Questions of the Víctor Grífols 03 i Lucas Foundation

Surrogate pregnancy: an analysis of the current situation

VÍCTOR GRÍFOLS i LUCAS Surrogate pregnancy: an analysis

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INTRODUCTION

On 22 April, the Víctor Grífols i Lucas Foundation organized a discussion day with the title "Surrogate pregnancy: an analysis of the current situation". This has been a particularly controversial issue for bioethics, and the practice is banned in most countries. However, in a globalized world, the fact that surrogate pregnancy is permitted in some countries has opened up the possibility of people travelling to these places to engage in a practice which is banned in their country of origin.

This issue has gained particular relevance in recent months in Spain as a result of widespread media coverage of Spanish citizens who have circumvented the ban contained in art. 10 of the Assisted Reproduction Techniques Act of 2006 by entering into surrogacy contracts in countries where this is permitted. The purpose of this session was to examine surrogate mother-hood from a range of perspectives, in order to consider whether current Spanish legislation should be reformed and what direction any such reform should take.

The session was chaired by Francesca Puigpelat, Professor of Legal Philosophy and Co-director of the Postgraduate Programme in Gender and Equality at the Autonomous University of Barcelona, and Ventura Coroleu, Head of the Reproductive Medicine Department at the Dexeus University Institute and President of the Spanish Society for Fertility. The participants were: Itziar Alkorta, Senior Lecturer in Civil Law; Montserrat Boada, Director of the Assisted Reproduction Laboratories at the Dexeus University Institute; Victòria Camps, President of the Víctor Grífols i Lucas Foundation; Diana Guerra, psychologist with IVI Barcelona; Juan Ortiz, lawyer and legal coordinator of NQ Abogados España; and Carme Valls-Llobet, Specialist in Internal Medicine and Endocrinology and President of the Centre for Research into Health Programmes (CAPS) and of Fundació Catalunya Segle xxI.

Participants were invited to present a short text considering the issue of surrogate motherhood from their professional perspective. Ventura Coroleu

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and Montserrat Boada considered the medical and biological aspects, Diana Guerra focused on the psychological and sociological implications, while Juan Ortiz explained the position in India, one of the countries in which this practice is most widespread. Carme Valls raised the issue of whether we need to reform existing legislation in this area, Francesca Puigpelat considered the issue from the perspective of women's reproductive rights, and Itziar Alkorta proposed a possible approach to reform based on the British model. This publication brings together these texts and the conclusions drawn from them.

Francesca Puigpelat

Medical and biological aspects of surrogacy
Montserrat Boada

Montserrat Boada and Bonaventura Coroleu

Introduction

The World Health Organization (WHO) estimates that there are currently around 80 million couples in the world with fertility problems which prevent them from having children. In Spain, 16% of couples of childbearing age are affected by fertility problems.

Historically, traditional reproductive medicine, which often bore more resemblance to alchemy than to conventional medical science, could do little to help in those cases which required medical treatment or surgery. During the last two decades, the situation has changed radically as a result of the consolidation of assisted reproduction techniques including ovulation induction, artificial insemination (AI) and *in vitro* fertilization (IVF).

Using gametes either from the prospective parents or from donors, assisted reproduction techniques (ART) are currently able to solve a huge range of fertility problems: both female (e.g., anovulation, endometriosis, fallopian tube obstruction, ovarian failure), male (e.g., oligoasthenospermia, azoospermia, vas deferens obstruction, genetic factors), and combined. However, the only way for a woman who does not have a uterus to have her own children is by surrogacy, employing a combination of assisted reproduction techniques and the use of another woman's uterus for gestation.

From a practical point of view, however, surrogacy is only permitted in very few countries, as a result of which it may not be a realistic option for many. Differences between the legislation in different countries leads to a situation which encourages the flow of patients from countries where surrogacy is banned to those where legislation is more permissive or even non-existent (a specific instance of the wider phenomenon of "cross border reproductive care"). Women or couples for whom surrogacy is the only reproductive option and who live in countries such as Spain, where the practice is illegal, usually travel to other states in order to pursue this course of action. Spanish couples generally travel to the USA, and in particular to California, although recently there has been a trend towards other countries where this technique is available at lower cost, such as India, but where quality and standards can-

not always be guaranteed. The medical and social conditions in which surrogacy occurs vary widely from country to country, and to ensure good medical practice, in the interests of both doctor and patient, financial cost should not be the sole factor on which to base the choice of centre where the surrogacy procedure is to be performed.

The first pregnancy achieved as a result of *in vitro* fertilization and the transfer of embryos to a surrogate mother was published by Utian *et al.* in 1985. However, the lack of any official record of surrogate pregnancies means that there is no real data available, and it is therefore to know how many children have been born to date using this technique.

It would also be wrong to discuss this issue without mentioning the importance and usefulness of adoption as an alternative to surrogacy in which neither of the prospective parents make a biological contribution to the process.

Definition

Surrogacy is a treatment option for mothers who are unable to become pregnant or for whom it is contraindicated, and which allows them to have children who are genetically their own.

The term *surrogate pregnancy* is applied when gestation is performed by another woman, the *carrier* or *surrogate mother*; the woman on whose behalf the pregnancy is undertake is termed the *intended mother*.

Medical indication for surrogate pregnancy

The medical indications for surrogate pregnancy typically relate to women's health issues, either due to the absence of the uterus or for other reasons.

Absence of uterus

- Congenital: for example, Rokitansky syndrome.
- Acquired: hysterectomy; benign conditions, the most common of which is severe fibroids; malignant tumours.

Presence of uterus

- Non-functional uterus: of gynaecological origin, such as multiple myomatosis (whether operated upon or not, severe Asherman's syndrome, etc.); endometrial atrophy as a result of pelvic radiotherapy treatment.
- Functional uterus: gestation is also contraindicated in other medical conditions, including kidney disease and immunological, rheumatological and oncological pathologies. (The category of medical indications does not include causes with a psychological origin or considerations of an aesthetic nature.)
- Functional uterus but with a history of reproductive failure: repeated failure with IVF (sterile or infertile women); repeated miscarriages (infertile women).

Other situations

Recently, some prospective parents have turned to surrogacy as a reflection of the different models of family life which exist in today's society. Examples include male homosexual couples or single men. In these cases, rather than being the solution to a female medical problem, surrogate pregnancy is a response to the fact that there is no woman to bear the child and the resultant need to find a surrogate mother.

Classifying surrogacy on the basis of the intended parents

- **Heterosexual couple:** if there is another medical problem, apart from those relating to the uterus, the intended parents may need to use oocytes and/or sperm from donors.
- Woman with no male partner (lesbian couple or single woman): donated sperm is required. If there is another medical problem, in addition to that relating to the uterus, the intended parent(s) may need to use donated oocytes. This could come from the surrogate mother or a third woman who will act solely as the oocyte donor.
- No female intended parent (male homosexual couple or single man): in this case, in addition to a surrogate mother to gestate and give birth, an oocyte donor will be required, who may be the surrogate mother or another woman.

Classifying surrogacy on the basis of the participation of the surrogate mother

- Surrogate mother's participation is limited to gestation and birth. the child is the biological offspring of the intended parents and receives no genetic contribution from the surrogate mother. In the case of a heterosexual couple, the child is the biological offspring of a sterile couple (the intended parents).
- In addition to gestating the foetus, the surrogate mother also donates her oocytes. The child will have genetic material from the surrogate mother and from the intended father.

In any of the situations above, if the woman does not have a male partner or if he suffers from azoospermia, then donor sperm may be used, in which case the child will not inherit any genetic material from the intended father.

Assisted reproduction techniques for surrogate pregnancy

Artificial insemination (AI)

Artificial insemination is the process by which sperm is placed into the uterus to facilitate contact between the sperm and the oocyte without sexual intercourse occurring. AI can be classified according to whether the sperm comes from the intended father or from a sperm bank. Thanks to sperm washing and sperm preparation techniques, it is possible to remove seminal plasma and concentrate reduced volumes of sperm with improved motility for injection into the uterine cavity.

In surrogate pregnancy, the use of AI means that the surrogate mother will always provide the female gamete (oocyte), as a result of which the offspring will inherit genetic material from the surrogate mother. Where donor sperm is also used, there will be no genetic contribution from the intended parents of the child. It is only possible to perform AI when there is no pathology of the fallopian tubes; otherwise, IVF must be used.

In vitro fertilization (IVF)

In vitro fertilization consists of a series of medical and biological procedures designed to ensure that oocytes and sperm fuse in the laboratory, with the aim of obtaining embryos which are then implanted in the uterus for gestation. IVF usually starts with ovarian stimulation using drugs whose action replicates that of hormones produced by the woman's body. The purpose of this treatment is to encourage the development of follicles which contain oocytes. The ovarian stimulation process is usually monitored by analysing levels of certain ovarian hormones in the blood or by vaginal ultrasound to identify the number and size of the developing follicles. The dose and frequency of administration depend on the clinical characteristics of each patient, and response to treatment may vary.

Oocytes are extracted by inserting a needle through the vaginal wall into the ovaries and aspirating the follicles using ultrasound. This is usually performed as an outpatient procedure, and requires anaesthesia and subsequent monitoring for a variable period. The oocytes are then prepared and classified in the laboratory. The number of oocytes extracted depends on how each individual responds to hormone treatment, and it is therefore impossible to accurately predict their maturity and quality.

Once the oocytes have been obtained, the laboratory needs sperm cells from the intended father or an anonymous donor to inseminate them. The sperm is prepared in the laboratory with the aim of selecting those sperm which are most suitable for use in fertilization. There are two different insemination procedures: conventional IVF, in which oocytes and sperm are cultivated together in the laboratory under conditions which favour spontaneous fusion, and intracytoplasmic sperm injection or ICSI, in which fertilization is achieved by injecting one sperm into each oocyte.

The day after IVF or ICSI, the fertilized oocytes or embryos are counted. The embryos are kept in the culture medium until the first cell divisions occur, and the number and quality of the developing embryos is then assessed. The embryos are kept in the laboratory for a period of from 2 to 6 days, after which they are transferred.

Embryo transfer involves depositing the embryos in the uterine cavity via the vagina. This is an outpatient procedure which does not normally require either anaesthesia or hospital admission. Hormone treatment is also prescribed to help embryo implantation. In order to reduce the risk of multiple pregnancies, by law no more than three embryos may be transferred to the uterus in one cycle. Where there are extra embryos which are not transferred during the cycle, they can be cryopreserved for use in subsequent cycles.

Surrogate pregnancy by IVF varies according to the origin of the gametes (oocytes and sperm) and whether the embryos have been transferred while fresh as part of a single cycle or after prior freezing. If embryos are transferred while fresh, the ovulatory cycles of both women (surrogate and intended mother) must be synchronized, something which is achieved

through the use of drugs. If this is not an option, then freezing all the embryos makes it possible to postpone transfer to the surrogate mother until the best moment, in accordance with her own cycle.

IVF with own gametes

This is the typical situation of heterosexual couples where the woman ovulates properly, the man does not suffer from a sperm disorder and the only problem is the absence or poor function of the uterus. In these cases, the woman undergoes ovulation stimulation and follicle puncture. The oocytes are inseminated with her partner's sperm and the embryos are transferred to the surrogate mother, whose role is thus limited to gestation. The child inherits all his or her genetic material from the couple.

IVF with donor gametes

- **Donor sperm:** this option is chosen by women who do not have a male partner (single or with a female partner) or when the man has very severe fertility problems. In these cases, the intended mother undergoes ovulation stimulation and follicle puncture. The oocytes are inseminated with donor sperm, and the child inherits genetic material from the intended mother, while the paternal genes come from the donor who provided the sperm. The surrogate mother's role is thus limited to gestation.
- **Donated oocytes:** this option is usually selected when the woman suffers from an ovulatory dysfunction, in addition to the uterine problem. In this case, two different situations may arise:
 - When the surrogate mother, in addition to gestation, also contributes the oocyte. The surrogate mother undergoes ovulation stimulation and follicle puncture, and the oocytes are inseminated with the intended father's sperm, with the result that the child will inherit genetic material from the intended father and the surrogate mother.

- When the surrogate mother's role is limited to gestation and childbirth and a third woman is the oocyte donor. The oocyte donor undergoes ovulation stimulation and follicle puncture. The sperm used to inseminate these cells comes from the intended father, and the embryos are transferred to the surrogate mother, who is only the bearer of the child. In this case, the child will inherit genetic material from the intended father and from the oocyte donor.
- Donated oocytes and sperm: this option is the least common and is chosen only when the woman has both ovulatory and uterine problems, and the man also has severe fertility problems, or where there is no male partner (single woman or woman with female partner). In such cases, there are also two possibilities, depending on whether the surrogate mother provides the oocyte or an external donor is used.
 - When sperm from a donor is used, and the surrogate mother, in addition to gestation, also contributes the oocyte. The surrogate mother undergoes ovulation stimulation and follicle puncture. The oocytes are inseminated with donor sperm, and the child does not inherit any genetic material from the intended parents: the maternal genetic material comes from the surrogate mother who provides the oocyte, and the paternal material comes from the donor who provided the sperm. Genetically, the situation is the same as in embryo donation or adoption.
 - When donated sperm is used, the surrogate mother's role is limited to gestation, and a third woman is the oocyte donor. The oocyte donor undergoes ovulation stimulation and follicle puncture. The sperm used to inseminate these cells comes from a donor, and the embryos are transferred to the surrogate mother, who bears the child. In this case, as in the preceding situation, there is no genetic contribution from the intended parents: the maternal genetic material comes from the oocyte donor, and the paternal material comes from the sperm donor.

SURROGATE MOTHER (Assisted Reproduction Technique)	ORIGIN OF GAMETES	GENETIC INHERITANCE	INTENDED PARENTS (most likely)
Limited to gestation (IVF)	Own gametes Egg + sperm cells from intended parents	Maternal and paternal: intended parents	Heterosexual couple
	Donor sperm Oocyte from intended mother + donor sperm	Maternal: intended mother Paternal: sperm donor	= Heterosexual couple with o [₹] factor = Lesbian couple = Single woman
	Donated oocytes Oocyte from donor + sperm from intended father	Maternal: oocyte donor Paterna: intended father	 ■ Heterosexual couple with ♀ factor (ovulatory + uterine) ■ Male homosexual couple ■ Single man
	Gametes from donor Oocyte from donor + donor sperm	Maternal: oocyte donor Paternal: sperm donor (no genetic contribution from intended parents)	 Heterosexual couple with ♀ factor (ovulatory + uterine) and ♂ factor Single woman with ♀ factor (ovulatory + uterine)
Gestation + Oocyte donor (AI or IVF)	Donated oocytes Oocyte from surrogate mother + sperm from intended father	Maternal: surrogate mother Paternal: intended father	 ■ Heterosexual couple with ♀ factor (ovulatory + uterine) ■ Male homosexual couple ■ Single man
	Gametes from donor Oocyte from surrogate mother + donor sperm	Maternal: surrogate mother Paternal: sperm donor (no genetic contribution from intended parents)	 ■ Heterosexual couple with ♀ factor (ovulatory + uterine) and ♂ factor ■ Single woman with ♀ factor (ovulatory + uterine)

Some conclusions

We are aware that, at present, Spanish assisted reproduction legislation prohibits surrogacy arrangements, despite the fact that, as specialists in reproductive medicine, we know that there are various medical indications where this is the only therapeutic option for reproduction. We therefore believe that this option should be available, so long as it is properly regulated and does not violate the rights either of the surrogate mother or of the intended parents. In our opinion, authorization should only be granted on a case by case basis, taking into account the medical indications, the relationship of the intended parents, their background, etc.

Authorizing surrogate pregnancy in Spain would offer advantages for our patients, who would not need to have recourse to centres in other countries to perform this procedure. The countries where this practice has been regulated have adopted very different models. The US model strikes us as excessively commercial: in our opinion, any financial payment received by the surrogate mother should be regulated by the health authorities just as it is for oocyte or sperm donors. And we believe that the Indian model may, in some regards, be considered to constitute exploitation of the poor.

The UK model appears to be the one which is best suited to the Spanish situation, although it should also allow for fair financial compensation of the surrogate mother, to make surrogacy arrangements involving a woman with no links to the intended parents a practical rather than just a theoretical option.

In order to avoid potential problems or disputes, and despite the fact that it complicates the process (because it involves three parties), a genetic contribution by the surrogate mother should be avoided, and her role should be limited to that of gestation.

Having analysed these models, we believe that it is essential to create an official register of surrogate mothers, as we have for other assisted reproduction techniques, in order to improve our knowledge of these cases and how they develop.

Psychological and sociological aspects of surrogacy
Diana Guerra-Díaz

Surrogacy arrangements probably represent one of the most controversial ways of forming new families. Surrogacy is a clinically viable practice which has found a degree of acceptance in certain situations, such as sterility due to medical causes (infertility due to absence or serious malformation of the uterus, or spinal injuries which prevent pregnancy; Abellán, Sánchez-Caro, 2009). However, surrogacy remains a focus of ethical, legal and moral dilemmas.

The method is usually understood as the identification of a fertile woman who will become pregnant and gestate and give birth to a child in exchange for financial compensation, with the intention of giving the baby to others, and in the clear knowledge that the child will not form part of the surrogate mother's family (Van den Akker, 2007). Surrogate motherhood consists of substituting the gestation of the mother who will be responsible for the upbringing of the child with the gestation of another woman who has agreed to renounce any future claim to the child. Usually, as has already been noted, this involves financial payment of the surrogate mother (Abellán, Sánchez-Caro, 2009).

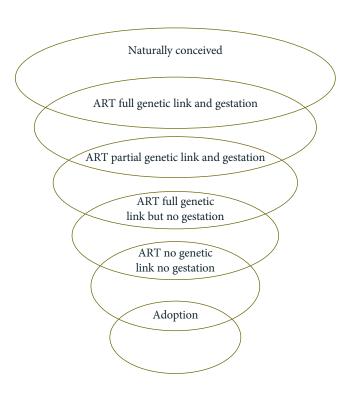
Criticisms of surrogacy have arisen from a variety of perspectives, including religious, moral and sociological. Concerns include the potentially exploitative relationship whereby poor women have children for those who are richer, particularly in cases where the surrogacy contract involves a financial transaction.

Studies of attitudes among infertile populations have show that surrogacy is the least accepted means of having a child (Dunn *et al.*, 1988), while public opinion surveys show that acceptance of surrogacy is very limited. Religious beliefs play an important role in this area, with research showing that those who practise a religion are less accepting of surrogacy as an option for themselves (Murphy *et al.*, 2002). There are also studies which show that commercial surrogacy is considered to be unacceptable, and that while noncommercial gestational surrogacy (altruistic surrogacy) is seen as being more acceptable, this is only in comparison to genetic surrogacy (Van den Akker, 2007).

Figure 1 shows that, after adoption, assisted reproduction techniques (ART) where the mother does not gestate are the least popular among the general population.

Figure 1
Spiral of preferences from genetically natural conception to adoption without genetic or biological links.

Taken from Van den Akker (2007).



Just as for adoptive families or families created using ART, it is unclear how many families have been created using this technique. There is a gap in the medical literature regarding the prevalence and experiences of these families, in part at least because of ethical concerns about the potentially intrusive nature of following up such children. However, it has been calculated that over 25,000 women have acted as surrogate mothers, giving birth legally and within the context of a commercial relationship, in the United States since the start of the 1970s (Keen, 2007).

When we talk about surrogacy, various possibilities arise: genetic surrogacy, in which the surrogate mother's oocyte is used, a practice which is not widely accepted despite the fact that it dates back to the remote past (Schenker, 1997); and gestational surrogacy, where the surrogate mother's own oocytes are not used (Van den Akker, 2007). The specific issue which arises concerns where the gametes come from, and in what combination: are the gametes of the intended parents used; are oocytes and/or sperm from donors used; do both sets of gametes come from donors; is sperm from the intended father used together with the oocytes of the surrogate mother; or, finally, is donor sperm used together with oocytes from the surrogate mother (Abellán, Sánchez-Caro, 2009)?

Some of these possible combinations of gametes in a uterus which does not belong to the intended mother may strike our European society as bizarre, and thus be rejected. Figure 2 shows the various options for conceiving a child using this technique (Van den Akker, 2007).

Strathern (2002) proposes a new terminology for understanding maternity and paternity in situations of infertility, the "new reality" of parenthood which is not based solely on chromosomes (Van den Akker, 2007).

From the psychological perspective, three questions arise (Van den Akker, 2007). Firstly, are there specific psychological or social conditions which characterize the individuals who use this procedure? Secondly, what are the psychological effects of surrogacy on the populations involved in these arrangements? And finally, what are the long-term effects on each member of the threesome and on the offspring?

Figure 2

The nine (theoretically) possible combinations of offspring when gestation is performed by the surrogate mother.



Studies among the general population show the strong negative influence of the media. The idea of surrogacy seems subversive because it appears to threaten two basic concepts which lie at the heart of western society: the family and maternity. At a time when the traditional family structure is

becoming fragmented in the face of rising divorce and separation rates, and alternative families are proliferating, surrogacy represents the most radical departure from long-held notions of what the family is (Markens, 2007).

Attitudes to traditional and non-traditional parenthood differ widely between fertile and infertile individuals. Populations who do not suffer from any fertility problems have seen no need to redefine the concept of parenthood and, as a result, maintain what Festinger (1957) calls "a consistent cognitive state". This is defined as a state of equilibrium between one's thoughts and beliefs (for example, about the family) and one's actions or behaviour (how one creates that family).

Infertile couples who choose the option of surrogacy as a solution to their problem do so only after spending a lot of time thinking about how this family pattern could function for them. That is, they pass from a state of cognitive dissonance – the choice of a surrogate mother and the use of her oocytes or their own to create a family – to a consistent one – deciding to have the child they want but cannot have by other means (Van den Akker, 2007).

In my clinical experience, most of these couples do not have the possibility of accessing other ARTs and do not view adoption as an acceptable alternative. Of the 70 Spanish cases interviewed between 2000 and 2006, only two couples were rejected because one or other of the members presented problems of mental illness upon completing the screening tests. In the remaining 68 cases, it was noted that from the point when the couples began to find out about surrogacy, 65 of them had reached a consistent cognitive state and had begun to use positive thoughts which would enable them to adapt well to the experience. In three other cases there were difficulties achieving this consistent cognitive state, as a result of which they decided not to explain the process in their family and social contacts, and sought strategies to simulate pregnancy and explain the arrival of their child.

The general assumption in our society is that a woman who offers to gestate and give birth to a child for others must be mentally ill or have questionable motives, whether this is a commercial arrangement or not. As we have noted, the traditional concept of maternity is threatened by the image of women who voluntarily renounce a child whom they have carried for months and then hand over to a couple they barely know.

Studies have been conducted to identify the characteristics and motives of women who act as surrogate mothers. They themselves recognize that this activity requires a special type of individual. One of the difficulties these studies identify is the fact that some of these women are very young and may therefore be unable to understand the consequences and potential feelings of regret about their decision after handing the baby over. At present there is insufficient information about potential mental health problems in these women, with some studies finding no disorders (Van den Akker, 2003; Hanafin, 1987), and others identifying minor psychological problems (Franks, 1981).

The most difficult aspect to study, and one which is a focus of ethical concerns, is what motivates these women to become surrogate mothers. Ragone (1994) refers to surrogate mothers in the United States as women who want to "give the gift of life". For some surrogate mothers, money is one of the reasons for fulfilling this role; a lot of the women in the study said that they did it for altruistic reasons, because they enjoyed pregnancy and childbirth, and many said that surrogacy "added something to their lives" (improved their self-esteem and self-confidence and provided the basis of an unusual friendship with the intended parents, and in particular with the mother). According to Van den Akker (2005), some of the surrogate mothers went through a stage of positive personal development. Handing over the baby was a positive event for the surrogate mothers, and many of them commented that they felt calm in the knowledge that the process was over. Feelings shifted from happiness to sadness in some of the surrogate mothers studied.

Finally, information about the consequences for families created by surrogacy is very scarce. Some argue that, as in adoption, the gestational or genetic link is less important in the mother-child relationship than the desire to have offspring (Singer, Brodzinsky, Ramsay, Steir, Waters, 1985; Golombok, 2006). The few studies conducted to date show encouraging results with respect to the mental health of children born as a result of surrogacy, and

there are no differences between children born using this technique and those born using natural methods. Some studies, for example Golombok and Murray (2004) into families who had children through surrogacy, reported good family functioning and satisfactory development of children born to surrogate mothers in comparison with a sample of families who had conceived using natural methods. The children in these studies are still too young to allow us to conclude that they will not have any problems due to having been gestated in another uterus. However, it seems unlikely that this will be a problem which prevents them from having a good relationship with their parents. What could be problematic and has yet to be studied is the fact of having been gestated using donated gametes or the possibility that the parents may have kept aspects of this secret. The few studies of this issue have found that the majority of parents who use gamete donation prefer to keep it secret, and we therefore do not know how this may affect their children in the future (Golombok *et al.*, 1996).

Surrogate pregnancy as a reproduction technique is controversial and little studied, perhaps due to the ethical, moral and religious concerns which it raises and the fears generated by the notion of creating a family by methods which differ from those found in nature. However, like other ARTs it seems important to think of surrogacy as a new opportunity for those populations who are unable to benefit from more widely accepted clinical methods.

The lack of published results in leading journals, together with limited opportunities for disseminating information and debating the issues, would appear to be holding back the normal development of a technique which, like many others, could generate new alternatives over the medium and long term, both for people with reproduction difficulties and for women who benefit from this arrangement (the surrogate mothers) both financially and personally.

It seems premature to attempt to reach a definitive conclusion as to the appropriateness or otherwise of the technique, given how few studies have actually been conducted to date. However, what research there is would appear to suggest that the social, psychological and emotional results, for the offspring, for the intended parents and for the surrogate mothers, are posi-

tive. While it is impossible to ignore the numerous instances of women being exploited in this context and of the many means which are used, outside of the margins of the law, to achieve these results, it also seems clear that the procedures and outcomes could be more closely controlled and performed in the best manner possible if they took place within a legal framework.

It is also clear that if we are to understand and accept this procedure we need to consider the results of any scientific studies conducted to date. However, in Spain there is no information about this issue, due to the fact that such practices are banned. It is important to consider whether, as a country, we are ready to add a new assisted reproduction technique to the ones which we already use. Would there be women prepared to offer their uteruses to other women? And if so, what would motivate them to do so? Should there be a family tie between the surrogate mother and the intended parents? In this respect, it is worth considering the development of other ARTs in our society, such as gamete donation. At the beginning, these techniques met with some resistance, although they now form part of the range of solutions offered to couples with fertility problems.

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Surrogate pregnancy in practice: the Indian example

Joan Ortiz Heredia

Introduction

Until very recently, when a woman found that she was unable to gestate her own children, whatever the reason - endometriosis, lack of ovulation, myomas, cancer of the uterus, Asherman's syndrome, or undefined infertility - the only option available to her was adoption. However, reproductive science and medicine have transformed this situation by offering options to all women and couples with fertility problems and making it possible for them to realize their dream of having their own children. Everyone knows that it is possible to use fertility techniques to fertilize a woman's ova with her partner's sperm or sperm from a donor; this is what is referred to as *in vitro* fertilization. This practice may help women to become pregnant using their own embryos and then give birth to a child, but it may also be used to help women who will never be able to give birth, even with embryos obtained in vitro and then transferred to their uterus, due to specific health problems (for example, very thin uterus walls). The differences between the two situations are clear: in the first, the woman may gestate the foetus in her uterus if she has recourse to in vitro laboratory techniques, and give birth to her own child; in the second, the woman may be able to have access to her own ova and, therefore, embryos, but she cannot bear her child herself or give birth to it. As a result, she would need to turn to the option referred to as surrogate motherhood.

Surrogate motherhood

Existing reproductive science techniques allow us to help women and couples with fertility problems through IVF treatment and implanting embryos in another woman who does not suffer from health problems and has the demonstrated capacity to give birth. However, in Spain there is legislation forbidding such practices (art. 10 of Act 14/2006, of 26 May, on Assisted Reproduction Techniques).

In practice, we can distinguish between the following surrogate motherhood situations:

- Woman who is able to become pregnant but who, for whatever medical reason, suffers from repeated miscarriages; doctors may even recommend that she avoid becoming pregnant to protect her own health. In this case, it would be possible to obtain the woman's own embryos, by using IVF techniques to fertilize her ova with her partner's sperm. Once these embryos have been obtained in the laboratory, they must be implanted in the uterus of another woman, who is known as the surrogate mother. The child will inherit all its genetic material from the woman and her partner, because the surrogate mother does not transmit any genetic material to the foetus she carries in her uterus.
- Woman who does not produce ova and is unable to become pregnant for medical reasons; partner's sperm is satisfactory. She could receive donated ova in India and fertilize them with her husband's sperm. She has to use a surrogate mother. The child will be genetically related to the intended father but not the mother.
- Couple who arrange with another woman for her to gestate a child and hand it over to them after birth, after using donated ova and sperm to create a fertilized embryo. In this case, the child will have no genetic link to the parents. This situation would not be permitted in India, nor of course in Spain, as we are really talking about a concealed international adoption.
- Couple who cannot attempt to have a child using their own sperm or ova, but where the woman is able to gestate and give birth to a child. In this case, she could receive donated embryos in India. The child could be registered without problem in Spain in the parents' name, because Spanish legislation recognizes the birth parents.
- Woman who does not produce ova but is able to gestate. In this situation (legal in Spain), the woman could receive donated ova and fertilize them with her partner's sperm, or use donor sperm (anonymous, legal in Spain). The result would be that the mother would not have contributed any genetic material to her child but would none-theless be recognized as its mother in Spain as a result of the birth link. In this case, there would be no need to have recourse to surrogate motherhood.

We shall now evaluate the first two situations, which in practice account for most surrogacy arrangements in India. In both cases, a contract is drawn up between the intended parents and the surrogate mother. In practice, there is a wide range of models of contract in India which regulate the relationship between the two parties, some of which are more detailed than others, and only some of which are valid, with others being null and void under Indian legislation. As a lawyer, I have encountered surrogacy contracts containing a clause which expressly stated that the surrogate mother was to provide a birth certificate in the name of the intended parents, something which is not legally possible in India because, as in Spain, it is only the competent authorities who can issue such a birth certificate.

In the contract between the intended parents and the surrogate mother, it is essential that each and every one of the aspects of the legal relationship between the parties is regulated, including the names of all the people who are a party to the agreement, addresses, phone numbers, amount to be received by the surrogate mother, the place where she will give birth, express renunciation of any claim to the child by the surrogate mother, and any other details required in any legal agreement. Although many couples enter into surrogacy arrangements abroad on an individual basis, on the basis of our practical experience we believe it is essential to be able to draw on the support of professionals with expertise in this area, including Indian clinics specializing in this area, and to receive legal support both at the start and at the end of the process. This involves drawing up a contract between the intended parents and the surrogate mother and recording it with a notary public, monitoring the gestation process and registering the child with the Spanish authorities in India.

The main problem which can arise when the child is born is if the surrogate mother refuses to hand the child over to the intended parents. In practice, since 2005, when India began to get involved in surrogate pregnancy arrangements, there has not been a single case of this occurring, and if it were to happen the surrogate mother would be in clear breach of contract. Although it is not absolutely required, in order to ensure compliance the contract agreed between the intended parents and the surrogate mother

should stipulate the name of a lawyer or legal practice to which both parties agree to submit in the event that any problem or dispute may arise during the process. The lawyer can then act as an arbitrator, thus preventing problems between the intended parents and the surrogate mother from ending up in the Indian courts.

In the extreme eventuality of the surrogate mother deciding not to hand the child over, the intended parents would have the option of filing a claim with the courts and would be almost certain to be successful under Indian surrogacy legislation. The criteria governing this process were established by the Indian Council of Medical Research in 2005, and the contract under which the surrogate mother relinquishes any claim to the child at the point of conception is fully valid in the eyes of the authorities and the law in India. It is important to remember that this only applies to surrogacy in India, and that (as noted above) Spanish law does not recognize any contract under which gestation is agreed, either with or without remuneration, and the mother then renounces her claim in favour of that of another party.

The situation in Spain

Article 10 of Act 14/2006 of 26 May, on Assisted Reproduction Techniques, states that "any contract under which it is agreed that gestation will be performed, either with or without remuneration, by a woman who renounces her maternal rights in favour of the contracting party or another third party shall be null and void."

There is no room whatsoever for doubt: surrogate motherhood is banned in Spain and any contract between two parties designed to regulate this situation will be null and void. As a result, it is clear that if a child is born as a result of a surrogate pregnancy in Spain, parenthood will be determined by birth, as stated in article 10.2 of Act 14/2006: "The parenthood of children born as a result of a surrogate pregnancy will be determined by birth."

The other legislation which applies to the situations under discussion here are the Decree of 14 November 1958 (updated in the BOE [Official State Gazette]

of 19 September 1986), the Civil Registry Regulations, articles 112 and following of the Civil Code, and The Hague Convention of 5 October 1961.

Possibility of regulation in Spain

Given that a growing number of couples with fertility problems are travelling abroad to enter into surrogacy arrangements, it would clearly be helpful if there was a body of legislation in Spain to regulate this process and provide it with a legal framework. If surrogate pregnancy were legalized in Spain, it would be to the benefit of all involved in the process: the intended parents, the surrogate mother, clinics, etc.

I believe it to be essential that any regulation cover the following issues:

- Surrogacy should be limited to couples with medical problems in gestating their own children. It would, therefore, not be available for purely aesthetic reasons, for example.
- It should be available to homosexual couples, as the fact that they are able to adopt means they should also be able to access this form of paternity.
- The anonymity of sperm and oocyte donors should be guaranteed.
- Legal guarantees for the surrogate mother, ranging from medical issues (HIV, hepatitis, etc.) to financial ones (setting minimum and maximum sums).
- Review of legal situations in which abortion could be performed.
- Stipulation of who can decide on abortion, time limits, etc.
- Stipulation of the legal relationship between the intended parents and the surrogate mother.
- Modification of the Civil Registry Act and Regulations (requirements for registration of newborn child).
- Medical issues to be taken into account in any process (conservation of embryos, maximum number to be transferred to surrogate mother, requirements for storage of sperm, ova, embryos, etc.)
- Repeal of article 10 of the Assisted Reproduction Act.

Do we need surrogate motherhood?
Carme Valls-Llobet

The first surrogate pregnancies

One of the first organizations in the world dedicated to connecting women who are prepared to act as gestational surrogates for people who want to have children but are unable to do so was COTS (Childlessness Overcome Through Surrogacy), a non-profit association founded by Gena Dodd and Kim Cotton in 1988. Gena was given care of a child by its biological mother, while in 1985 Cotton had been the first surrogate mother in the UK, something which caused a real scandal at the time but helped open up debate in society. After Cotton's decision to take that first step, Britain's medical community debated the ethics of "gestational surrogacy" at length, until even the public health service appears eventually to have recognized at least tacitly that surrogate mothers are an option of last resort for couples who otherwise would be unable to become parents.

The role of COTS is restricted to putting potential surrogate mothers and desperate couples in touch with each other. This is completely legal in the United Kingdom, as the only legal requirement is that no money changes hands: both parties sign a contract which establishes which expenses – food, medical insurance, transport – must be met by the intended parents, and a copy of this is sent to COTS. Other than that, the only requirements are that the mother must be in good health and any couples who contact COTS must have exhausted all other fertility methods before deciding to pursue this option.

To date, according to its website, COTS has enabled 350 couples to have children. "All heterosexual," explains Jayne Frankland, a volunteer with the association, "because we are bound by the 1994 legislation which means that couples must apply for a Parental Order before approaching us for help. Basically, the intended parents must be married, resident in the United Kingdom and at least one of them must have a genetic link with the child. Homosexual couples can also access a surrogate mother, but the legal process is much more complicated and it's not something we get involved in."

Psychological consequences?

The first child born to a surrogate mother is now 18 years old, and there are no studies of the possible psychological consequences of this situation for individuals conceived in this way.

It is not compulsory for parents to tell their children the truth about how they were conceived, but finding out late, as for children who have been adopted, can bring psychological problems because of the potential importance attributed to unknown biological parents during adolescence, which is often a time of conflict between children and the adults who are bringing them up and who fill the symbolic role of parents. This symbolism may be rejected if the adolescent discovers that he or she has been lied to, and experiences this deception as a betrayal which throws the whole credibility of the relationship into crisis.

Vasanti Jadva presented a study at the annual meeting of the European Society of Human Reproduction and Embryology, held in July 2008, involving 165 people aged between 13 and 61 conceived by sperm donation. The study found that only 9% of children conceived using AI and whose parents were a heterosexual couple received information about their origins during infancy, while 56% of the offspring of homosexual couples and 63% of the children of single mothers were informed during childhood. The author recommends that the minor should know about having been conceived with donated sperm as early as possible, to avoid feelings of betrayal upon finding out as an adult.

In 2010, a number of people who were adopted as children formed a group to search for their biological parents, and some associations therefore recommend that ties with the biological family be maintained, in a similar way to the links between some families and surrogate mothers in India. The anthropologist Diana Marre, of the Autonomous University of Barcelona, is conducting a study of "The family and social interactions of adopted minors", and advocates a system of "open adoption" which facilitates transparency and contact with the biological family.

Illegal in Spain

Spain's Assisted Reproduction Act of 1988 expressly banned "gestational surrogacy", and allocated all rights to the biological mother, warning that, "any contract under which it is agreed that gestation will be performed, either with or without remuneration, by a woman who renounces her maternal rights in favour of the contracting party or another third party will be null and void." Nor did it allow adoption to be agreed, because when a child is given into the care of parents other than its biological ones, this arrangement must be approved by the courts (there are around 2000 adoptions per year in Spain). Surrogate pregnancy is therefore practically impossible, at least within the framework of the law, because the existing legislation of 2006 maintains the prohibition established in the 1988 act.

Spanish couples travel abroad to arrange surrogate pregnancies

Large numbers of Spanish couples have travelled to the United States to hire the services of surrogate mothers, paying between 75,000 and 95,000 euros so that a woman will grant them use of her uterus through an agency.

Several companies offer catalogues showing photos of potential mothers, together with specific information about each of them: medical history, race, origin, religion, studies and personality features. The majority are women aged between 25 and 35 who have already had children with their partners and who receive 20 to 25% of the total sum. The majority of the money paid by the intended parents goes to the company, which also pays for the contracts, the couple's accommodation costs and the implantation of the embryo.

An article in *Le Monde* dated 20 June 2009 reported that, "in India, where surrogacy is permitted, over 3000 mothers offer this service. The number of customers, from across the globe, is growing rapidly. The 'service' costs approximately 13,000 euros, of which the surrogate mother receives between

2000 and 4000 euros, a significant sum in a country where the average annual salary is around 550 euros."

The cost in the United Kingdom is around 20,000 euros, but only couples who are resident in the UK are allowed to enter into such arrangements.

Some general thoughts

We need to think about what the rights of the surrogate mother are, just as we should consider the rights of men who donate sperm. Surrogate mothers put their health at risk and have to undergo hormone treatment, although we do not yet fully understand the long-term effects of repeated treatments in the same individual. (By contrast, sperm donation does not involve any hormone treatment for the man.) We also need to consider the degree to which in countries such as India it is the precarious economic position of potential mothers which leads them to decide to become surrogates as a way of supporting their families financially.

Another issue concerns the need to conceive one's own child, possibly with the help of another person's ova or sperm. Are we solely capable of loving those who carry our own genes? Is it right that this demand for children who are genetically related to us should be the cause for endangering the surrogate mother's life? Can we be sure that the pregnancy entails no risk and that it is certain to be free of complications? Are surrogate mothers warned of all these risks?

In the context of global overpopulation, the reproduction industry should make us ask to what degree having a child should be a way of forging links between couples. One surrogate mother who recounted her experience asked whether her actions had really been useful: "I haven't heard anything more from that first couple. The girl will be four in June and I would like to have some news about her, make sure that she's okay, that she's happy ... Sometimes I think that first choice was a terrible mistake. The woman was nearly 50, she had two kids from a previous marriage and a young grandchild. He was younger, about 40, and he seemed to be the only one who was really excited about the thought of becoming a father. It's not the ideal environment for a child."

We need to think about what it means to have children. Do we have them so we can love them, or to own them? To some degree, it's the same relationship of ownership expressed in a lot of couples where one or both partners are possessive. Does paternity or maternity mean owning your offspring, or producing human beings who are "autonomous, compassionate and joyful"?

Is surrogacy just a business?

If it is a business, as in the case of the United States and India, can we really be sure that it is based on a contract entered into by people who "freely consent" to its terms? Offices which bring together potential parents and surrogate mothers claim to be working with "consenting" adults, and this seems to be the case in the United Kingdom, where surrogacy for financial gain is prohibited. However, contrary to the individuals selected for presentation to the media, consisting of perfectly balanced young women prepared to undergo a nine-month pregnancy solely out of love or to help another person who cannot bear children, the reality is often more sordid, as shown in programme "Nens made in India" ("Babies made in India") shown as part of the 30 minuts documentary strand on TV3 in Catalonia. Can we talk of "consent" with reference to social relationships between individuals who are not on an equal footing? How far is this a new form of commercial market which exploits women who want to escape from poverty? Is it a new form of sexual exploitation?

I am not advocating banning or restricting these actions, but I do wish to prevent their trivialization, ignoring the mental and physical state of women who have to prepare for a surrogate pregnancy by restricting the mental and emotional investment which always accompanies the maternity process. Women are encouraged to become alienated for the benefit of couples who want their own children; they are encouraged to enter a market which is part of the lucrative business of selling ova, one which has not been regulated and raises the risk of potential interbreeding between brothers and sisters, as there are no gene banks. Nor is it a question of forbidding solidarity between sisters or female friends, but not at the cost of defending the traditional family which produces children so that these can inherit property.

It is important to distinguish, as Sylviane Agacinski (2009) points out, between the right to have a child and the right to a child, and to understand that this cannot be compared to the right to health, education or work. One may suffer as a result of an inability to have one's own children, but nothing can justify solving this problem by transforming other women into "baby factories", as Josette Trat (2010) has argued.

Zamora Bonilla (1998), reviewing financial relationships with respect to surrogacy, presents this as an exchange from which all parties benefit when he analyses from a liberal or utilitarian perspective the question of whether surrogacy can be justified by the fact that all of the parties to the exchange improve their situation (more money, a much-wanted child). But this utilitarianism does not take into account the fact that each pregnancy brings its own risks, that it can be both physically and psychologically draining, and that the majority of decisions taken by human beings are not motivated by money alone. The interdependence between the desire to achieve the greatest possible wealth and to live in accordance with one's own values is not always negative (Sen, 1987). Can we only be satisfied with more money? Can we only derive full satisfaction from having children whom we consider to be "our own"? Are we only capable of loving children who bear our genetic material or that of our partner, or can we love those who are not biologically related to us?

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Surrogate motherhood: a way to extend women's reproductive rights? Francesca Puigpelat Martí

Introduction

Spain's Act 35/1988 on Assisted Reproduction Techniques, one of the first pieces of European legislation to regulate this area was, according to Pitch, modest and effective. By avoiding any effort to impose a specific model of the family and leaving a wide margin for individual decisions, its provisions were generally observed. However, despite its "modesty" it did not permit surrogate motherhood.

The current Spanish legislation, Act 14/2006, upholds in article 10 the principle that surrogacy contracts are null and void and that the paternity of children born by gestational surrogacy will be determined by birth. Unlike some other European countries, Spain does not criminalize such arrangements, but where surrogate motherhood takes place in Spain, the attribution of maternity to the intended mother could involve the criminal offence of handing children into the care of others to alter or modify their status, and that of misrepresenting childbirth.

The fact that Spanish legislation is more permissive than other European countries has meant that Spain has become a destination for what is referred to as *reproductive tourism*, in a similar way to what has happened in countries where surrogate motherhood is permitted. According to Orejudo (2009), this *reproductive* tourism, in addition to its health aspects, can become a form of *legal* tourism when the patient receiving the treatment which enables reproduction seeks to create a parental link under the law of the state in which the treatment occurs which would not be established in his or her country of origin. This is what occurs when the state to which the person has travelled accepts the legality of surrogate motherhood and considers the intended parents to be the legal parents of any children who are born. The fact that this practice is legal in the destination country means, in turn, that Spain's criminal courts cannot prosecute such people, because their competency over crimes committed by Spanish citizens abroad is conditioned by the requirement of dual criminal liability.

The problem arises, however, when attempts are made to have this relationship recognized by the Spanish state, as seen in the case which gave rise to the resolution of the General Directorate for Registries and Notaries (DGRN) of 18 February 2009. This resolution ordering the transcription in the Spanish Civil Register of a foreign registration certificate, has its origin in an appeal lodged by two Spanish men, who were married and resident in Spain, against a ruling of the Registry Official at the Spanish Consulate in California refusing to register the birth of their two children gestated by a Californian surrogate mother, on the basis of the prohibition in article 10 of the Assisted Reproduction Techniques Act.

This case is of great significance, because it highlights the problems which derive from divergent national legislation in an ever more closely connected world. However, I will not consider the problems of international private law as a result of the recognition in Spain of the legal efficacy of the practice of surrogate motherhood performed abroad, as these issues have already been analysed in great detail elsewhere (Quiñones, 2009; Orejudo, 2009).

This case enables, indeed obliges, us to consider the motives underlying the prohibition in Spanish law (and in most other European countries) against surrogate motherhood. This consensus is indicative of the reservations which remain with regard to this practice, although the arguments put forward to justify prohibition vary widely. The most frequent are: that it violates the dignity of mother and child; that it contravenes the natural order; that it institutionalizes the sale of children; that it may open the door to the exploitation of poor women, and that it only favours women and couples who are rich (Puigpelat, 2001: 122).

However, there are also some legal systems which permit the practice, and arguments which support it. I will not consider the scope and the reasoning which underlies each of these systems. Instead, I am concerned to set the issues within the context of feminist debate, where there are conflicting positions about this legislation and whether it should be amended. The disagreement around this issue to some extent reproduces the tension within feminism as to whether or not reproduction techniques contribute to the liberation of women, a shared aim of the whole feminist movement.

Feminism and surrogate motherhood

Some of the arguments raised against surrogate motherhood are also shared by feminists. I will focus, however, on considering the arguments raised by Carmel Shalev and Carol Pateman, respectively, in favour of and against surrogate motherhood. And not just because they express two diametrically opposing positions with regard to this practice, but also because they represent two very significant currents at the heart of the feminist movement: liberal feminism and radical feminism.

Carmel Shalev (1992) accepts the arguments of many feminists that, in the current social context, ARTs have increased the control of men over reproductive processes and reduced the power traditionally exercised by women in this area. However, following Robertson, she believes that these techniques also contain liberating elements by permitting women to go beyond the simple right to reproduce or not which is offered by contraceptive methods. With respect to surrogate motherhood, she values those aspects which question patriarchal culture: the surrogate mother gives birth outside of the bounds of the institution of marriage, the bond between biological and social motherhood is broken, and surrogacy permits women to participate in the market economy by treating pregnancy as paid work. Opposing surrogacy would not only entail denying women their independence, but would also mean maintaining a traditional vision of maternity as an act which should be altruistic and selfless.

And banning surrogacy contracts does not just limit the autonomy and responsibility of women. It also applies a paternalistic logic by allowing pregnant women to break the initial agreement by appealing to the concept of a maternal instinct which develops naturally during pregnancy and childbirth (Shalev, 1992: 126).

For Carol Pateman (1995), rather than surrogacy contracts representing a route to the recognition of women's autonomy the opposite is in fact true. This is nothing more than a new form of the sexual contract, a new mode by which men access and use women. It strikes her as particularly suspicious that this is presented as a service provided by one woman to another without

any consideration of the highly problematic issue of the way in which men participate in the contract and what requesting this service means. She believes that such contracts conceal the fact that the surrogate mother is receiving money in exchange for a man making use of something which is the unique property of a woman, her uterus. And it doesn't stop there, but extends to rights over "the unique physiological, emotional and creative capacity of her body, that is to say, of herself as a woman" (Pateman, 1995: 295). "To extend to women the masculine conception of the individual as owner, and the conception of freedom as the capacity to do what you will with your own," according to Pateman, "is to sweep away any intrinsic relation between the female owner, her body and reproductive capacities" (Pateman, 1995: 296). In this way there is nothing specific to the condition of being a woman. If, until now, this condition had been considered as being inseparable from the condition of motherhood, surrogacy contracts have separated this link.

She believes it is paradoxical that although when a woman becomes a surrogate mother this is because, as an individual, she provides a service and her condition as a woman is irrelevant, while at the same time "she can only be a 'surrogate' mother because she is a woman" (Pateman, 1995: 298).

When we examine what underlies these two positions we see that, as Pitch has pointed out, what is at stake are different ways of conceiving subjectivity. In Shalev, this, in line with a liberal position, is not mediated by the body but only concerns the abstract capacity for abstract choice. In Pateman, by contrast, subjectivity cannot simply ignore everything which makes a person what she is, and this inevitably includes her body and her gender (Pitch, 1998: 38).

Neither of these positions strikes me as completely satisfactory. Respect for autonomy and personal responsibility is not always guaranteed by the existence of a contract, and nor does our acceptance of such contracts prevent us from imposing significant restrictions on the freedom of both parties. These reservations arise from my belief that it is doubtful that a globalized reproductive market, based on the law of supply and demand and broad freedoms to enter into contracts are the most appropriate way of guaranteeing the

rights of the gestating mother, those of the intended parents, and those of children born under such agreements. Nor do I believe that this model of exchange is the most appropriate for helping to ensure that reproduction is based on close personal relationships and emotional bonds.

At the same time, I do not accept that surrogacy contracts can be seen merely as a new form by which men access women's bodies. I do not believe that surrogate motherhood can be understood in this way, when it is the only means by which a woman can realize her autonomous project of biological motherhood, as is the case if the intended mother has viable ova but is unable to gestate for medical reasons. In this event, one woman is accessing the body of another to realize her own project of genetic motherhood, although this may also indirectly contribute to her partner realizing his project of genetic paternity. Men have always needed to access women's bodies to satisfy their desire for genetic paternity, but what surrogate motherhood allows is that a woman can realize her desire for genetic and social motherhood thanks to another woman.

Surrogate motherhood and the reproductive rights of women

Surrogate motherhood should not be a cause for concern in the case of an intended mother who cannot gestate for medical reasons but does have viable ova. Preventing a woman who for medical reasons is unable to gestate from agreeing with a surrogate mother to gestate an embryo with which the intended mother has a biological link strikes me as an excessive restriction of her reproductive rights. Biological motherhood is part of the life project of many women and is at the very heart of the right to reproduction. The wish to be a biological mother is a social desire which should not be underestimated, and to do so reveals both a lack of respect for her personal autonomy and ignorance of the importance of reproduction for the maintenance of any society.

The necessary criticism of existing social stereotypes of maternity should not lead us to dismiss the fact that inability to realize this life project may cause

severe mental suffering. It is true that attributing excessive importance to the personal achievement of biological motherhood is problematic, and that it would be helpful to weaken the notion that social maternity or paternity is dependent upon a biological relationship. Perhaps ARTs are not the best mechanism for this, given that they help to reinforce the desire for biological maternity by generating expectations that all sterility problems can be solved. At the same time, it is also true that in so far as they use donated gametes they help to build acceptance of the notion that social and biological maternity and paternity are not necessarily the same thing (Birke, Himmelweit and Vines, 1992: 244).

Addressing infertility problems as an individual issue to be resolved through ARTs can have the negative consequence of undermining attempts to address the socioeconomic factors which often cause them. We know, for example, that female infertility rises with age. Because women today delay maternity in order to participate in the employment market, they have an ever greater need to use ARTs. If these techniques were not available, the need to transform social and employment structures to allow women to have children earlier without affecting their careers would be clearer.

Surrogate motherhood, when considered from a contractual perspective, raises the question of what the object of the contract is. We often talk of *surrogate motherhood*, *motherhood by substitution* or *motherhood for hire*, but also of *uterine surrogacy*, which would appear to imply that the object of the contract is the hire of a woman's uterus in exchange for financial payment. In other words, it only concerns the hire of reproductive services.

Understood in this manner, one could argue that the impact of a ban on surrogate motherhood would differ between the gestating and the genetic mother. For the gestating mother, a ban would represent a paternalistic restriction on her rights over her own body, while for the genetic mother it would be a restriction on her reproductive autonomy.

The purpose of restricting the right of the gestating mother to use her own body, according to some feminists, is to prevent the exploitation of the female body, in a similar manner to bans on prostitution. But this analogy

glosses over some important differences. Firstly, partial surrogate mother-hood does not solely allow the surrogate to freely dispose of her body during a specific period of time in exchange for financial payment. In addition, the pregnant mother undertakes to hand over the person she has formed and to transfer her maternity rights, given that in most legal systems these are attributed to the birth mother. It is for precisely this reason that critics have claimed that surrogate mothers, rather than offering reproductive services, are actually offering a finished "product", and that as a result surrogate motherhood is actually a form of selling children which violates their dignity. This seems to me to be going too far, because it disregards the fact that the child, in the case of partial surrogacy, is also the offspring of the genetic mother, who is the one who has initiated the whole procedure.

Secondly, unlike female prostitution, partial surrogacy using an ovum from the intended mother should, as we have noted, be viewed as an expansion of the reproductive rights of the genetic mother rather than as an instrument in the service of men; to argue that the woman's desire to become a biological mother responds primarily to pressure from her partner is to underestimate her decision-making capacity. This is why I would like the financial aspects of surrogacy to take second place, as it should not be motivated primarily by a desire for profit on the part of the surrogate, and I would stress that partial surrogacy extends the reproductive rights of women. And this is why I would argue for understanding it as a mechanism of cooperation between two women to bring to completion a biological maternity project.

However, as we have already seen, accepting partial surrogate motherhood does not necessarily imply that this mode of reproduction can only be established under a contract subject to the laws of the market. While it is understandable that contracts are seen as being especially suited to the task of regulating such relations between autonomous individuals, establishing bonds which go beyond traditional ties, from a feminist perspective I do not believe it is appropriate to configure surrogacy as a purely contractual and financial relationship, enforceable under the terms established at the moment of signing the agreement and necessarily ending upon the birth of the child.

It is particularly problematic that such contractual relationships are mediated by private agencies which make a profit out of the reproductive market. While I do not fully subscribe to the notion that such market involvement is inherently degrading, the prospectuses of Californian agencies are a clear example of a model of surrogate motherhood which I cannot share. Nor am I attracted by the Indian model of surrogate mothers receiving pregnancy care from the staff of clinics where the embryo was implanted, despite the fact that the financial payment they receive may significantly transform their own lives and that of their family.

In my opinion, surrogate motherhood should be seen as a form of collaboration between two women who relate to each other as individuals to carry out a parental product. Perhaps the best way to channel this help would be through a public surrogacy body, whose participation would be less crucial in the case of partial surrogacy where the surrogate mother is a relative of the intended mother. The pregnant mother could receive financial payment but would only be able to act as surrogate very few times, and there would need to be a series of mechanisms to encourage emotional ties between the birth mother and the child.

This process of shared maternity is not, however, without problems. During pregnancy, conflicts may arise between the autonomy of the pregnant mother and her duty of diligence. It is questionable how far it is possible to restrict the autonomy of the pregnant mother with regard to her lifestyle during pregnancy, beyond those limitations deemed socially acceptable, such as not smoking, drinking alcohol or taking drugs, and attending for regular medical check-ups. There can also be conflicts after the birth if the pregnant mother refuses to hand over the baby.

One difficult issue concerns the question of voluntary abortion. In normal sexual reproduction, the final decision regarding voluntary termination of pregnancy must correspond to the pregnant mother, and the same should also apply to pregnancies achieved with the aid of assisted reproduction techniques. Therefore, when the pregnant mother provides her own ova, fertilized with sperm from a donor or from her partner, to realize a shared parental project, the decision as to whether to terminate the pregnancy must be

hers. And this is also the case when the woman gestates an ovum which has been fertilized with her partner's sperm to realize a shared parental project. In contrast, when assisted reproduction techniques are used in the context of surrogate motherhood, the rule does not appear to be so straightforward. If the woman is gestating an ovum provided by another woman and fertilized with sperm provided by that woman's partner or by a donor, in order to realize the parental project of the woman who has provided the ovum, then the notion that the decision should be taken by the pregnant mother alone may seem more controversial.

In this case, there are some specific circumstances. The conflict which normally arises with respect to abortion concerns the value of the life of the embryo versus the rights of the mother, but in partial surrogacy there is an additional potential conflict between the pregnant and the intended mother as to whether the pregnancy should be continued to term. If, as we believe, the right to voluntary abortion is based on respect for reproductive autonomy and not the right over one's own body or the right to private life, then the most coherent approach would be for the decision to be taken by the intended mother, except where this decision – whether to interrupt or to continue the pregnancy – endangers the life or health of the pregnant mother.

It would be best if termination of the pregnancy required the consent of both women. However, we must also recognize that abortion affects the pregnant mother's rights and cannot be imposed against her will, while at the same time it is possible for an abortion to be performed without the intended mother's knowledge. Legislation on surrogate motherhood should therefore delimit the situations in which termination of the pregnancy is possible and the consequences of failure to comply with these provisions. The pregnant mother could reserve the right to refuse to terminate the pregnancy when drawing up the surrogacy agreement. Alternatively, both parties could agree that the pregnancy could be terminated if either of them did not wish it to continue, within the existing legal framework. Finally, it would also be possible to agree that the decision as to whether to terminate a pregnancy should lie with the intended mother.

If the pregnant mother does not accept that the genetic mother should be the one to decide about abortion under legally permitted circumstances, she could of course simply refuse to act as a surrogate, but she may also agree with the intended mother that if this woman does not wish to continue with the pregnancy then the surrogate mother may continue to do so alone, and will have care of the child after it is born. This could be the case if, for example, foetal deformities are detected which for the genetic mother would constitute grounds for voluntary abortion but not for the pregnant mother: the disagreement could be resolved by the gestating mother assuming full maternity of the child. In so far as the intended mother is the one who has involved another person in the parental project and the interests of the minor must be protected, it could also be agreed that in this event she should contribute to the maintenance of the child.

Surrogate motherhood, while it represents an extension of women's reproductive rights, also raises complex issues which go beyond abortion. Addressing these in a satisfactory way would, as we have argued, require legal regulation. This should include institutional controls to ensure that, in the event of conflict, any decision reached reflects the interests of the child.

If we accept partial surrogacy, we can compare the situation of a woman who is unable to gestate with the position of a woman who, thanks to ARTs, is able to realize her wish to become a mother by gestating a donated ovum. Accepting surrogate motherhood when this is used solely to satisfy the desire for biological parenthood of the male partner of a woman who cannot provide her own ova, the wishes of a male couple, or the wishes of a single woman who is unable to provide her own ova raises greater problems.

Surrogate motherhood strikes me as particularly problematic when the intended parents or parent – whether male or female – do not contribute either ova or gametes. Although solving infertility problems is not the only purpose of ARTs, it seems reasonable to argue that they should not be used to promote an alternative form of adoption without the costs associated with it. In these cases, it becomes difficult to distinguish surrogacy from the acquisition of children and also to conceptualize it as part of the right to reproduction of the intended parents, when these are not actually reproducing in any way.

It could be argued that these rights do apply to the pregnant mother, particularly if she has contributed the ovum. However, this strikes me as questionable. The right to reproduce should refer, at least in principle, to the intention to personally assume parental responsibilities, even if circumstances may subsequently make it impossible to fulfil this role. In the case of surrogate motherhood, the aim is not to help the pregnant mother to reproduce in order to become the child's mother, but rather to enable another person to reproduce and take on parental responsibilities.

This objection would therefore not apply to surrogacy when it is designed to help realize the desire for biological paternity of men, whether heterosexual or homosexual, even if the pregnant mother does not intend to bring up the child. However, in this case one would have to address those arguments which stress the possible exploitation of the creative capacity of women's bodies by men and whether this is offset by the liberational aspects which Shalev attributes to surrogate motherhood in so far as this represents participation by women in the economy by means of payment for their recreational labour.

When we consider what has happened with low added value jobs, it seems unlikely that once we accept the normality of such payment a globalized market would put an appropriate value on what pregnancy and childbirth entail. Nor can we ignore the fact that many surrogate mothers in poor countries do not even have the legal capacity to act. And we can also question whether the pregnant woman should become totally invisible despite having made a fundamental contribution to the reproductive process.

Although the principle of non-anonymity at birth may be disputed, if it is understood as a means of attributing to women the responsibility for caring for others, I believe it should be defended as a recognition of the primary role of women in reproduction which reflects the fact that gestation and child-birth are not equivalent to donating ova or sperm.

At the same time, whatever scope is granted to surrogate motherhood as a means of extending reproductive rights, we should not ignore the interests of the child. These interests should include the option of knowing the identify of the birth mother and even, where applicable, of the donors of ova or sperm.

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The legal regulation of surrogate motherhood Itziar Alkorta Idiakez

Background

Surrogate motherhood was conceived as a way of providing a child for women who, although they were able to produce ova, were unable to gestate due to severe uterine or heart problems. An ovum was obtained from the woman and fertilized *in vitro* with her partner's sperm. The embryo was then implanted in another woman who had agreed to gestate it and hand over the child to the intended parents. In this scenario, the intended parents are the child's genetic parents, while the woman who bears the child is its biological mother. In other words, surrogacy is limited to gestation.

The first documented case of this type occurred in 1989. A woman who was unable to bear a child due to severe uterine and cardiac problems, but who produced healthy ova, hired another woman to gestate the embryo produced by fertilizing one of her ova with her husband's sperm, and to hand over the newborn child in exchange for payment. In this situation, although gestation is performed by another woman, the child inherits genetic material from the intended parents (Utian, 1989).

The first legislation on surrogate pregnancy

The first Spanish legislation on assisted reproduction was passed in 1988. Some years earlier, the Surrogacy Act of 1985 had prohibited the practice of commercial surrogacy in the United Kingdom. Spain's Act 35/1988, of 22 November, on Human Assisted Reproduction Techniques, ruled that any surrogacy contract would be null and void, irrespective of whether it involved payment. Children born as a result of such arrangements were recognized as the offspring of the woman who had given birth to them. The same legislation defined the agreement of surrogacy contracts as a very serious offence. The new Act 14/2006, which replaces the earlier legislation, retains the same wording in this regard.

Legislation in this area by the Spanish Congress of Deputies coincided with the furore surrounding the case of $Baby\ M$. in the United States. This case

established a framework for the social perception of surrogate motherhood, and conditioned its subsequent regulation in both the United States and Europe (N.J. Super. Ch., 1988). In the *Baby M.* case, the Sterns, a wealthy American couple, used a New York agency to hire a US woman to gestate an embryo conceived using AI with sperm from the intended father and an ovum from the gestating mother. When the child was born, the gestational mother (Mrs Whitehead) refused to hand it over, claiming that she was the legal mother. Initially, the courts recognized the validity of the surrogacy contract, and ordered the biological mother to hand the child over to the Sterns; however, the Supreme Court then ruled that surrogacy contracts were invalid but still awarded custody to the Sterns on the basis of best interest, and endorsed the decision to grant Mrs Whitehead extensive visitation rights.

The *Baby M.* case has been extensively studied in American legal literature. Scott (2009), for example, argues that the way the case was presented in the media meant that hostility towards surrogate motherhood became the norm, creating a social panic towards surrogacy. Feminists, religious groups and pro-life campaigners argued that surrogate motherhood exploited poor women who did not understand the scope of their actions or found themselves compelled to act in this way to earn money – something which was compared with prostitution – in addition to which, such arrangements were argued to constitute the commodification or sale of children, an argument which was taken up by politicians. We should bear in mind that at the time IVF was a relatively new development, and society was afraid that this phenomenon would render the process of procreation artificial, with Aldous Huxley's *Brave New World* being cited as an example.

As a result of this reaction, the first American laws on surrogate motherhood were very strict, with commercial surrogacy being made the target for particularly harsh penalties (Illinois). However, the arrangement was declared legal in some states, such as California, which accepted payment of surrogate mothers.

During the last two decades, the practice of surrogate motherhood has evolved towards the almost exclusive use of partial surrogacy, that is, gesta-

tional surrogacy in which the embryo is provided by the intended parents. The combination of IVF with the fact that in some countries it is possible to have the intended parents recognized as the child's legal parents has led to a preference for gestational surrogacy.

Commercial practice in surrogate motherhood: legal problems

In recent years, there have been requests in Spain and elsewhere in Europe to accept the practice of surrogate pregnancy, both by heterosexual couples who want to have access to this option and by male homosexual couples who view full surrogacy as an alternative to adoption. In the meantime, the practice remains banned in Spain, and California has become the destination of choice for many Spanish couples who resort to this service in order to have offspring.

Hiring surrogacy services abroad, however, runs into a major problem. Spain's General Directorate for Registries and Notaries, and the consulates which are bound by its decisions, do not permit the registration of a child born from surrogate motherhood as the child of the intended parent, on the basis that the practice is banned in Spain and the child already has a biological mother. However, there has recently been a significant change to jurisprudence in this area. A resolution of 18 February 2009 permitted a homosexual couple of Spanish nationality to record as their own twin babies born in California as a result of a surrogacy arrangement. The resolution invoked the best interest of the minors and their right to an identity, which meant they had the right to a single set of parental relationships which would be valid in all countries rather than varying if they crossed the border. It was also argued that the Californian birth certificate constituted a decision which did not undermine international public order or harm basic rights in Spain, given that Spanish law allows two men or two women to be identified as the parents in the case of adoption by a homosexual couple. This ruling, however, is not final, and the authorities have appealed against the decision, alleging documentary fraud on the basis that the mother's name does not appear on the birth certificate, and claiming in addition that the case represents an example of *forum shopping*.

The British solution

The United Kingdom, as we have seen (Quiñones, 2009) has banned commercial surrogacy. It is forbidden to pay for this service, and related commercial activity is penalized, including the payment of intermediaries and advertising. However, surrogacy is allowed for therapeutic reasons so long as it does not involve a contract. The birth mother is recorded as the parent of the newborn child and parenthood is only transferred to the intended parents (after a period of reflection) if they apply to the courts for a parental order. No charge may be made for surrogacy, although the pregnant mother may be paid reasonable expenses for the costs arising from the pregnancy.

Under the conditions established by the act, UK courts can identify the intended parents as the parents of the newborn child by means of a parental order in which they replace the birth mother as the parents. As a result, there are two birth certificates. In the first, the birth mother is recorded as the mother and has a period of time to withdraw. If she agrees, a new birth certificate is issued naming the intended parents. These requirements echo the legislation of 1985 and the reformed legislation of 1990 (together with court practice).

The legislation was strengthened by the introduction, on 1 April 2009, of the Human Fertilisation and Embryology Act, 2008, which follows the same principles as the Surrogacy Arrangements Act, of 18 July 1985, modified by the Act of 1 November 1990) which relaxed some of the conditions (N.J. Super 267, 1988); in particular by making it possible to register the minor as the child of two people who have entered into a same sex civil partnership.

This requirement, which is a condition of both domestic and international legal competency and of the applicable legislation, provides the basis for assigning parental responsibility for the minor, in accordance with UK law, regardless of whether the surrogacy arrangement has taken place in that

country or overseas. The conditions or material requirements stipulated by the UK legislation as the conditions for recognition of the parents are extraterritorial in their scope, an issue which has been contested in the courts (Quiñones Escámez, 2009).

Acceptability of this practice

In my opinion, the demand for the recognition of surrogacy arrangements in Spain, which is not exactly overwhelming, could be satisfied without any need to authorize commercial arrangements. It should be born in mind that there appears to be consensus between legal and bioethical opinion in Spain with regard to the need to ban commercial surrogacy. At the same time, for as long as it remains impossible to establish the legal maternity of the intended mother and even if the DGRN were to change its approach, the practice of surrogate motherhood will clearly entail significant legal risks for those involved in it, including any children born as a result.

The solution to the social demand for surrogacy without recourse to commercial arrangements could be to accept gestational surrogacy subject to strict supervision and ensuring that the rights of the pregnant mother are carefully protected. Maintaining the current wording of article 10 of Act 14/2006, which recognizes the legal maternity of the woman who gives birth, it would be possible to design a mechanism similar to the one provided in UK legislation to allow adoption by the intended parents after first registering the child as the offspring of the birth mother. This solution would involve extending the option of adoption at birth to the biological intended parents of children born through gestational surrogacy. This measure would also ensure the right of the child to know the identity of his or her birth mother, by accessing her details in the Civil Registry under conditions similar to those which apply in the case of adoption.

Just as with the UK legislation, any prior agreement between the surrogate mother and the intended mother would not be legally binding and could not be enforced by the couple. It seems appropriate that the birth mother should

have a period of reflection to help prevent this practice from becoming a business.

The clearest therapeutic basis for accepting this practice would be precisely that which gave rise to the first surrogacy case: a woman who for health reasons is unable to gestate a foetus, but who has viable ova. In this case, the intended mother could agree with another woman to transfer an ovum fertilized with her husband's sperm for gestation and, without payment, the birth mother could then hand the child into the care of the intended mother if she so wished, after a specific time period and following certain procedures.

At the same time, in order to avoid the commercialization of gestational surrogacy, it seems advisable that this practice should only be eligible to Spanish women, in the same way that the UK legislation is restricted to women domiciled in that country. Overseas demand for surrogacy can be reduced, and covert commercialization prevented, if Spanish citizenship or permanent residency are made conditions for accessing treatment. In this regard, the British Act (HFE Act 1990) establishes in section 30.3.b that: "The husband or the wife, or both of them, must be domiciled in a part of the United Kingdom or in the Channel Islands or the Isle of Man."

The citizenship or residence requirement can be justified as a general measure which seeks to guarantee rights which would otherwise be at risk of violation if the individuals to whom the legislation refers do not reside in the territory where its application is guaranteed. This is the case, for example, of the right of the child to the legal recognition of its parenthood, something which would not be guaranteed in those countries where surrogacy is not permitted.

In any event, as has been stressed with regard to assisted reproduction, the only way of preventing people from seeking such services in other countries is by means of international harmonization which establishes certain minimum standards both in order to prohibit practices deemed ethically unacceptable by the international community, and to establish the basic rights of users of the health systems of the signatory states, who would thereby acquire obligations with respect to their citizens in the area of assisted reproduction.

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Discussion and conclusions

Following the presentation of the papers, the discussion session focused on the key general issues in this area. The first thing to strike us from the texts was the fact that a number of different terms are used in this area. While in English the terms surrogate motherhood or just surrogacy are used, in Spanish one can refer to maternity by substitution (maternidad de sustitución), surrogate motherhood (maternidad subrogada), uterus surrogacy (subrogación de útero), mothers for hire (madres de alquiler), uterus hire (alquiler de útero) etc. In all these cases, the shared point of reference is the fact that a woman, under an agreement prior to the pregnancy, undertakes to gestate and hand over the resulting child to people who have "commissioned" the gestation (the intended parents) in exchange for financial payment. However, the contribution by the gestational mother can be either "full" or "partial": in addition to gestating the foetus, she may contribute an ovum, or her role may be restricted to that of gestation. As was clear from the presentations, there are also a number of other significant variables which affect our view of such arrangements, including the genetic contribution of the intended parents, their personal situation and their motives for entering into a surrogacy contract.

All of the speakers shared the belief that surrogate motherhood is a complex reality which can lead to conflicts between those involved, and that these situations must therefore be managed with great care. But they also agreed that this difficulty is complicated by the strongly held ideological, moral and religious convictions, some of which give rise to paternalistic or perfectionist solutions.

Spanish legislation was seen as being excessively restrictive and participants argued for the need to revise it, although there was a wide range of opinion with respect to how far such change should go and which regulatory model should be applied.

The participants agreed that the legislator should permit partial surrogacy when the intended mother provided her ova but was unable to gestate for a

variety of medical reasons. They also took the view that partial surrogacy should be permitted for couples where the woman was unable either to gestate or provide ova for medical reasons but where it was possible to use her partner's sperm.

No firm conclusion was reached as to whether, in addition, full surrogacy, in which the surrogate mother also provides the ovum, should be allowed, and whether surrogacy should be made available to homosexual couples, given that they are allowed to adopt, and lesbian couples and single lesbians may receive ARTs.

There was, however, agreement that surrogate motherhood should not be permitted where there is no genetic contribution from either of the intended parents. It would be hard to justify this as a means of exercising reproduction rights, and would instead constitute a new form of adoption, which would go beyond the limits usually imposed on such arrangements and would be open to the charge that it really constitutes a form of purchasing a child. Nor did participants accept those cases where there is a genetic contribution from the intended parents but where surrogacy is chosen not for medical reasons but simply for aesthetic motives or questions of comfort.

With regard to the regulatory model, some of the participants argued for the need to avoid the Californian approach, which attracts large numbers of people who want to get round restrictions on surrogacy in their own countries. The broad recognition of the individual autonomy of the parties entering into the contract, and the existence of private agencies which make significant profits were the cause of major concerns.

Despite the freedom and legal security provided by the Californian legislation, many people travel to India in order to take advantage of lower costs. Although the situations in which surrogacy is permitted there are actually more restrictive, some of the participants felt that the context of such arrangements made this a particularly unacceptable option. In addition to the danger of commercialization and exploitation inherent in any commercial surrogacy arrangement, there is the additional risk that Indian women may be coerced into acting as surrogates, given the restrictions on their autonomy.

For this reason, some of the participants felt that the UK model could offer a good starting point for a review of the Spanish legislation. In this model, surrogacy is permitted for therapeutic reasons, but mediation and advertising are forbidden, although the payment of reasonable expenses to the surrogate mother is permitted. The birth mother is granted a period of reflection before handing the child over, and she is named as the legal parent until a parental order is granted by the courts reassigning parenthood to the intended parents.

Irrespective of their preferences for one model or another, all the participants agreed that any satisfactory legislation must take into account all those issues which have been a source of conflict in the practice of surrogacy. As was highlighted in the presentations, it does not seem advisable to leave the following issues to the individuals and the market alone: decisions about abortion, the use of coercion to hand over the child, the style of life which the pregnant mother must lead, the expenses to be met, maternity leave, the consequences arising from cancellation of a surrogacy agreement, the situations in which it is acceptable for such arrangements to be used, etc.

Participants also considered an issue which, while not specific to surrogate motherhood, is one of the key aspects of legislation concerning assisted reproduction techniques, donor anonymity, which makes it impossible for individuals born as a result of these techniques to trace their genetic parents. The majority of participants felt that this model is appropriate in so far as it encourages donations and avoids potential conflict in family relationships, while there does not appear to be any evidence that ignorance of one's specific genetic identity is a cause of psychological problems in children born using donated gametes.

However, a minority held the view that the Swedish model of non-anonymity should be adopted. In response to the objection that this would discourage donations, they argued that this would also help prevent the danger of commercializing and depersonalizing reproduction and exploiting the people who participate in it. And although it is true that ignorance of one's genetic identity is unlikely to cause psychological problems, this does not justify depriving people of their right to such knowledge when this is accepted in other legal contexts. Furthermore, as these techniques become more

widespread, demand for such knowledge is likely to increase, as is already evidenced by the fact that people born using such techniques are using the internet to confirm the existence of shared genetic connections.

All the participants agreed on the need to create an official register of surrogacy cases, similar to the one established for other assisted reproduction techniques, and for care to be taken to ensure this was actually implemented.

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