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REVIEW

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

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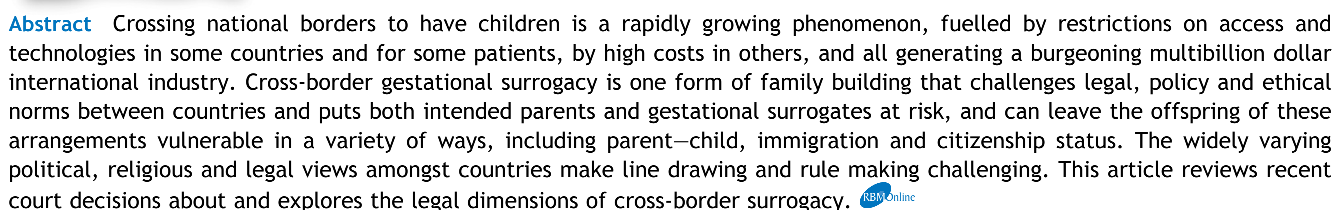

Abstract Crossing national borders to have children is a rapidly growing phenomenon, fuelled by restrictions on access and technologies in some countries and for some patients, by high costs in others, and all generating a burgeoning multibillion dollar international industry. Cross-border gestational 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.

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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. 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

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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. Certain 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

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