

Chapter 10

Domestic and International Surrogacy Laws: Implications for Cancer Survivors

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Introduction

Much of the focus in the new field of oncofertility has been on preserving cancer patients' fertility prior to treatment that is likely to diminish their fertility or render them sterile. Less attention, however, has been paid to the logistics of using frozen eggs, embryos, or ovarian tissue following cancer treatment. It is usually assumed that, following some manipulation, the frozen eggs, embryos, or ovarian tissue will be transferred back into the women's bodies via assisted reproductive technology (ART) so that they can become pregnant. Some women, however, cannot utilize this technology because their cancer treatment has left them unable to gestate. If these women desire biological children and have banked eggs, embryos, or ovarian tissue, then the only option available to them is surrogacy¹. Our goal in this chapter is to examine the availability of surrogacy¹ to cancer patients. To this end, we will provide an overview of both domestic and international surrogacy laws and discuss their impact on cancer survivors and others seeking surrogacy.

This chapter is divided into five parts. In the first part, we present the types of cancers and cancer treatments that can leave a woman unable to gestate. In the second part, we outline different types of surrogacy arrangements. The third part is where we examine surrogacy laws in the United States, explaining how early surrogacy cases led to different state laws. We explore international surrogacy laws in the fourth part, categorizing them by degree of regulation and highlighting one country that exemplifies each category. In the last part, we discuss surrogacy tourism as an option for cancer survivors and underscore the importance of fully informing cancer patients about surrogacy, including potential legal barriers in utilizing it, before they make fertility preservation decisions prior to cancer treatment.

The Inability to Gestate Due to Cancer and Cancer Treatment

Various cancers and cancer treatments can result in a woman being unable to gestate. Frequently, one of five types of gynecologic cancers (uterine, ovarian, cervical, vaginal,

¹ It is important to note that we are only dealing with the legal side of surrogacy. We are not making any normative claims about the morality of surrogacy.

and vulvar) is the underlying cause. In the United States and similarly developed countries like France, uterine cancer tends to have the highest incidence rate of the group. In lesser developed countries like Brazil and India, it is not uncommon for the incidence of cervical cancer to be higher than that of uterine cancer (See Fig. 10.1) [1]. Like most cancers, the three main treatment options for gynecological cancers are surgery, radiation therapy, and chemotherapy (or any combination of the three). Given their location, any form of treatment for gynecological cancer has the potential to prevent a woman from safely carrying a fetus to term.

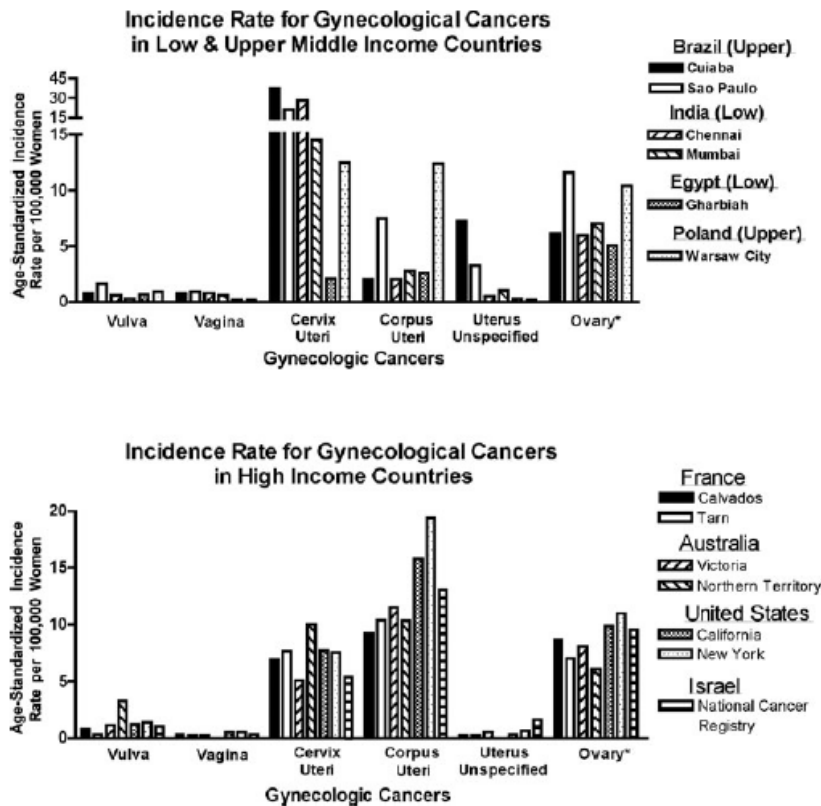


Fig. 10.1 Incidence of gynecological cancers around the world. * – Special care should be taken in comparing ovarian cancer incidence rates because of recent changes in coding and classification. See original source for more details. Age-Standardization – See original source for the demographics of the population used for standardization. Sources: *Incidence Rates* – Curado et al. [1] *Country Income Classifications* – The World Bank, July 2009 (<http://go.worldbank.org/D7SN0B8YU0>)

Surgery for gynecological cancers can entail a hysterectomy – the removal of the uterus – thereby eliminating any possibility of gestation. Under certain conditions, a hysterectomy may be performed to prevent cancer. Endometrial hyperplasia, a condition in which there is an increase in the number of cells lining the uterus, is one example [2]. Some surgical procedures, however, allow for the possibility of gestation. For instance, a woman who has undergone a radical vaginal trachelectomy (the removal of the cervix, part of the vagina, and the lymph nodes in the pelvis) may be able to experience pregnancy [3]. However, women who have had this procedure have been observed to have a high rate of delivering prematurely [4].

Radiation to the pelvic area to treat gynecologic cancers increases the risk for pregnancy-related complications. Such complications include spontaneous miscarriages, preterm labor and delivery, low-birth-weight infants, and placental abnormalities, and their likelihood is dictated by the dosage and specific location of the radiation. There are several explanations for the occurrence of these complications. First, radiation may cause a reduction in the size of the uterus. Second, possible uterine vasculature damage may lead to decreased fetoplacental blood flow. Third, damage to tissue may prevent the uterus from being able to accommodate the growth of a fetus. As cancer continues to be detected at younger ages, it is important to note that the negative effects of radiation on the uterus are thought to be greater in prepubertal girls [5].

For radiation therapy not directed in the pelvic area, there is potential risk of hindering fertility if the hypothalamic-gonadal hormonal axis is altered or damaged. This axis helps regulate the hormones estrogen and progesterone, which play key roles in regulating menstruation and maintaining a viable uterus [5].

Chemotherapy can affect fertility in a similar fashion by altering hormone regulation. Tamoxifen, a chemotherapeutic agent used to treat breast cancer, has been found to increase a woman's risk for uterine cancer by causing an increase in estrogen production [6]. The use of Tamoxifen as a chemopreventive agent for those with an elevated risk of developing breast cancer has risen. However, it is not the only cancer preventative measure that can affect fertility. Women with BRCA mutations may decide to have their ovaries removed to reduce their risk of ovarian cancer thus causing them to rely on IVF (in vitro fertilization) or surrogacy to have a biological child.

In various international clinics, the most common reason why women pursue surrogacy is because of a hysterectomy (see Table 10.1) [7–9]. Consequently, as our society continues to be more active and aggressive in treating cancer, it is important that patients who have had a hysterectomy are knowledgeable about the available fertility options, including surrogacy. However, surrogacy is not always an easy option due to various domestic and international laws.

Types of Surrogacy

With advancements in the preservation and transferring of gametes, surrogacy (along with other ART) has further challenged how we define parents. Today, there are three parental roles in any surrogacy agreement. The first is the role of

Table 10.1 Indications for treatment by IVF surrogacy around the world

	British clinic [7]	American clinic [8]	Australian clinic [9]
Following hysterectomy (%)	48	45.5	40
Damaged or congenital absence of the uterus (%)	17	13.4	24
Repeated failure of IVF treatment (%)	17	N/A	16
Recurrent miscarriage (%)	13	N/A	8
Severe medical conditions incompatible with pregnancy (%)	5	N/A	12
Total number surrogacies	37	112	25

the intended or social parents. These are the people who intend to raise the child; they are the ones usually considered the child's legal guardians. Both women and men can be social parents and most children have one or two social parents. Second, the biological parents are the ones who are genetically related to the child. Every child has exactly one biological mother and one biological father. The third role is that of the birth or gestational mother, that is, the woman who carries the fetus and ultimately gives birth to the child. There can only be one birth mother and no birth father since men cannot experience pregnancy. An individual can fulfill one or more of these parental roles.

While there are numerous possible permutations for fulfilling these roles, there are two common surrogacy arrangements. The first is traditional surrogacy, where the surrogate or birth mother is also the biological mother and the intended father is also the biological father. In this situation, the surrogate mother is usually artificially inseminated with the intended father's sperm. Before IVF became broadly available, traditional surrogacy was the only type of surrogacy infertile couples could use. For many heterosexual couples, the significant disadvantage of this type of surrogacy is that the intended mother is not also the biological mother. As IVF became more common and accessible to the general public, another type of surrogacy burgeoned: gestational surrogacy. The only difference between this type of surrogacy and traditional surrogacy is that in gestational surrogacy the birth mother is not genetically related to the child. In both arrangements, the intended father and the biological father are the same person, unless donor sperm is used. IVF made gestational surrogacy possible because of an improvement in technology: physicians are now able to remove an egg from the intended mother, fertilize it with the sperm of the intended father, and then implant the resultant embryo into the uterus of another woman.

In addition to differentiating surrogacy by parental roles, surrogacy can also be classified into two types based on financial compensation. The first is altruistic surrogacy, in which the surrogate is not financially compensated for her role, though the intended parent or couple may cover any fees and costs associated with bringing an embryo to term. This type of surrogacy is most common among family members or close friends (e.g., a woman serving as a surrogate for her sister). The typical reason given for why no financial compensation is needed is that, in this type of surrogacy, the decision to be a surrogate stems from love, not from personal gain or even avarice. While the language of generosity is often employed in the other type of surrogacy – commercial surrogacy – the surrogate is financially compensated beyond expenses associated with the pregnancy. That is, the surrogate is paid for her gestational “services.” Gestational surrogacy is

typically arranged by surrogacy agencies, which collect a fee from intended parents and are responsible for the exchange of money between intended parents and surrogate.

Given the complexity of surrogacy arrangements, especially when money is involved, most people enter into contracts to ensure that all actors are aware of, and will adhere to, the rules and their responsibilities. Indeed, the purpose of a surrogacy contract, like any other type of contract, is to form a legal obligation for the involved parties to meet certain expectations and to provide legal recourse if they do not. However, the legality and enforceability of such an agreement varies not only from country to country, but also from state to state within countries like the United States and Australia. In the next sections, we will discuss the laws surrounding surrogacy in both the United States and for select international countries, exploring the social and political explanations for such laws and examining their impact on those seeking surrogacy, especially cancer survivors.

Surrogacy Laws in the United States

In this section, we will provide a brief history of the most influential surrogacy cases in the United States that established precedent for the surrogacy laws (and lack thereof) we have today. The first recognized surrogate arrangement in the United States was in 1976; from then to 1988, there were roughly 600 children born as a result of surrogacy [10]. During this time, surrogacy arrangements were generally covert and inconspicuous, with limited attention from the media and no legal regulation.

This all changed when the now infamous Baby M case garnered national attention from 1986 to 1988 [11]. William and Elizabeth Stern, a couple from New Jersey, sought gestational surrogacy because they feared pregnancy would exacerbate Elizabeth's multiple sclerosis. However, gestational surrogacy was not readily available in 1984 because IVF was in its infancy. They settled on traditional surrogacy, consulted with Noel Keane's Infertility Center of New York, and were matched with Mary Beth Whitehead in January 1985. A contract was drafted stating that for ten thousand dollars plus expenses, Whitehead would be artificially inseminated with William's sperm and upon birth, she would relinquish her maternity rights and give the child to William [12]. In addition to this contract, Whitehead handwrote a Declaration of Intent which stated that it was in the best interest of the baby for William to have "immediate and uncontested custody" [13, p. 129]. Accordingly, Whitehead agreed to name William as the father on the birth certificate and to let the Sterns name the child [13].

However, when Whitehead gave birth on March 27, 1986, things went amiss. Instead of listing William as the father, Whitehead listed her husband and named the baby Sara Elizabeth, rather than Melissa as the Sterns had requested. Because William was not named as the father on the birth certificate, he had no legal claim to the baby. Regardless, 3 days after giving birth, Whitehead gave the Sterns custody of the baby. Whitehead, however, soon regretted doing this, and out of fear, the Sterns allowed Whitehead temporary custody [12]. Refusing to return the baby in exchange for the money the contract promised, Whitehead threatened to flee if court action was pursued. This threat did not stop the Sterns from going to the county court on May 5 to enforce the surrogacy

contract [13]. When the judge ordered Whitehead to return the baby to the Sterns, Whitehead acted upon her word and fled to Florida with the baby, threatening to kill the baby if the issue was not dropped [12]. She was not found until July, and the baby was then returned to the Sterns [13].

Whitehead and the Sterns went to court to determine parental rights. In a lower court, a New Jersey judge declared their surrogacy contract valid and enforceable. Consequently, the judge terminated Whitehead's parental rights (though she was given limited visitation rights), which allowed Elizabeth to legally adopt the baby. On appeal, the New Jersey Supreme Court found the contract to be unlawful because it violated the prohibition against financial compensation for children, a law originally designed for adoption cases. Furthermore, the Supreme Court ruled that surrogacy cases should follow adoption laws, which typically allow pregnant women the legal right to reclaim full custody of the child within a given period of time. Whitehead reclaimed her maternity rights, invalidating Elizabeth's parental rights. However, William was granted full custody based on the best interests of the child. Because Whitehead had parental rights, she was granted uninterrupted and unsupervised visitation rights [13].

Only a few years after the Baby M case – from 1990 to 1993 – another surrogacy case from California was in the national spotlight: *Johnson v. Calvert*. While this case also involved a surrogate, Anna Johnson, seeking custody of the child from the intended parents, Mark and Crispina Calvert, it differed in three significant ways from the Baby M case [11]. First, gestational surrogacy was performed instead of traditional surrogacy. California law only recognizes one mother, and motherhood is based on who gave birth to the child and who is genetically related to the child. In most cases, the birth mother and the genetic mother are the same person. In this case, however, Johnson was the birth mother while Crispina Calvert was the biological mother. The lower court, as well as the California Supreme Court, gave custody to the Calverts on the basis of intent. Specifically, the Supreme Court argued that when there is a conflict between the birth mother and the genetic mother, the woman “who intended to procreate the child – that is, she who intended to bring about the birth of a child that she intended to raise as her own – is the natural mother under California law” [13, p. 360].

Second, the agreement between Johnson and the Calverts was made without a broker. Some claim that the absence of a broker partially explains why a disagreement over the custody of the child materialized. According to this line of thought, brokers screen potential surrogates to ensure that they are emotionally equipped to give up the baby at birth. For instance, many people lauded California broker Bill Handel and his Center for Surrogate Parenting for their stringent screening process, which they saw as the reason why “none of the center's 141 surrogate births has wound up in court” [13, p. 122]. Some believed Johnson's strong desire or need for financial compensation blinded her from the potential difficulties she might face in relinquishing the child and that this is something a broker would have noticed and taken into account when considering if she should be hired. Using a broker does not necessarily obviate concerns about possible broken contracts. Keane, the broker hired by the Sterns, was scrutinized for his lax surrogate screening process in the media. Keane's image was tarnished to the point that, reportedly,

the main impetus for Michigan outlawing surrogacy contracts was a state senator who wanted to shut down a surrogacy clinic in Dearborn, Michigan run by Keane [11].

Third, the media presented these two cases in different ways. According to an analysis done by Susan Markens, editorials in the *New York Times* (which more intensely covered the Baby M case) tended to equate surrogacy with “baby selling,” whereas editorials in the *Los Angeles Times* (which focused more on *Johnson v. Calvert*) often framed surrogacy as a “plight of infertile couples.” These different media perspectives can be linked to the aforementioned specifics of each case. In the case of Baby M, surrogacy was not a last resort for the Sterns. As published studies before and during the 1980s show, pregnancy does not detrimentally affect women with multiple sclerosis [14]. Additionally, the use of a broker and its associated fees highlighted the commercial aspects of surrogacy beyond compensation to the surrogate. In *Johnson v. Calvert*, the only option the Calverts had if they wanted a genetic child was surrogacy because Crispina had undergone a hysterectomy. Since the Calverts did not use a broker, the commercial aspects of surrogacy were not as blatant. The main impact of these varying media reports on the details of each case was on how public opinion in the local area was shaped, thus leading to geographic differences in how people view surrogacy [11]. These differing geographic opinions are reflected in the state laws. New York has statutes that ban surrogacy contracts and make it a criminal offense to broker contracts or engage in commercial surrogacy. In contrast, California has no state legislation regarding surrogacy, thereby leaving the courts to solve individual conflicts [15].²

In addition to media coverage of these surrogacy cases, another contributing factor to the geographically diverging surrogacy laws is the public’s view on family law. For example, California was the first state to implement the no-fault divorce and has a community property standard that requires any assets acquired while married to be split evenly upon divorce. These laws reflect an understanding of marriage and family as a contractual and commercial relationship, so permitting surrogacy contracts coheres with these existing laws. New York’s family laws do not reflect the same values of California. New York followed California in adopting a no-fault divorce option, but New York’s law that requires couples to be separated for a year before divorce is granted illustrates that marriage is viewed as more than a contractual agreement in New York state [11].

As the comparison of New York and California shows, the legality and enforceability of surrogacy contracts can vary dramatically from state to state. Each state has to determine how they want to regulate surrogacy because there is no federal legislation, though there was a push for it following both the Baby M and *Johnson v. Calvert* cases. Surrogacy laws can be categorized into three categories. The first category is comprised of laws that

² It is interesting to note that Marken’s theory – the way the local media framed surrogacy influenced state laws – may not be as relevant today as it was in the late 1980s and early 1990s due to the explosion in global media outlets, particularly the internet. If a controversial surrogacy case emerged today (perhaps one involving international surrogacy since the United States does not have laws to handle these arrangements), editorials, especially in the form of blogs, would probably be written by people all over the country, and perhaps the world, not just the local area. One can question how these presumably heterogeneous views would shape and change local laws.

permit surrogacy contracts by outlining the criteria for the contracts to be lawful and enforceable. For example, surrogacy laws in Florida require that the intended couple must be over 18 years old and married, the intended mother must be incapable of gestating a pregnancy without physical risk to herself or the fetus, and at least one of the intended parents must be biologically related to any resulting child. These requirements have to be fulfilled in order for any surrogacy contract to be legal and enforceable [15].

Rather than enumerating the necessary criteria for surrogacy contracts to be legal and enforceable, laws in the second category do the opposite by stating what is *not* legal with regards to surrogacy, such as commercial surrogacy, advertising for surrogacy, or getting paid to broker a contract. One drawback of these laws is that they do not address the legality of surrogacy contracts that do not violate the restrictions. In Kentucky, for example, statutes deny the enforceability of surrogacy contracts when compensation is given to the surrogate or if an attorney or agency is paid to negotiate the contract. However, these statutes are not clear about covering the ordinary expenses associated with a surrogacy and they only directly refer to traditional surrogacy. Therefore, it is unclear if altruistic and gestational surrogacy is also illegal [15].

Unlike laws in the first two categories, laws falling under the third category are clauses that mention surrogacy in the context of other civil laws. Like the secondary category, these clauses fail to take a clear stance on surrogacy. For example, Iowa and Alabama have included clauses within their adoption law that forbids payments in adoption proceedings in order to allow surrogates to be financially compensated. In Wisconsin, a statute was passed that outlines how a birth certificate should be issued in the event that a surrogate gives birth. The legality and enforceability of surrogacy contracts is not addressed in this or any other Wisconsin statute [15].

These categories are not mutually exclusive, so laws can fall into two or more of these categories. For example, a surrogacy law in Louisiana stipulates that a surrogacy contract can be enforceable as long as no financial payments are made. This law falls into the first two categories because it outlines how to make a surrogacy contract legal and states what is not allowed with regards to surrogacy [15].

Challenging the constitutionality of laws that restrict surrogacy has not yielded positive results. Two court rulings in Michigan attest to this outcome. In *Doe v. Kelly*, the constitutionality of a statute that banned compensation for adoption, including within surrogacy arrangements, was challenged on the basis that it hinders a person's right to procreate. The statute was found to be constitutional because it still allowed altruistic surrogacy and uncompensated adoption. In *Doe v. Att'y Gen*, the constitutionality of a law that outright banned surrogacy agreements was brought into question on the basis that it violated private, procreative decisions. The court affirmed the constitutionality of the law in question by claiming it is preventing the commodification of children, promoting the best interests of children, and preventing the exploitation of women [15].

Finally, some states do not have any laws dealing with surrogacy. Recognizing the complexity of surrogacy, especially the numerous possibilities for surrogacy contracts,

some states have concluded that legislation is not the best way to address this issue. Consequently, courts have been left with the burden of resolving conflicts and dictating informal policies within these states. Many courts defer to precedents set by *Baby M* and *Johnson v. Calvert* to resolve surrogacy disputes, such as looking specifically at whether surrogacy arrangements follow adoption laws, the best interests of the child, and who the intended parents are. These precedents have also been a guideline for some states with regards to their statutes on surrogacy. For example, Arizona and Indiana explicitly make surrogacy contracts unenforceable so surrogacy can follow adoption laws in allowing the surrogate to change her mind and keep the baby within a certain timeframe after giving birth [15] (For a summary of state laws see Table 10.2).

International Surrogacy Laws

Having explored surrogacy on the domestic level, we now turn to the international level. Just as states in the US have surrogacy laws based on their views of surrogacy, so too do countries. We have separated international approaches to surrogacy into three categories – free market, regulated, and prohibited – and examine one country in each category – India, Israel, and France, respectively.

Free Market

A free market approach permits surrogacy with limited or no government regulation. This is akin to states in the United States that have no laws or statutes regarding surrogacy. With this approach, individuals, brokers, and clinics, rather than the government, determine what appropriate measures need to be taken in order to protect all involved parties. India epitomizes the free market approach to surrogacy. Since commercial surrogacy was legalized in 2002, nonbinding suggestions from a government sponsored medical research council have been the basis for the little regulation that is present for surrogacy [16]. This has resulted in there being few restrictions on who can

Table 10.2 Summary of domestic surrogacy laws

	Regulates surrogacy contracts	Refuses to enforce contracts	Bans commercial surrogacy	Exempts surrogacy from baby-selling states	Allows "reasonable" payment to surrogate	Prohibits a third party from brokering a contract
Alabama				X		
Arizona		X				
Arkansas						
California		X	X			
District of Columbia	X		X			
Florida	X				X	
Illinois						
Indiana		X				
Iowa				X		
Kentucky		X ²				X
Louisiana		X ²				
Maryland		Z ²			Z	
Massachusetts	Y ⁴	Y ⁴			Y ⁵	
Michigan		X	X ³			
Nebraska		X ²				
Nevada	X		X			X
New Hampshire	X					
New Jersey		Y	Y			
New York		X	X			X
North Dakota		X				
Ohio						

Table 10.2 (continued)

	Regulates surrogacy contracts	Refuses to enforce contracts	Bans commercial surrogacy	Exempts surrogacy from baby-selling statutes	Allows "reasonable" payment to surrogate	Prohibits a third party from brokering a contract
Oregon		Z ⁴			Y	
Pennsylvania		Y ⁵				
Utah	X				X	
Virginia	X		X			
Washington		X ²	X			X
West Virginia						
Wisconsin				X		

States with no statutes addressing surrogacy: Alaska, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Kansas, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Wyoming.

Key: X – State Statute; Y – Court Precedent; Z – Attorney General Opinion; 2 – Commercial Surrogacy; 3 – Altruistic Surrogacy; 4 – Traditional Surrogacy; 5 – Gestational Surrogacy.

Sources: Kindregan and McBrien [15]; Rao [22].

partake in surrogacy (e.g. homosexual couples can use a surrogate) and has led to more flexibility in legally defining parents. For instance, a surrogate can relinquish her motherhood rights before giving birth and not have her name be on the original birth certificate. Additionally, it enables each clinic to be self-regulated and implement independent policies to assure a smooth transaction. The Center for Human Reproduction

in India, for example, does not permit contacts between the egg donor, surrogate mother, and the future parents. The Center only practices gestational surrogacy because of the belief that the surrogate will be less likely to form a bond with the child [17].

Regulated

A regulated approach condones surrogacy so long as it follows specific parameters. Countries with this approach fear that if left unregulated, surrogacy will likely violate public interests and cultural values. Government regulation, therefore, is necessary to restrict who can partake in surrogacy agreements and/or what types of surrogacy are permitted.

Israel, for example, has a regulated approach to surrogacy, which was achieved with the passage of the Surrogate Motherhood Agreements Law in 1996. As part of this law, the Committee for Approving Surrogate Motherhood Agreements was established to pre-approve all surrogacy agreements and ensure their adherence to regulations in order to protect all parties involved in surrogacy. In addition to written legislative surrogacy regulations, there are precedents set by the committee that serve as unofficial regulations for surrogacy contracts [18].

Israel has several regulations regarding surrogacy to protect a variety of agents: society and social values, future children, surrogates, and intended parents. While many of the following regulations also benefit individuals, their main purpose is to uphold specific social values. Some restrictions deal with who can enter into a surrogacy contract. For example, only couples with medical justification can use surrogacy; surrogacy cannot be used for convenience or cosmetic reasons. In addition, couples who already have two children are automatically denied. Moreover, only Israeli residents are allowed to enter into an agreement with a surrogate and establishing residency is not an easy task. The contract review committee recommends that couples interested in surrogacy wait at least 18 months after immigrating to Israel before submitting a surrogacy application. Another important restriction on who can enter into a surrogacy agreement is due to the taboo on incest: a surrogate cannot be related to the intended parents. Other restrictions address the types of surrogacy arrangements permitted. For instance, the intended father's sperm must be used in order to respect Jewish law to ensure the child's paternity is known. Also, traditional surrogacy is illegal because it is seen as akin to adultery [18].

In addition to restrictions to uphold social values, there are also regulations that seek to protect individuals, such as the future child. The interests of the intended child are served by requiring what is thought to be the most ideal living arrangement for a newborn. This includes allowing only heterosexual couples who are married or living together to be the intended parents. It is also required that the father be younger than 59 and the mother be younger than 48 [18].

Third, some regulations are intended to protect surrogates by restricting who can serve in this role. Surrogates must be older than 22 but younger than 40, must have given birth no more than five times, and must have undergone a maximum of two Cesarean sections. An

unofficial restriction established by the Committee is that a surrogate has to have given birth to at least one child so that she knows from firsthand experience what pregnancy involves, which will hopefully give her a better idea of whether she will be able to relinquish the baby. To protect surrogates' health, they undergo mandatory physical and psychological examinations. The results of these examinations are included in a woman's application to become a surrogate. Once a surrogate gives birth, she is entitled to 6 months of counseling paid for by the intended parents. A surrogate's legal rights are supported by mandatory legal council from a lawyer independent of the intended parents [18].

The rights of the intended parents are protected by oversight from the Committee. Intended parents are not only permitted to provide compensation above the costs of all the medical procedures, but are also expected to because surrogates give their time and may undergo suffering. The Committee must approve compensation – by requiring preapproval for all compensation, it is thought that the intended parents are protected from extra demands by the surrogate before, during, and after the pregnancy. The parents are further protected by the requirement that the surrogate must appeal to the committee if she changes her mind and wants to keep the child at any point during the process. It is believed that the Committee will rule in the best interests of the child if such a dispute ever arises [18].

Prohibition

A third approach is a legal ban on all types of surrogacy. France is one country that has taken this approach, outlawing surrogacy with the 1994 Act on Bioethics. France's position on surrogacy has been reaffirmed through additional court cases and legislation. The impetus for banning surrogacy in France was a 1991 court case involving an altruistic traditional surrogacy. The surrogate gave birth anonymously, which is legal, in order to forgo her claim of motherhood. While the intended father was able to assume custody of the child through his genetic relationship, the intended mother, who was not genetically related to the child, was unsuccessful in her adoption attempts. A lower appeals court found the surrogacy contract legal and granted the adoption. However, the higher court overturned the decision, ruling that surrogacy violates the principle of inalienability of the human body and the principle of inalienability of individual status [19].

A 2002 court case upheld France's ban on surrogacy. In this case, a French couple, Emmanuel and Isabelle, entered into a contract with a gestational surrogate in California. After the resultant twin girls were born, the couple brought the twins back to France and tried to legally adopt them. The French consulate in California was wary of this arrangement and notified officials back in France. Traditionally, when French authorities suspect that an adoption stems from a surrogacy contract, they allow fatherhood to be claimed through genetic tests. For motherhood, however, genetic contribution does not outweigh the bond created through pregnancy. In Isabelle's case, therefore, proceedings in France led to the nullification of her declaration that she was the mother of the twins. A French court could grant a woman in Isabelle's position a partial adoption, which

restricts a parent's legal rights to the child. Not having full legal or custodial rights can be problematic for a mother if the couple gets a divorce or the father passes away, as the child may not be awarded to her [19] (For a summary of international laws see Table 10.3).

Options for Cancer Survivors: Surrogacy Tourism

As our discussion of domestic and international surrogacy laws shows, the ability to use surrogacy varies widely. What does this mean for cancer survivors who are unable to gestate? In short, a cancer survivor's ability to use a surrogate greatly depends on her geographic location.³ Surrogacy tourism has emerged to fill the need of those wanting to use surrogacy, but living in a place where it is highly regulated or banned. Domestic surrogacy is one option for those within the United States: people living in a state that bans surrogacy may set up a surrogacy arrangement in a nearby state that permits it. However, the enforceability of such an arrangement is unclear among most states as there are few laws that specifically address this issue. Washington is one state that has addressed the issue by making commercial surrogacy arrangements within and outside the state unenforceable to its residents [15]. International surrogacy is another option, and this option extends to people in countries where surrogacy is highly regulated or banned is international surrogacy. Even people in places with a limited regulatory or a free market approach to surrogacy sometimes opt for international surrogacy because it is much cheaper than domestic surrogacy. India, for example, is an attractive destination for surrogacy tourism for precisely this reason. The average cost of a surrogacy arrangement in India is approximately \$25,000, which is significantly cheaper than a conservative estimate of \$70,000 in the United States. The price for Indian surrogacy covers all medical procedures, payment to the surrogate, as well as airfare and hotel accommodations for two trips (the first trip to implant the embryo and the second one to collect the baby). The lower cost in India makes surrogacy a more feasible option for individuals or couples of a lower socioeconomic class. In addition to the lower cost, India, as discussed, has very few regulations on surrogacy and allows surrogates to waive their parental rights before birth, thus giving intended parents a higher level of assurance that they will receive the baby [17].

Although international surrogacy tourism may be the only option or a more attractive option for some, it can run into serious legal complications when the

³ Some may argue that geography should not determine one's ability to use surrogacy. They may claim that this raises various justice concerns. These concerns are outside the scope of our chapter

Table 10.3 Summary of international surrogacy laws

	Gestational surrogacy		Not mentioned	Bans traditional surrogacy	Bans altruistic surrogacy	Bans commercial surrogacy	Bans brokers	Contracts unenforceable	Case by case approval
	Allowed/used	Not allowed/not used							
Argentina		X							X
Australia	X				X				
Belgium		X							
Brazil	X								
Canada	X/X		X			X			
Chile									
Colombia	/X								
France		X		X		X			
Germany		X					X		
Greece	X/X				X				
Hong Kong	X/?						X		
India	X/X							X	
Israel	X/X								X
Italy		X			X				
Japan		X		X					
Jordan		/X							
Mexico									
New Zealand	X/X					X		X	
Norway		X							
Romania	/X								
South Africa	X								X
Sweden		X				X			
Switzerland		X							
Thailand	X								
United Kingdom	X/X					X		X	

Sources: American Society for Reproductive Medicine [23]; Schuz [18]; Daniels [24]; Kindregan [15]; Werb [25]; Bateman [26]; Keppeler and Bokelmann [27].

laws in the surrogate's country and laws in the intended parents' country reduce the intended parents' rights. A 2008 arrangement in India left a baby girl parentless – a “surrogacy orphan.” The intended parents were a couple from Japan who got divorced while the surrogate was still pregnant. As a result of the divorce, the intended mother no longer wanted any claim to the baby. The surrogate also did not want to claim the baby. While the intended father was willing to take custody of his biological daughter, Indian law does not allow single men to adopt girls, so he was denied custody rights. Also, the

father could not adopt the girl under Japanese law since the baby was still considered an Indian citizen [20]. One way to prevent similar problems from arising is for nations to establish guidelines on how a couple can establish citizenship for a child born through an international surrogate. The Australian embassy in India, for example, has outlined specific steps Australian parents need to follow in order to establish citizenship for their child after he or she is born from a surrogate in India. On its website, the embassy has the necessary forms available for download and lists recommended DNA testing labs in Australia to verify the genetic ties between the intended parents and the child [21].

Despite potential legal complications, the demand for surrogacy tourism continues to increase. In India, commercial surrogacy is growing so rapidly that the Indian Council of Medical Research predicts that it will soon become a \$6 billion per year industry [16]. Planet Hospital in California, just one of many medical tourism agencies, connected 25 US clients to Indian clinics in 2007 [17]. As cancer treatment continues to improve and to save the lives of more women of reproductive age, we can expect the popularity of surrogacy to increase due to the potential reduction or elimination of their ability to gestate as a result of their cancer treatment. Indeed, surrogacy offers female cancer survivors who cannot gestate the opportunity to have biological children, as long as they are able to overcome the legal barriers found in various geographic locations.

Conclusion

Providers who are advising patients of their fertility preservation options should include surrogacy in their discussion, rather than assume that the patients will be able to become pregnant following treatment. This is especially important for patients whose cancer or cancer treatment will probably result in an inability to gestate. In addition to general information on surrogacy, providers should mention to their patients that surrogacy is not legal in all states or all countries and that they may have to resort to surrogacy tourism. Providers do not need to be familiar with surrogacy laws in their local area, but they should be able to refer patients to surrogacy resources for more information. Knowledge of the legal barriers to surrogacy may factor into patients' decisions about fertility preservation, who may decide on another fertility preservation method in order to avoid any legal obstacles. In sum, in order for cancer patients to make informed choices about fertility preservation, they should be made aware of surrogacy as an option of having biological children and the challenges that accompany this choice.

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References

1. Curado M, Edwards B, Shin H, et al. Cancer incidence in five continents (1998–2002). Vol. IX, No. 160. Lyon: IARC Scientific Publications; 2007.
2. Uterine Cancer: Who's at Risk? *What You Need To Know About: Cancer of the Uterus* [2002; <http://www.cancer.gov/cancertopics/wyntk/uterus/page4>]. Accessed August 24, 2009.
3. Treatment. *What You Need To Know About: Cancer of the Cervix* [2008; <http://www.cancer.gov/cancertopics/wyntk/cervix/page8>]. Accessed August 24, 2009.
4. Milliken DA, Shepherd JH. Fertility preserving surgery for carcinoma of the cervix. *Curr Opin Oncol*. 2008; 20(5):575–80.
5. Wo JY, Viswanathan AN. Impact of radiotherapy on fertility, pregnancy, and neonatal

- outcomes in female cancer patients. *Int J Radiat Oncol Biol Phys*. 2009; 73(5):1304–12.
6. Tamoxifen: Questions and Answers. *National Cancer Institute: Fact Sheet* [2008; <http://www.cancer.gov/cancertopics/factsheet/Therapy/tamoxifen>]. Accessed August 25, 2009.
 7. Brinsden P. Clinical aspects of IVF surrogacy in Britain. In: Cook R, Sclater S, Kaganas F, Eds. *Surrogate motherhood international perspectives*. Portland: Hart Publishing; 2003: 99–112.
 8. Goldfarb JM, Austin C, Peskin B, Lisbona H, Desai N, de Mola JR. Fifteen years experience with an in-vitro fertilization surrogate gestational pregnancy programme. *Hum Reprod*. 2000; 15(5):1075–8.
 9. Stafford-Bell MA, Copeland CM. Surrogacy in Australia: implantation rates have implications for embryo quality and uterine receptivity. *Reprod Fertil Dev*. 2001; 13(1):99–104.
 10. Surrogate motherhood. In: Lehman J, Phelps S, Eds. *West's encyclopedia of American law*. Vol. 9, 2nd edn. Detroit: Gale; 2005:408–16.
 11. Markens S. *Surrogate motherhood and the politics of reproduction*. Los Angeles: University of California Press; 2007.
 12. Baby M, In Re. In: Lehman J, Phelps S, Eds. *West's encyclopedia of American law*. Vol. 9, 2nd edn. Detroit: Gale; 2005:431–3.
 13. Andrews L. *Between strangers: surrogate mothers, expectant fathers & brave new babies*. New York: Harper & Row; 1989.
 14. Bennett KA. Pregnancy and multiple sclerosis. *Clinical obstetrics and gynecology*. 2005; 48(1):38–47.
 15. Kindregan C, McBrien M. *Assisted reproductive technology: a lawyer's guide to emerging law & science*. Chicago: American Bar Association; 2006.
 16. Chang M. Womb for rent: India's commercial surrogacy. *Harvard Int Rev*. 2009 Spring: 3111–2.
 17. Gentleman A. India nurtures business of surrogate motherhood. *New York Times*. 2008.
 18. Schuz R. Surrogacy in Israel: an analysis of the law in practice. In: Cook R, Sclater S, Kaganas F, Eds. *Surrogate motherhood: international perspectives*. Portland: Oxford; 2003: 35–54.
 19. Hunter-Henin M. Surrogacy: is there room for a new liberty between the French prohibitive position and the english ambivalence. In: Freeman M, Ed. *Law and bioethics*. New York: Oxford; 2008:329–57.
 20. Surrogacy Orphan Trapped in Red Tape After Mothers Abandon Her. *The Times*; 2008. <http://www.timesonline.co.uk/tol/news/world/asia/article4474231.ece>.
 21. Children born through Surrogacy Arrangements applying for Australian Citizenship by Descent. *Australian High Commission: India*. [http://www.india.embassy.gov.au/ndli/vm_surrogacy.html]. Accessed September 17, 2009.
 22. Rao R. Surrogacy law in the United States: the outcome of ambivalence. In: Cook R, Sclater SD, Kaganas F, Eds. *Surrogate motherhood: international perspectives*. Oxford: Hart Publishing; 2003.
 23. American Society for Reproductive Medicine. IFFS Surveillance 07. *Fertil Steril*. 2007; 87 (4 Supp 1) S50–S51.
 24. Daniels K. The policy and practice of surrogacy in New Zealand. In: Cook R, Sclater S, Kaganas F, Eds. *Surrogate motherhood: international perspectives*. Oxford: Portland; 2003:55–74.
 25. Werb J. Gay man seeks perfect woman: surrogate mothers find a new market niche: single gay men. *Macleans*. May 21, 2007.
 26. Bateman C. New Law will say no payment to surrogate mothers. *CME: Your SA Journal of CPD*. 2007; 25:343.
 27. Keppler V, Bokelmann M. Surrogate Motherhood – The Legal Situation in Germany. *The American Surrogacy Center*; 2000. <http://www.surrogacy.com/legals/article/germany.html>