intended parents, and even extended family members sometimes think all surrogacy follows one path. It does not. Modern clinical practice distinguishes sharply between gestational surrogacy and traditional surrogacy because the medical setup, the family-building process, and the surrounding concerns are not interchangeable.

What gestational surrogacy actually involves

At its medical core, gestational surrogacy is an IVF-based arrangement. An embryo is created outside the body, then transferred into the gestational carrier's uterus. If pregnancy occurs, the carrier continues the pregnancy and gives birth for the intended parent or parents.

That short description is accurate, but it can sound abstract until you picture the sequence. The intended parent or parents, along with any genetic contributors, go through medical and psychological screening. Embryos are created through IVF. The gestational carrier is also screened and tested. She is informed about the medical, legal, and contractual aspects of the arrangement. Then an embryo transfer takes place. If the transfer leads to pregnancy, the carrier carries the baby and ultimately gives birth for the intended family.

This is one of those areas where a brief summary can hide how structured the process really is. Fertility practices do not treat gestational surrogacy as a casual agreement. Screening exists to reduce medical complications and to make sure the people involved understand what they are entering.

A concise way to think about the process is this:

1. Intended parent or parents and any genetic contributors complete screening.
2. Embryos are created through IVF.
3. The gestational carrier is screened, tested, and fully informed.
4. An embryo is transferred to the carrier's uterus.
5. If pregnancy occurs, the carrier carries the pregnancy and gives birth for the intended parent or parents.

That sequence is straightforward, but it helps explain why the phrase how does surrogacy work cannot be answered with one sentence. It is not simply "someone else carries the baby." In gestational surrogacy, the pregnancy depends on assisted reproduction, careful evaluation, and planning well before transfer.

Why a gestational carrier is different from a traditional surrogate

The simplest answer is genetic relationship.

In gestational surrogacy, the gestational carrier has no genetic relationship to the baby. She carries the pregnancy, but the embryo was created through IVF using the intended parent's and or donor gametes.

In traditional surrogacy, the surrogate uses her own egg. That makes her both the person carrying the pregnancy and the genetic mother.

That is not a small technical detail. It shapes almost everything that follows. Medical professionals, ethics committees, and legal professionals do not regard a pregnancy with no genetic link as equivalent to one with a direct genetic link. The emotional dynamics can differ. The legal questions can differ. The ethical concerns can differ. ACOG specifically notes that traditional surrogacy is more legally and ethically complex because of that genetic connection between the birth mother and child.

People sometimes assume that all surrogacy carries the same level of complexity because any third-party pregnancy is inherently complicated. Experience shows that this is too broad a statement. All family-building arrangements deserve careful handling, but the presence or absence of a genetic link is one of the clearest dividing lines in the field.

Why gestational surrogacy became the modern standard

Once IVF became established, gestational-carrier arrangements became possible in a way that traditional surrogacy simply never addressed. That changed the field. It gave intended parents and fertility practices a path in which the person carrying the pregnancy would not also be the genetic mother.

Over time, this became the dominant model in U.S. Clinical practice. Nearly all U.S. Agencies and fertility practices favor gestational arrangements, and current medical guidance describes traditional or genetic surrogacy as rare. That is a meaningful shift. It tells you that the modern standard is not just based on popularity or language preference. It reflects the way assisted reproduction is actually practiced today.

Traditional surrogacy has not disappeared from public awareness, which is part of the confusion. It remains familiar in movies, older news stories, and everyday conversation. But familiar is not the same as common in

current fertility medicine. In real-world practice, gestational surrogacy is the framework most clinics and agencies recognize as standard.

There is good reason for that. A model with no genetic connection between the carrier and child avoids one of the major complications built into traditional surrogacy from the start. That does not make gestational surrogacy simple or easy. It does make it distinct, and in many settings more workable.

The role of screening and informed consent

One of the most important facts about gestational surrogacy is that it is not just a medical procedure. It is a medical arrangement involving multiple adults, expectations, and responsibilities. That is why professional guidance emphasizes screening and informed decision-making.

ASRM recommends screening and testing for intended parent or parents, any genetic contributors, and the gestational carrier. The purpose is to reduce medical complications. Just as important, the carrier should be fully informed about the medical, contractual, and legal aspects of the arrangement.

That phrase, fully informed, deserves more attention than it usually gets. In fertility settings, people often focus on the embryo transfer because it is the most visible step. But experienced professionals know that clarity before transfer matters just as much. Surrogacy arrangements ask everyone involved to understand not only the hopeful outcome, but also the framework around the pregnancy itself.

A rushed process is rarely a wise one here. Even when everyone is enthusiastic and aligned, informed consent is not a formality. It is part of the integrity of the arrangement. The screening process exists for a reason, and it should be treated with the seriousness it deserves.

A practical comparison

For many readers, the difference becomes easiest to grasp when the two models are placed side by side.

Topic	Gestational surrogacy	Traditional surrogacy	--- --- ---	How pregnancy begins	IVF with embryo transfer
Surrogate uses her own egg		Genetic link to baby	No genetic relationship to the carrier	Surrogate is the genetic mother	
Current status in U.S. Clinical practice	Modern standard, widely favored by agencies and fertility practices	Rare in current medical practice		Ethical and legal complexity	Present, but distinct from traditional surrogacy
Greater complexity because of the genetic link					

That table captures the central point without oversimplifying it. The difference is not cosmetic. It reaches into the structure of the pregnancy itself.

What intended parents usually need to understand early

People who are just beginning to research family-building options often jump straight to logistics. They want to know timelines, eligibility, and next steps. Those are important questions, but there is a more basic issue to settle first: what type of arrangement are you even considering?

If someone says they are exploring surrogacy, a useful follow-up is whether they mean gestational surrogacy through IVF or whether they are picturing a traditional arrangement. Many are surprised to learn that the standard route in modern U.S. Fertility care is gestational, not traditional.

That early clarification helps avoid a lot of confusion. It also prevents misunderstandings with friends and relatives who may be working from outdated assumptions. I have seen conversations derail simply because one

person was describing a gestational carrier while another was imagining a traditional surrogate. They thought they were discussing the same model. They were not.

This is where precise language earns its keep. Asking whether the carrier would have any genetic relationship to the baby usually clears up the issue immediately.

Why terminology matters more than it seems

Outside fertility care, people often treat terminology as a matter of preference. Inside fertility care, words define the arrangement.

If you call every carrier a surrogate without clarifying the type, you can accidentally flatten a major distinction. That can create confusion in consultations, paperwork, and family discussions. The term **gestational carrier** is not unnecessary jargon. It tells you something medically important, namely that the person carrying the pregnancy is not providing the egg.

Likewise, the term **traditional surrogacy** tells you this is not simply an older label for the same thing. It names a different structure, one in which the surrogate is genetically related to the child.

This is especially important for intended parents who are beginning the research process online. A great deal of public discussion still blurs the terms. Articles, forum posts, and casual conversations often use [Abundant Beginnings Surrogacy Co. Surrogacy Agency](#) “surrogate” as a blanket label, then switch without warning between gestational and traditional examples. For anyone trying to make decisions, that is more than a minor annoyance. It can lead to mistaken assumptions about what clinics and agencies actually do.

How the experience differs from the outside and inside

From a distance, all surrogacy can look similar. Another person carries the pregnancy, there is an intended family waiting, and birth marks a major transition. That broad picture is true in both gestational and traditional arrangements.

From the inside, though, the setup is fundamentally different.

With gestational surrogacy, the pregnancy begins with IVF and embryo transfer, and the carrier has no genetic link to the baby. That shapes how the arrangement is framed from the start. The medical process is designed around embryo creation outside the body and transfer into the carrier.

With traditional surrogacy, the surrogate’s own egg is part of the arrangement. That fact changes the ethical and legal landscape enough that current medical guidance treats traditional surrogacy as the less favored path and a rare one in modern clinical practice.

That distinction is why professionals in this area often sound careful, even when answering what seems like a simple question. They are not being evasive. They are trying to keep two very different models from being collapsed into one.

Common misunderstandings that deserve a clearer answer

A few points cause repeated confusion.

First, a gestational carrier is not the baby’s genetic mother. In gestational surrogacy, the carrier carries the pregnancy, but the embryo comes from IVF using intended parent and or donor gametes.

Second, traditional surrogacy is not just a different name for the same role. It involves the surrogate's own egg, which means she is genetically related to the child.

Third, when people ask how does surrogacy work, the answer depends on which form they mean. The standard medical pathway in current U.S. Practice is gestational surrogacy through IVF, not traditional surrogacy.

Fourth, screening is not optional window dressing. Professional guidance recommends screening and testing to reduce medical complications, and it emphasizes that the gestational carrier should be fully informed about the arrangement's medical, contractual, and legal aspects.

These points may sound basic, but they shape every serious conversation in this field.

Why traditional surrogacy is now rare

Traditional surrogacy is rare in modern clinical practice, and that rarity is not accidental. Professional organizations note that it raises distinct ethical and legal issues. ACOG specifically points to the added complexity created by the birth mother's genetic link to the child. ASRM notes that nearly all U.S. Agencies and fertility practices favor gestational arrangements.

That does not mean traditional surrogacy is imaginary or merely historical. It means it is not the preferred model in current fertility medicine. People who enter the subject assuming both forms are equally common usually need to recalibrate quickly.

This is one of the clearest examples in reproductive medicine of how a technical development, in this case IVF, reshaped practice norms. Once gestational-carrier arrangements became possible, they gave clinics and intended parents a different route, one that avoided the surrogate's genetic connection to the child. Over time, that route became the modern standard.

The question behind the question

Many people who ask what is a surrogate are not really asking for a dictionary definition. They are trying to understand who the pregnant person is in relation to the baby and the intended family. Are they the genetic mother? Are they carrying someone else's embryo? Is this the common route or the unusual one?

Those are good questions, and they deserve a direct answer.

If the arrangement is gestational surrogacy, the pregnant person is a gestational carrier. She becomes pregnant through IVF and carries an embryo created outside the body. She has no genetic relationship to the child.

If the arrangement is traditional surrogacy, the surrogate uses her own egg and is the genetic mother as well as the person carrying the pregnancy.

Everything else starts there.

What clear understanding makes possible

When people understand this distinction early, discussions become more grounded. Intended parents can ask better questions. Families can avoid outdated assumptions. Conversations with fertility practices are easier to follow. Most importantly, the people involved can speak about the arrangement with accuracy rather than approximation.

Gestational surrogacy is not simply a modernized label for surrogacy in general. It is a specific IVF-based arrangement in which a **gestational carrier** has no genetic link to the baby she carries. Traditional surrogacy is a different model, one in which the surrogate uses her own egg and is genetically related to the child. That difference explains why gestational arrangements became the standard in current U.S. Clinical practice and why traditional surrogacy is now rare and treated as more legally and ethically complex.

For anyone beginning this research, that is the distinction worth learning first. It is the one that makes the rest of the subject make sense.