Reproductive BioMedicine Online (2013) xxx, xxx–xxx

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ARTICLE

Growing families in a shrinking world: legal and ethical challenges in cross-border surrogacy

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Abstract Crossing national borders to have children is a rapidly growing phenomenon, fuelled by restrictions on access and technologies in some countries and for some patients, by high costs in others, and all generating a burgeoning multibillion dollar international industry. Cross-border gestational surrogacy is one form of family building that challenges legal, policy and ethical norms between countries and puts both intended parents and gestational surrogates at risk, and can leave the offspring of these arrangements vulnerable in a variety of ways, including parent–child, immigration and citizenship status. The widely varying political, religious and legal views amongst countries make line drawing and rule making challenging. This article reviews recent court decisions about and explores the legal dimensions of cross-border surrogacy.

KEYWORDS: brokers, citizenship, cross-border reproductive care, reproductive tourism, surrogacy

Introduction

Fittingly for a man of such sweeping and multidisciplinary vision, Bob Edwards' legacy goes far beyond creating a revolutionary medical technology to bypass blocked Fallopian tubes. Thirty years after Louise Brown's birth, IVF and the assisted reproduction treatments that have made it possible have literally changed the faces and compositions of the modern family (see also Franklin, 2013, this issue). By combining IVF technology with egg donation, sperm donation and gestational surrogacy, biological parenthood is now possible for a myriad of would-be parents: including same-sex couples, single parents and older women. Given the new opportunities these technologies offer for family building, it should come as no surprise that their use and impact has reached a global scale.

Yet, while the desire to have children may be universal, there is no worldwide consensus on assisted reproduction treatment. Both legal restrictions on access and legal protections available to the participants and resulting offspring vary immensely from country to country, often reflecting different if not conflicting cultural and religious values. Cer-

1472-6483/$ - see front matter
http://dx.doi.org/10.1016/j.rbmo.2013.06.006

Please cite this article in press as: Crockin, SL Growing families in a shrinking world: legal and ethical challenges in cross-border surrogacy. Reproductive BioMedicine Online (2013), http://dx.doi.org/10.1016/j.rbmo.2013.06.006

tain technologies may be unavailable in some countries (such as gamete donation, preimplantation genetic diagnosis or surrogacy). Due to religious or policy proscriptions, some countries deny access to categories of intended parents (often single persons or same-sex couples). Individuals may find that treatment in their home countries is too expensive to utilize, that the technology is not sufficiently medically advanced or that privacy protections are inadequate. This paper explores the legal dimensions and implications of international disparities on one rapidly growing treatment: cross-border surrogacy.

The incentives and risks of cross-border surrogacy

As a result of such widely divergent religious, policy and legal perspectives throughout the world, and the impact of those perspectives on access to reproductive technologies from country to country, a growing number of would-be parents are seeking treatment outside of their home countries. Consequently, cross-border reproductive care (CBRC) is now an exponentially growing phenomenon worldwide. The World Bank anticipates Indian surrogacy alone will be a US$2.5 billion industry by the year 2020 (Hyder, 2011). In 2010, the Human Fertilisation and Embryology Authority (HFEA) called 'reproductive tourism' the 'most pressing and challenging new development in assisted reproduction treatment' (Gürtin-Broadbent, 2010).

Critics and proponents alike cannot agree on what to call the phenomenon of individuals and couples seeking fertility treatments abroad, let alone how to address the daunting challenge of addressing the myriad of conflicting issues this phenomenon presents in a world that reflects deep religious, ethical, political and policy differences surrounding family building. Many refer to cross-border treatment as 'reproductive tourism' (Pennings, 2002). Programmes marketing their services to international patients often use terminology such as 'reproductive' or 'medical' holiday (Scott, 2010). In contrast, Inhorn and other anthropologists have coined the term 'reproductive exile' to refer to what they describe as forced travel for some patients seeking treatment outside their restrictive home countries (Inhorn and Pasquale, 2009). The European Society of Human Reproduction and Embryology (ESHRE) has recently recommended using the less value-laden term 'CBRC' including 'cross-border surrogacy' (CBS)' (Pennings et al., 2008; ESHRE Taskforce on CBRC, 2010). By whatever name, CBRC has repercussions for patients (be they intended parents, donors or surrogates); providers and offspring; lawmakers and policy-makers worldwide; and the public at large. Understanding the significant legal dimensions of this burgeoning phenomenon is an important first step in attempting to craft any form of an international framework or minimum guidelines.

While some providers and countries continue to offer 'traditional' surrogacy options (artificial insemination of the surrogate with either the intended father's or a sperm donor's spermatozoa, which results in the surrogate being the genetic mother of any offspring), the majority of intended parents seek, and professionals offer, 'gestational' surrogacy (IVF using the intended mother's or an egg donor's eggs, but not those of the surrogate). Although gestational surrogacy is undeniably more expensive as it requires IVF as opposed to artificial insemination, it avoids any genetic connection between the child and the gestational surrogate. This reduces the legal risk that the surrogate will be considered the legal mother in many jurisdictions around the world which, in contrast to the UK, recognize motherhood based on genetics and/or intention rather than gestation in the context of surrogacy. This article, and the presentation on which it is based, focuses primarily on cross-border *gestational* surrogacy ('CBS').

In December 2010, a groundbreaking, multidisciplinary conference on CBRC was held in Cambridge, UK: 'Cross-border reproductive care: ethical, legal and socio-cultural perspectives', with the proceedings published in 2011 in this journal (Symposium: CBRC, 2011). Chaired by two internationally prominent anthropologists, Marcia Inhorn and Zeynep Gürtin, the 16 presentations explored many of the critical issues in this field, and identified four primary categories of 'drivers' for patients seeking CRBC: (i) legal and religious prohibitions; (ii) resource considerations, such as cost, lengthy in-country waits or fewer available assisted reproduction facilities or treatments; (iii) quality, including success rates and safety concerns; and (iv) personal preferences, including patients choosing to travel abroad for cultural, family or privacy reasons.

Examples of such restrictions abound. In Western Europe, legal restrictions in Belgium, France, Germany, the Netherlands and Italy all deny IVF treatment to same-sex couples. In May 2013, France enacted legislation recognizing same-sex marriage (Smith-Stark, 2013). Public debate had been spirited in that country, with public rallies and outcries by opponents of the law (Alpert, 2013). Spain passed legislation recognizing same-sex marriages in 2005, but objections to the law by the country's conservative Popular Party were only finally rejected by that country's Constitutional Court in 2012 (Votava, 2012). In 2005, Italy enacted restrictive laws that replaced a much more liberal legal structure which had made it an assisted reproduction treatment destination before the Catholic-based government took over; until overturned by the European Court of Human Rights in 2012, Italy had also prohibited preimplantation genetic diagnosis (Costa and Pavan v. Italy, 2012).

In the UK, both surrogacy and gamete donation are highly regulated through a series of comprehensive laws, including the 1985 Surrogacy Arrangements Act (and amendments) and the Human Fertilisation and Embryology Act (first enacted in 1990 and amended in 2008, and subsequent regulations). Commercial surrogacy, facilitating commercial surrogacy arrangements and payments to surrogates above 'reasonable expenses' are all prohibited. Centralized ongoing oversight of all assisted reproduction treatment practices in the UK is provided by HFEA, an independent regulatory authority. Effective in 2012, HFEA authorized an increase in compensation to egg donors from £250 to £750, which may dramatically reduce shortages of egg donors and long waits. Such shortages, lack of donor anonymity and long waits have historically been seen as reasons why many UK patients who can afford it seek treatment in the USA and other countries where anonymous donation and surrogacy, with compensation or payment in excess of

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actual documented expenses, is both permitted and common (Hudson and Culley, 2011).

The 2008 HFE Act amended the law to allow same-sex and unmarried couples (but not single individuals) to apply for a parental order as intended parents and regulations enacted in 2010 incorporated into the law the 'paramount consideration' of the 'welfare of the child' (Re: L (a minor), 2010, citing HFE Act § 8). Interestingly, for same-sex couples and single parents, in 2008 the HFEA also amended its 1990 statute, substituting the child's need 'for a father' to a need for 'supportive parenting' (HFE Act 2008).

Under the 1985 Surrogacy Arrangements Act, and subsequent HFE Act amendments, several restrictions were enacted to prevent professional surrogacy arrangements. While the HFE Act did not make surrogacy illegal, surrogacy agreements are not contractually enforceable, the surrogate is considered to be the legal mother, and an order transferring or reassigning legal parentage to intended parents is only permitted with her consent, which may be given only after 6 weeks have passed following birth. If married, her partner is considered the second legal parent (HFE Act § 6). Surrogate compensation is permitted only for what are deemed 'reasonable expenses' and facilitation of commercial surrogacy arrangements is a criminal offence. The law has other requirements, including that at least one of the intended parents must be domiciled in the UK and the parentage order must be applied for within 6 months of birth and while the child is living with the intended parents. While the law applies to both in-country and overseas surrogacy births, it has created an incentive for UK citizens to seek CBS.

Two separate cases from the UK, in 2008 and 2010, illustrate the legal challenges CBS can create when those families seek to return home with their child. In 2008, a married British couple contracted with a married Ukrainian surrogate, including an agreement to pay her UA$35,000 for twins, a sum clearly in excess of her actual expenses. The twins were conceived with the commissioning British father's spermatozoa and a donor egg and were born in the Ukraine. Upon the couple's return to the UK with the twins, the court was asked to exercise its 'discretionary power' to 'authorize' the arrangement (Re: X and Y, 2008) and grant the couple a parental order. One issue involved the question of payments. The court posed three questions in determining whether the payments should preclude granting a parentage order: (i) did the expenses paid offend public policy; (ii) were the parent applicants party to any attempt to defraud the authorities; and (iii) did the parent applicants act in good faith and without 'moral taint' in their dealings with the 'surrogate mother'? Answering the first two questions in the negative, the third in the affirmative, and finding that the other criteria were met, the British court granted the requested order transferring legal parentage.

In 2010, another British couple hired and paid a married US surrogate from Illinois, a state where compensated, commercial surrogacy is both allowed and where genetic intended parents are entitled to recognition of their legal parentage upon birth by a gestational surrogate under Illinois statutory law (Re: L (a minor), 2010). The UK High Court ruled that careful scrutiny was required, but under the 2008 HFE Act and 2010 Regulations, once born, the child's welfare becomes the court's 'paramount consideration' (Re: L (a minor), 2010), with Justice Hedley ruling that, 'it will only be in the clearest case of the abuse of public policy that the court will be able to withhold an order if otherwise welfare considerations supports its making' (In Re L (a minor), 2010).

Thus, notwithstanding the commercial aspect of the surrogacy, the court ruled it should not deny a 'parental order' as a result of the monetary payments. The resulting public reaction included media stories, for example captioned 'Childless couples win the right to pay surrogate mothers' (Beckford and Ross, 2012). As in other countries, British restrictions have driven a number of its citizens to more hospitable countries to undertake commercial surrogacy arrangements and risk the immigration and legal parent–child status uncertainties that accompany their return home.

Although these two British court cases permitted the transfer of parentage status to the intended parents, effectively affirming the parent–child legal status previously granted outside the country, not every case or country has been so flexible with its returning citizens, as discussed below. These uncertainties suggest the ongoing need to examine whether and how a more cohesive and predictable international framework might be created that at the same time respects the very different values and policies of many countries.

In Belgium, a same-sex married male couple met a different outcome with respect to their twins born to a Californian gestational surrogate. Despite fully complying with US law and receiving a California court's order of parentage for the two men, both a lower and appellate Belgium court refused to recognize the court order (Court of Appeal of Liège, 1st Chamber, 2010). After the lower court refused to recognize either man as the father of the twins, on appeal the Belgium High Court ruled it would only recognize one father and solely by virtue of his biological connection. The courts, citing both Belgium law and Article 27 of the Code of Private International Law, found that foreign acts regarding personal status are only recognized if they comply with comparable Belgium laws and rules. The lower court ordered the submission of the surrogacy contract and a review of the entire history between the parties and found against the men under human rights principles and conventions. On appeal, the higher court reversed in part and affirmed in part: it found that paying a surrogate is 'difficult to reconcile with human dignity', and that the surrogacy contract was 'contrary to public order in Belgium law', but that refusing to recognize the birth certificate as to the biological father would be prejudicial to the children by depriving them of any link to a parent. By allowing the biological father alone to be recognized as the children's legal father, the court left the non-biological father needing to adopt to secure his legal status (Court of Appeal of Liège, 1st Ch., 2010).

Until December 2012, IVF was completely banned in Costa Rica, based on a judicial interpretation within that country that an IVF embryo is entitled to full legal status. The Inter-American Court reversed a Costa Rican court's ruling upholding the national law (Artavia Murillo and others ('IVF') v. Costa Rica, 2012). Given the status and authoritative power of the Inter-American Court, its decision would

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appear to have a significant and potentially wide-ranging impact on any attempted restrictions on treatments and proposed laws in the Americas that would elevate IVF embryos to personhood status or prevent embryonic stem cell research. Costa Rica is the only country to ban IVF entirely and the repercussions and impact of the most recent ruling is still unfolding (Crockin et al., 2013).

In August 2012, a section of the European Court of Human Rights ruled in favour of an Italian couple obtaining preimplantation genetic diagnosis despite Italy's law precluding such treatment. The couple sought to avoid a third pregnancy affected by cystic fibrosis and the court decided the Italian law violated Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms (Costa and Pavan v. Italy, 2012). Italy has announced it is requesting referral for reconsideration to the Grand Chamber of the ECHR. At the time of writing, no appeal or reconsideration has been decided.

In 2011, ESHRE published a Good Practice Guideline for CBRC (Shenfield et al., 2011), suggesting that medical clinics co-operate, share records and attempt to facilitate easier CBRC. The countries covered are obviously limited to those practising CBRC, and, while useful in moving some transnational consensus forward in assisted reproduction, does not extend beyond Western Europe.

CBS and the USA

Why do international patients come to the USA for surrogacy and what legal and ethical issues does it raise?

The USA has generally liberal gestational surrogacy laws. Although there is no federal surrogacy or parentage law in the USA, and each state makes its own such laws, there is a substantial number of states with relatively liberal laws and policies surrounding the assisted reproduction treatments and gestational surrogacy. A growing number of states, by statute or court decision, authorize prebirth or post-birth orders for intended parents, at least for married couples with a genetic tie to the child (embryo, spermatozoa or eggs), thereby establishing a legal relationship between intended parents and the child upon birth (Crockin and Altman, 2013). This can make a post-birth adoption unnecessary (at least for heterosexual couples whose marriages are legally recognized in all states) and protects intended parents' legal status vis-à-vis both their gestational surrogate and one another (the latter can be important if donor eggs or spermatozoa were used). When there is no genetic connection to the child, establishing legal parentage can be less predictable and is much more variable from state to state.

International differences in legal recognition of same-sex marriages can also create complex legal issues and vulnerable families for those who come to the USA or other countries for surrogacy and wish to return home with their child. Same-sex couples, especially male same-sex couples, from countries that do not recognize their marriages, can be a particularly vulnerable patient group who pursue CBS or even interstate surrogacy within a country such as the USA. Currently, most same-sex couples creating families through any form of assisted reproduction treatment in the USA are strongly advised to undergo post-birth adoption regardless of their marital status in order to ensure recognition of their joint legal parentage in any state they may move or travel to (Crockin and Altman, 2013). There are fast-moving developments in same-sex marriage in the USA: nine states and the District of Columbia now recognize same-sex marriage, with three of those just enacted in the most recent 2012 election cycle (Maine, Maryland and Washington). One federal law, the Defense of Marriage Act or DOMA (1 U.S.C. § 7; 28 U.S.C. § 1738C) enacted in 1996 in reaction to the growing number of states recognizing same-sex marriage, permits any state to disregard a same-sex marriage entered into in another state. The law, however, has been ruled unconstitutional at an intermediate appellate level by two federal circuit court rulings (Massachusetts v. USA, 2012; Windsor v. USA, 2012).

The Obama administration subsequently announced it will not defend the law against future challenges (US Department of Justice, 2011), and in March 2013 the United States Supreme Court heard arguments in the Windsor case, as well as a second case challenging the validity of California's effort to repeal its same-sex marriage law (Golinsky v. USA, 2011), that may determine the fate of DOMA in that country. Decisions in those cases are anticipated by the end of that court's 2013 term. Thus, it may be possible in the near future that same-sex couples within the USA will not need to worry about different treatment from state to state, although international differences are likely to remain.

Outside the USA, recognition of same-sex marriage is also occurring in a growing number of countries. Denmark recognized same-sex marriage in 2012, the same year Spain's high court rejected a challenge to legalized same-sex marriage, and in France, a final vote on the issue, which is supported by the government, occurred in 2013 (Masci et al., 2012).

As same-sex marriage becomes more accepted and legally recognized across the world, the incentives for same-sex couples to utilize CBRC in the USA may come to more closely align with those of different-sex couples. In home countries that recognize same-sex marriage, greater access to care may mean fewer same-sex couples will utilize CBS. For same-sex couples who seek CBRC abroad for reasons such as lower overall costs, greater availability of gestational surrogates or more liberal compensation rules, returning home with their new families should not bring with it the uncertainty of being unable to legitimize the parent–child relationship for both members of the couple.

Legal and ethical concerns remain. One extreme example involving US CBS and attenuated genetic connections involved two US surrogacy attorneys, Theresa Erickson and Hillary Neiman, who created an illegal surrogacy programme involving donor embryos from the Ukraine (U.S. FBI Press Release, 2011). American gestational surrogate carriers were recruited by a third woman working with the attorneys and then sent to the Ukraine for the transfer of embryos created from unrelated donor spermatozoa and eggs. The women were told they would be matched after confirmation of pregnancy and each was then matched with an American couple who was falsely told that the woman had been abandoned by her intended, genetic parents. Court orders of parentage were obtained in California, a

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state that recognizes legal parentage based on intention at the *outset* of a pregnancy regardless of genetics. The attorneys made false representations to the court that the intended parents were the original, commissioning parents. California law requires that any agreement be entered into prior to establishing a pregnancy, so the false written representations and pleadings sent to the parties to sign and then submitted to the court were found to constitute a conspiracy to commit mail fraud, a criminal offence under US federal law (18 U.S.C. § 1343), which states: 'Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined under this title or imprisoned not more than 20 years, or both'. The two attorneys who devised and operated the scandal pled guilty to federal wire fraud charges in connection with the scheme and were each given a short jail sentence followed by home confinement (Crockin and Nussbaum, in press; Moran, 2012).

This case dramatically highlights the potential for exploitation of both intended parents and surrogates in CBS even in and between generally permissive CBS countries. While some citizens travel abroad because of restrictions within their country, these American gestational surrogates travelled from one permissive country to another because no US doctor would have transferred donor embryos without informed consent of donors, intended parents and surrogates as well as legal agreements. It may be impossible to prevent this type of elaborate criminal scheme given the sophistication and financial motivation of the attorneys involved. Nonetheless, efforts to identify, establish and ideally adhere to certain shared legal principles at least in those countries that support CBS could go a long way to making all CBS patients — intended parents and surrogates, as well as any gamete donors, and most importantly, the resulting offspring — less vulnerable.

In 2012 the American Society of Reproductive Medicine (ASRM) published professional guidelines on gestational surrogacy including a requirement for legal representation by an 'an appropriately qualified legal practitioner who is experienced with gestational carrier contracts and who is licensed [to practise] in the relevant state or states, or in the event of an international arrangement, in addition to any relevant states, the intended parent(s)' home country' (ASRM, 2012). The statement is laudatory in its goals, but neither practical nor practised in the USA, where few US attorneys are also licensed in the home country of their international patients. Many legal professionals, including this author, have suggested that a more realistic approach would be to require a separate attorney from the patients' home country and/or an immigration law specialist, be retained and consulted by patients before beginning assisted reproduction treatment in the USA.

Also in 2012, the ASRM Ethics Committee circulated a draft Statement to its membership on CBRC, attempting to address the duty of care owed by US medical professionals to international CBRC patients. That statement, which attempts to address the complex questions of scope of duty to both intended parents and gestational surrogates in an international arrangement, has received multiple comments but has not, as yet, been finalized or made available for public review.

CBS into the USA raises additional significant, potential legal, ethical and economic issues for gestational surrogates and offspring. Two major concerns are abandonment of offspring and insurance coverage for them. There have been a number of anecdotal stories of international parents who failed to return to the USA to pick up newborns in two different scenarios: the intended parents divorce prior to the child's birth or the child is born with a genetic anomaly unacceptable to them. Even where prebirth orders may have assigned legal parentage, it can be difficult if not impossible to get personal jurisdiction over foreigners. Where genetic connections are attenuated, through use of donor spermatozoa, donor eggs, and even more so if both donor eggs and spermatozoa are involved, legal parentage may be more difficult to determine and will likely very much depend on the state law where the gestational surrogate delivers (Crockin and Altman, 2013). Unlike California, most states within the USA do not base parentage on intention alone (Crockin and Nussbaum, in press).

A second, and more common, concern is insurance coverage for newborn medical expenses, especially in the event of multiples and/or premature births or other medical issues that can result in extremely high neonatal medical bills. For US citizens, most intended parents will have family medical insurance that will cover any legal child of theirs from birth. Thus, with a properly obtained recognition of parentage via statute or a court (pre- or post-) birth order, the intended parents, not the gestational surrogate, will be legally responsible for the child or children, and should have family insurance in place to cover even astronomical associated medical costs of delivery and neonatal care. With international parents, however, health insurance may not be available or specialized insurance, designed specifically for surrogacy, may be available but be both extremely costly and extremely restrictive in terms of coverage. Given such high costs and limited coverage, a number of surrogacy facilitators report they do not recommend it to their international clients. Some are prepared to negotiate with hospitals if uninsured neonatal costs are prohibitively expensive. In other instances, facilitators and attorneys have advised intended parents against obtaining a judicial prebirth order, in order to leave the gestational surrogate in place as the legal mother and her individual or family's insurance in place to cover the birth and baby. A more ethical approach, in the author's opinion, would be to obtain a prebirth order in every instance and contractually require intended parents to cover such costs (and to escrow at least some funds for that purpose) and be prepared to negotiate with the delivering hospital if necessary.

Such scenarios leave gestational surrogates and children of CBS legally vulnerable. In both, the gestational surrogate will have legal responsibility for the child, and in the insurance scenario she may also jeopardize her and her family's own insurance should her insurance company pursue a fraud-based claim.

Conflicts of interest may also arise in gestational surrogacy arrangements, with a gestational surrogate having less recourse if the arrangement involves international intended

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parents who may be less easily held accountable under their agreement. Moreover, if the same entity both facilitates the match and then represents or has a lawyer affiliated with that entity representing the intended parents for the contract and beyond, the gestational surrogate may receive only limited independent legal representation, and may not be aware of, or made aware of, the higher risks that may be associated with a CBS arrangement. As Richard Storrow noted in the seminal 2010 cross-border conference in the UK, 'a broker normally operates free of regulation and has no obligation to eschew conflicts of interest that would impede her from zealously promoting the interests of the patient' (Storrow, 2011).

Finally, as the cases cited above involving British and Belgium families reflect, significant legal problems may arise for international patients from a number of countries who attempt to return home from the USA following an otherwise uneventful and successful surrogacy and local court order of parentage. Legal recognition by a US state does not guarantee that parentage status will be recognized in their home country, as numerous international reproductive travellers have learned. Given the significant variation in countries' approaches to both parentage and citizenship, obtaining experienced and sound legal advice on these issues prior to undergoing CBS is critical. While it may not be practical for US attorneys to be licensed in foreign countries, consultations with home country counsel and/or experienced immigration counsel, would seem to be prudent, if not required, legal practice that any CBS patient should receive.

Why Americans go abroad for cross-border surrogacy

With relatively liberal gestational surrogacy laws and policies and an increasing availability of prebirth orders for intended parents, it is reasonable to ask why American patients would seek CBS. As a preliminary matter, it is important to recognize that the US family law, including child–parent status, is governed by individual state laws and there is no comprehensive federal law on surrogacy, assisted reproduction treatments or parentage. Only a few states, however, prohibit gestational surrogacy or paying for gestational surrogacy services, at least so long as payments are not tied to relinquishment of parental rights (an often expressed concern in 'traditional' surrogacy).

Yet, Americans continue to go to India, the Bahamas and other countries for surrogacy. One reason is cost. The average gestational surrogate carrier in India receives approximately $5000–7000 with the total costs for a surrogacy arrangement estimated between $18,000–30,000 (Bhowmick, 2013; Lazaro, 2011), a fraction of both the typical fees for American gestational surrogates (and more for multiples) and the total costs, given anticipated savings on medical and ancillary fees, including the facilitator's fee, legal fees and living expenses. If everything goes according to plan, the cost for an Indian surrogacy can be a third of what a US surrogacy arrangement costs (Bhowmick, 2013). Some intended parents have also expressed their belief that the legal procedures in the USA designed to protect all of the participants (and which many professionals worry only sufficiently protects the intended parents) constitute in effect 'too much red tape' that encumbers the entire process rather than protecting the participants. As one American mother who had an Indian surrogate deliver her daughter put it, 'you can sign a hundred documents [in the USA]. It doesn't matter. If that surrogate changes her mind she can sue you for that child, and often times she will win, and coming here to India, these women, they don't want my child. It's very cut and dry. They do not want my child. They want my money, and that is just fine with me' (Lazaro, 2011). Whether or not true, that view troubles some legal and ethical experts.

Recent developments impacting surrogacy in India

The appeal of Indian surrogacy may be changing, as regulations that have been under review in India for many years appear to be moving forward. Although a 2010 law has yet to be enacted, in 2012 a number of protective guidelines were put in place by India's Home Ministry and have been met with mixed reviews (Bhowmick, 2013). Protections include requiring all commissioning couples to: have a letter from their home country stating that their home country recognizes surrogacy; have a notarized legal agreement with the surrogate; have the surrogacy only performed in a nationally registered assisted reproduction clinic; provide assurance that the child will be permitted entry into the commissioning couple's home country as their child and that they will care for the child; and have 'exit permission' and a certificate from the treatment clinic confirming that the commissioning couple has fully discharged its obligations to the surrogate. The guidelines also require the couple be married a minimum of 2 years and gay marriage is not recognized in India. This final guideline is being interpreted to preclude Indian surrogacy for single intended parents and gay couples, a change of policy that is significant and being met with strong resistance. Thus, surrogates carrying pregnancies for gay men have expressed concerns about the impact on their pregnancies, whilst facilitators from countries such as Israel, who have regularly sent unmarried commissioning parents to India for surrogacy, are reportedly looking to other countries (Bhowmick, 2013). Whether the guidelines will be implemented as drafted, and their impact, is yet to be seen.

Published reports of outcomes from Indian–USA surrogacy arrangements to date have been mixed: many report less expensive arrangements, excellent medical care and easy re-entry into the USA. Other reports, however, are more concerning, involving lack of informed consent for gestational surrogates, including illiterate gestational surrogates, mixed-up embryos where DNA analysis proved that the intended parents were not the genetic parents as promised (Westhead, 2010) and multiple cases where expenses added up to more than anticipated and more than a US arrangement would have entailed. In short, the picture is quite varied and many ethicists and legal commentators have expressed concern over the impact on Indian women who agree to be surrogates (Bhowmick, 2013).

Legal cases, like those involving the Indian-born Balaz twins (Balaz v. Anand, 2009), continue to make news and present cautionary vignettes. In this case, a married Ger-

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man couple called Balaz used donor eggs and hired a married Indian gestational carrier who delivered twins for them in 2008. The twins' birth certificates initially issued in India listed the German wife's name as the mother; after the couple noted an error on the twins' birth date they petitioned an Indian court to correct the error. The Indian court then not only corrected the twins' birth certificates to reflect the corrected birth date but also replaced the intended mother's name with the gestational surrogate's name on the twins' birth certificates. That court also withheld the twins' passports as an international controversy over their parentage and nationality escalated. While India recognizes a surrogate, and not an egg donor, as a legal mother, only Indian citizens may adopt so their German father could not adopt the twins in India under Indian law. However, because surrogacy is not recognized under German law and German nationality transfers through the mother, Germany refused to recognize the wife as the mother, refused to recognize the children as German citizens and denied the twins German passports. The courts and two countries were in a virtual standoff for 2 years, while the twins remained in India, without passports and potentially stateless. Ultimately, an informal resolution was reached where India bent its own rules to allow the couple to adopt in India and Germany was therefore willing to recognize the wife's maternity by virtue of the adoption (Mahapatra, 2010). At the age of 2, the twins were permitted to go home for the first time.

Conclusions

There is little question that cross-border surrogacy is here to stay. Whether and how it may be possible to create an internationally acceptable framework, or at least basic legal principles, for this global phenomenon is a challenge that has to date eluded legal and ethical scholars, and law- and policy-makers alike. Legal complications have arisen in both restrictive and liberal countries. Even countries that prohibit surrogacy altogether or prohibit compensated surrogacy, have in many individual cases allowed the return of their citizens and judicially accorded legal recognition to their children. Yet, others, such as Belgium, have required an adoption. Some countries, such as Turkey, have gone so far as to put in place extraterritorial restrictions that are difficult, if not impossible, to enforce against patients and thus may have more symbolic weight than actual impact (Gürtin, 2011; Storrow, 2011; Urman and Yakin, 2010) Those same laws, however, restrict medical professionals from even informing their patients about international resources and may have a significantly chilling effect on the practice of medicine in those countries. Some scholars suggest that such extreme laws create 'reproductive exiles' of their citizenry and a sense of disenfranchisement that is extremely troublesome (Gürtin-Broadbent, 2010), and as the cases discussed here suggest, even in countries that restrict compensated or commercial surrogacy, a number of courts in individual cases have found it in the best interest of a particular child to find a way to assign parentage.

In July, 2011, the Council on General Affairs and Policy of the Hague Conference on Private International Law instructed its Permanent Bureau to consider the thorny questions arising from international, cross-border surrogacy' (HCCH, 2011). The mandate 'requires the Permanent Bureau to gather information on the practical legal needs in the area, comparative developments in domestic and private international law, and the prospects of achieving consensus on a global approach to addressing international surrogacy issues' (HCCH, 2011). No proposals have been suggested to date; not surprising given the enormity of the task.

CBS presents both a daunting challenge and a significant opportunity. It has created possibilities for family building that were heretofore impossible while at the same time opening the possibilities of exploitation for potential surrogates and at times intended parents; it is fuelled by commercialization in some countries coupled with prohibitions in others; and it produces children whose legal status and citizenship may be uncertain. Given both the serious stakes for a rapidly growing number of participants worldwide, including intended parents, gestational surrogates, donors and offspring, as well as the enormous amounts of money changing hands in this burgeoning international industry, the goal of attempting to reach even minimum consensus principles for cross-border surrogacy is a worthy one. But, the vast differences in values and polices amongst the countries involved will make these challenges extremely perplexing to resolve.

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Acknowledgements

The author would like to thank Nicholas Connell, Georgetown University Law Centre 3L, for his assistance in the preparation of this article.

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Declaration: The author reports no financial or commercial conflicts of interest.

Received 5 March 2013; refereed 24 May 2013; accepted 4 June 2013.