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LEARNING FROM CROSS-BORDER REPRODUCTION

Emily Jackson[♦], Jenni Millbank, Isabel Karpin, Anita Stuhmcke[♥]

Abstract

Drawing upon the preliminary findings of an Australian empirical project on cross-border reproduction (CBR), this article argues that regulators and policymakers could learn from the experiences of those who travel overseas in order to access fertility treatment and surrogacy. It makes four principal observations. First, the distinction between so-called ‘altruistic’ and ‘commercial’ gamete donation and surrogacy is increasingly unsustainable and is not experienced as meaningful by many participants in CBR. Second, the status of the law in CBR is profoundly equivocal; for participants it is often there and not there at the same time. Third, self-sourced information, from the internet and more specifically social media such as Facebook, is now the principal source of information and peer support for reproductive travellers. Fourth, and relatedly, domestic reproductive services providers are often sidestepped. If one of the goals of regulation is to minimise the risk of harm to participants, it is not clear that it is currently achieving this aim, and this article argues that any reforms will only work if they are more responsive to the reality of CBR.

I. INTRODUCTION

Over the past two decades, it has become increasingly common for people to travel overseas in order to access medical procedures and services, including fertility treatment.¹ People travel to receive fertility services for a broad range of ‘push’ and ‘pull’ reasons.² Some travel to receive procedures that are illegal or unavailable to them at home; others are in search of better care, shorter waiting times, greater privacy or lower costs.³ The United States, for example, is a destination for some reproductive travellers, including Europeans and Australians seeking surrogacy or sex selection. At the same time US citizens have travelled to India and Mexico in order to access cheaper surrogacy arrangements.⁴ ‘Diasporic’ travellers might travel to their

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¹ J Connell, ‘Contemporary medical tourism: Conceptualisation, culture and commodification’ (2013) 34 *Tourism Management* 1. Connell refers to this as ‘reverse globalisation’, however, some view it as the latest form of colonisation.

² MC Inhorn and ZB Gürtin, ‘Cross-border reproductive care: a future research agenda’ (2011) 23 *Reproductive BioMedicine Online* 665.

³ W Van Hoof, V Provoost, and G Pennings ‘Reflections of Dutch patients on IVF treatment in Belgium: a qualitative analysis of internet forums’ (2013) 28 *Human Reproduction* 1013; H Naraindas and C Bastos, ‘Healing holidays? Itinerant patients, therapeutic locales and the quest for health’ (2011) 18 *Anthropology & Medicine* 1.

⁴ SL Crockin, ‘Legal perspectives on cross-border reproductive care’ (2011) 23 *Reproductive Biomedicine Online* 811.

country of origin in order to have their cultural or religious needs met,⁵ or to access ethnically matched donors.

Cross-border reproductive treatment takes place within a rapidly changing legal environment. For example, Thailand banned foreigners from accessing surrogacy in 2015,⁶ and India restricted surrogacy to heterosexual married couples in 2013 and is in the process of implementing a ban on all foreigners, except those of Indian descent.⁷ Nepal and Mexico initially appeared to be alternative low-cost destinations, before restrictions upon foreigners' access to surrogacy were enacted in 2015 and 2016 respectively.⁸

It is impossible to tell how many people travel in order to access fertility services. In 2010, Shenfield et al estimated that there were about 24–30,000 cycles of cross border fertility treatment within Europe each year, involving 11–14,000 patients.⁹ There is, however, no systematic collection of data, so the prevalence and outcomes of reproductive travel are unknown.¹⁰

While the picture of cross border reproduction (CBR) is simultaneously incomplete and extraordinarily complicated, one certainty is that states can no longer assume that their citizens will seek fertility treatment and services in local, easily-regulated clinics.¹¹ Every country therefore faces the question of what the appropriate regulatory response, if any, should be to this dynamic and widespread (but ultimately unquantifiable) bypassing of domestic healthcare services and regulations. Our focus in this article is on domestic responses to CBR, but it is also worth noting that there is increasing interest in the development of cross-national minimum standards. These might take the form of a Hague Convention on surrogacy, in order both to protect the surrogate's welfare and to avoid the creation of 'stateless and parentless' children,¹² or it might simply involve collaboration among members of the International Federation of Fertility Societies in order 'to develop uniform clinical and safety standards'.¹³

Research emerging from the United Kingdom and Australia suggests a number of common threads, which make them useful comparators when developing responses to CBR. In

⁵ J Hanefeld, R Smith, D Horsfall and N Lunt, 'What Do We Know About Medical Tourism? A Review of the Literature with Discussion of its Implications for the UK National Health Service as an Example of a Public Health Care System' (2014) 21 *Journal of Travel Medicine* 410.

⁶ Protection of Children Born from Assisted Reproductive Technologies Act 2015.

⁷ S Cousins, 'Only married heterosexual Indian couples will be allowed to use surrogate mothers under proposed new law' (2016) 354 *British Medical Journal* i4669.

⁸ R Abrams, 'Nepal Bans Surrogacy, Leaving Couples With Few Low-Cost Options' *New York Times*, May 2 2016; S Saravanan, 'Addressing Global Inequalities' in E Scott Sils (ed) *Handbook of Gestational Surrogacy: International Clinical Practice and Policy Issues* (Cambridge University Press 2016) 41.

⁹ F Shenfield, J de Mouzon, G Pennings, AP Ferraretti, A Nyboe-Andersen, G de Wert, V Goossens and the ESHRE Taskforce on Cross Border Reproductive Care 'Cross border reproductive care in six European countries' (2010) 25 *Human Reproduction* 1361, 5.

¹⁰ K Nygren, D Adamson, F Zegers-Hochschild and J de Mouzon 'Cross-border fertility care—International Committee Monitoring Assisted Reproductive Technologies global survey: 2006 data and estimates' (2010) 94 *Fertility and Sterility* e4.

¹¹ This may not even be possible as only 48 out of 191 member States of the World Health Organization have IVF facilities. See further AM Whittaker, 'Cross-border assisted reproduction care in Asia: Implications for access, equity and regulations' (2011) 19(37) *Reproductive Health Matters* 107, 109 citing M Inborn Right to assisted reproductive technology: overcoming infertility in low-resource countries' (2009) 106 *International Journal of Gynecology and Obstetrics* 172.

¹² Hague Conference on Private International Law *The Desirability and Feasibility of Further Work on the Parentage/Surrogacy Project* (HCCH, 2014). See also the Council of Europe's Committee on Social Affairs, Health and Sustainable Development, *Children's rights related to surrogacy* (Council of Europe, 2016).

¹³ International Federation of Fertility Societies, *Policy Statement 2: Cross Border Treatment* (IFFS, 2010).

both the United Kingdom and Australia people who travel abroad for reproductive treatment may have multiple reasons for doing so, but as both countries provide high quality IVF treatment (with varying degrees of State subsidy) and can broadly be characterised as liberal in their access,¹⁴ our residents may be less likely to be motivated primarily by treatment exclusions or cost considerations.

In the UK, in their qualitative study of 51 interviewees in 2009-10, Culley et al found that those utilising cross border treatment were motivated by avoiding long waiting lists; the prospect of higher success rates abroad; the hope of receiving treatment in a less stressful environment; and by dissatisfaction with the treatment that they had received in the UK.¹⁵ In Australia and New Zealand a survey study in 2014 of 137 respondents (105 from Australia and 32 from New Zealand) by Rodino et al identified unavailability of treatment, treatment not permitted, long waiting lists for donor gametes and limited choice of donors as the most common motivations.¹⁶

In this article, we contribute to an emerging body of research into the experiences of reproductive travellers as part of our qualitative study examining CBR. In this project we are interviewing reproductive travellers from Australia, as well as regulators, agencies and clinicians both within and outside Australia, in order to better understand the motivations for, and experiences of CBR. At the time of writing, mid-way through a four year project, we had undertaken 54 interviews with 55 interviewees, of whom 28 had utilised cross border reproductive processes, as well as 11 facilitators and four medical practitioners engaged in cross border treatment.¹⁷ We are publishing these early findings in order to contribute to the development of a more nuanced analysis of CBR that explores both risks and benefits, attending to the perspectives of those who undertake it. Although the research is not yet finalised, the themes that we discuss here are significant and have the potential to contribute to legal and policy developments currently being debated in Australia, the UK and elsewhere.

The premise of this qualitative study, and of our argument here, is that regulators, clinicians, policymakers and law-reformers can and should learn from the lived experiences of those who cross borders in search of reproductive treatments and services. We suggest that

¹⁴ Australian states have different approaches to ART and surrogacy. Gay male couples continue to be formally excluded from IVF treatment for surrogacy in SA, Tasmania and WA. In Everingham et al's study of 249 intended parents seeking surrogacy overseas (of whom around half were gay men), domestic legal restrictions were a major 'push' factor: SG Everingham, MA Stafford-Bell and K Hammarberg, 'Australians' use of Surrogacy' (2014) 201(5) *Medical Journal of Australia*, 270. See also J Millbank, 'Responsive regulation of cross-border assisted reproduction' (2015) 23 *Journal of Law and Medicine* 346.

¹⁵ L Culley N Hudson, F Rapport, E Blyth, W Norton and AA Pacey 'Crossing borders for fertility treatment: motivations, destinations and outcomes of UK fertility travellers' (2011) 26 *Human Reproduction* 2373, 2379-80; AM Whittaker, *Thai in Vitro: Gender, Culture and Assisted Reproduction* (Berghahn Books 2015).

¹⁶ I Rodino, S Goedeke and S Nowoweiski 'Motivations and Experiences of Patients Seeking Cross-Border Reproductive Care: the Australian and New Zealand Context' (2014) 102 *Fertility and Sterility* 1422, 1425.

¹⁷ Pseudonyms are used for all interviewees. The study utilised a multi-method recruitment process, using both clinical avenues and broader advertising to the public. Volunteers were invited to participate through face-to-face or phone interviews and were also asked to complete an optional demographic survey either online or by hand. The inclusion criteria were that participants currently or previously engaged in surrogacy or egg donation or were service providers in CBR. Interviews were semi structured and duration varied between 30 minutes to 90 minutes, with most lasting around one hour. Qualitative data was subject to thematic analysis. Each member of the research team undertook multiple readings of interview transcripts throughout the data collection period and discussed emergent themes in depth. Identified themes were subject to comparative analysis among the entire research team to ensure uniformity of interpretation. Approval to conduct this research was obtained through the University of Technology Sydney Human Research Ethics Committee: UTS HREC Reference Number 2015000094.

patients'¹⁸ subjective experiences of risk, care, and legality differ markedly from the assumptions about patient behaviour that have tended to inform regulation in this area. We tease out this claim, and its implications for responsive regulation, across four preliminary observations.

First, the distinction between so-called 'altruistic' and 'commercial' gamete donation and surrogacy is increasingly unsustainable in law and policy.¹⁹ Further, this division of practices is not experienced as meaningful by many participants in CBR, and is openly rejected by some.

Second, the status of the law in CBR is profoundly equivocal. Even countries with extra-territorial criminal prohibitions against commercial surrogacy in practice often facilitate these prohibited arrangements through citizenship and parentage provisions. This ambiguity builds an experience of law as both there and not-there for reproductive travellers. In our interviews we have noticed that some people accessing CBR simultaneously acknowledge the presence of legal provisions (such as prohibitions in the criminal law; rules regarding legal parentage, or the likely unenforceability of surrogacy or egg donation contracts), at the same time as regarding these as abstract technicalities. Time and again our participants downplayed the significance of law, as compared with 'real life', or a 'well-trodden path', in which others before them, and they themselves, have returned home with children despite the existence of restrictive legal provisions, in Australia and the country of treatment.

Third, self-sourced information, from the internet and more specifically social media such as Facebook, is now the principal source of information and peer support for reproductive travellers. Clinics and agencies have their own Facebook pages, and there are Facebook groups for different cohorts of reproductive travellers: gay dads, egg donors, egg recipients, surrogate mothers and intended parents. 'Personal' recommendations and anecdotal 'evidence' about the quality of care appear to matter more to patients than doctors or regulators might expect.

Fourthly, and relatedly, domestic care providers are often sidestepped. Given that many patients self-refer with the help of internet forums and Facebook, reproductive travellers may be bypassing what has conventionally been a crucial source of information and support when undergoing complicated, stressful and invasive medical treatment, namely local healthcare professionals.

Drawing on these observations we suggest that finding a way to ensure that as many reproductive travellers as possible access accurate, balanced information before they depart in order to make an informed assessment of overseas (and domestic) treatment options should be an important, but by no means straightforward, regulatory objective. We need to learn more about why some citizens of countries that pride themselves upon having among the safest and the best regulated fertility services in the world are actively bypassing those services, and seeking

¹⁸ We acknowledge that much of the language in use in this field is loaded, and often highly contested. In using 'patient' we acknowledge that many but not all travellers are, in fact, patients. While a woman receiving donor eggs for her own pregnancy attempt, or undergoing egg retrieval for a surrogacy attempt, undertakes IVF treatment as a patient, her male partner – even if he travels with her and contributes sperm – does not undergo a physical treatment process in the same way; likewise gay men travelling for surrogacy could be characterised as service users more than patients in comparison to the women who undergo IVF treatment as egg donors and surrogates. Notably reproductive contributors are rarely spoken of, and arguably in some instances not properly regarded by medical professionals, as patients. The use of 'donor' and 'donation' is also contested when open forms of payment are involved; however we continue to use the terms because we do not accept the altruistic/commercial binary and in acknowledgement that participants may still experience the contribution as an act of sacrifice or 'gift' whether or not payment is provided.

¹⁹ See A Stuhmcke, 'The regulation of commercial surrogacy: The wrong answers to the wrong questions' (2015) 23 *Journal of Law and Medicine* 333.

out treatment in apparently less well-regulated environments, often on the basis of Facebook recommendations.

We do not suggest that domestic law and policy should uncritically reflect ‘consumer choice’ in CBR, or that a reform agenda should be shaped to the expectations of those who utilise CBR, especially if there is clear evidence of harmful practices or outcomes. However, we do argue that the experiences of those who travel for reproduction offer important insights that complicate common assumptions about CBR. For instance, as we shall show below, some women found the idea of altruistic surrogacy or egg donation to be *more* morally problematic than compensated surrogacy and egg donation. This finding directly contradicts existing regulatory assumptions which currently prohibit and limit ‘commercial’ involvement in assisted reproduction.

To inform a more nuanced approach to the provision and regulation of fertility treatment we must attend to the subjective experience of risk, quality and care in CBR, especially when this involves what Angela Campbell calls ‘morally ambiguous’ or even ‘ostensibly self-injurious’ choices.²⁰ In this paper we suggest that it is impossible to properly evaluate the role of law in CBR without attending to its impact upon participants’ lived experiences, and that, in the light of a dramatic mismatch between law’s goals and reproductive travellers’ experiences of law, there may be grounds for some form of realignment.

II. ALTRUISTIC OR COMMERCIAL: AN UNTENABLE DISTINCTION?

In many countries, including the UK and Australia, a sharp distinction between altruistic and commercial arrangements has shaped the legal response to surrogacy and assisted reproduction for the past 30 years.²¹ In Australia, commercial surrogacy is a criminal offence for all participants, as is trading in human gametes.²² In the United Kingdom, professional involvement in commercial surrogacy is criminalised, although surrogates and intended parents are exempt.²³ Since 2011, egg donors in the UK have been able to receive up to £750 per cycle of donation, to include all expenses, an amount which is not intended to incentivize donation, but which is instead, in the words of the then HFEA Chair, Lisa Jardine, ‘a level of compensation which will not deter those interested in donation but will retain donors already in the system, without attracting those who are merely financially motivated’.²⁴

An assumption underpinning much of the reaction to CBR in the UK and Australia is that travellers go to ‘commercial’ jurisdictions in order to avoid, directly or by implication, the constraints of altruistic regimes; that is to access a more immediate or wider range of reproductive contributors who are more plentiful (and who may also be less powerful

²⁰ A Campbell *Sister Wives, Surrogates and Sex Workers* (Routledge 2013), 47. See especially Campbell’s arguments for an empirically informed juridical feminist analysis of choice.

²¹ A Stuhmcke, ‘The regulation of commercial surrogacy: The wrong answers to the wrong questions’ (2015) 23 *Journal of Law and Medicine* 333.

²² I Karpin and J Millbank, ‘Assisted Reproduction and Surrogacy in Australia’ in J Eckelaar (ed), *Routledge Handbook of Family Law and Policy*, Routledge 2014.

²³ A Campbell *Sister Wives, Surrogates and Sex Workers* (Routledge 2013), 112-118; A Stuhmcke, ‘New wine in old bottles and old wine in new bottles: The judicial response to international commercial surrogacy in the United Kingdom and Australia’ in K Horsey (ed), *Revisiting the Regulation of Human Fertilisation and Embryology* (Routledge 2015) 200.

²⁴ HFEA Press Release, HFEA agrees new policies to improve sperm and egg donation services, 19 October 2011.

negotiators) because they are motivated primarily or solely by financial gain. We suggest that this flat characterisation fails to take account of the realities of payment *to whom* and *for what*, in *both* domestic and cross-border arrangements.

In contrast, a common theme among our interviewees is a rejection of the assumption that altruistic surrogacy is morally superior to commercial surrogacy because there are fewer financial incentives. Indeed, it was noted that there are aspects of altruistic surrogacy that might be described as coercive. For example, Beth had undergone a radical hysterectomy as part of her treatment for cervical cancer and, after an unsuccessful surrogacy arrangement in Australia, she travelled to California for an arrangement involving an egg donor and a surrogate mother. Beth found the assistance of the agency in California to be vital to the whole process. She was strongly critical of the Australian system and did not accept that altruistic surrogacy was less coercive than the commercial arrangements available in California:

Yes, but you'd have a bit of hinting going on, wouldn't you? If it's altruistic here and it's in-family there's a lot of hinting; aunties are talking to sisters, friends are saying 'would you do it for them, what about them, why don't you help them', or whatever. In America she's just receiving a whole stack of applications, there's no previous connection. Undoubtedly the role of the agency. Their role is paramount, is vital, because not only does their reputation rest on this, they have to protect the surrogate before they protect the intended parents, because if the surrogate doesn't have a good experience, the surrogate's going to tell other people. There are going to be other surrogates that are wishing to go through the process to be selected. Surrogates just don't fall out of trees. Even though you think in America they're paying for them, surely they've got loads of women, oh no, it's only a certain breed of lady that does this. Then that certain breed of lady is culled down to about four per cent. So it's not just a whole line of ladies waiting around the block, it's just a very small amount of certain special ladies.

The distinction between regimes, and practices, characterised as altruistic and those characterised as commercial is contestable both within and across different jurisdictions. For example, Australian policymakers categorise Canadian surrogacy practices as 'altruistic', because under Canadian law the surrogate cannot be paid more than her expenses. Nevertheless, Australians travel to Canada for surrogacy (and not, it appears, the other way around), and they do so in order to access paid brokering services, even though such services would be criminalised as commercial if they were operating within Australia.

Incoherence is also present in Australia's approach to the payment of egg donors, brokers involved in egg procurement and agencies who run egg 'banks'. So for example, eggs imported into Australia from US-based services such as the World Egg Bank involve a cost of \$20,000 USD to the patient for six eggs, comprising a payment of approximately \$3000 USD to the egg donor and \$17,000 in fees to intermediaries (described as 'administrative' and 'transport' costs).²⁵ In comparison, one US-based broker we interviewed, who matched donors and recipients and organised treatment in eight overseas destinations, reported that the egg providers

²⁵ This does not include the actual cost of IVF treatment for the recipient, just the cost of provision of the gametes themselves.

in her service were paid \$1500 USD as a ‘price’, with \$100 spending money and \$50 per day meal allowance on top of their travel expenses, while an additional ‘administrative fee’ of \$4500 USD was charged by her to patients (leading to a total cost to patients of less than \$10,000). Bizarrely, the first of these examples is regarded as altruistic donation under Australian law, while the latter is not.²⁶ There is also, as will be discussed below, an illogical and widening gulf between the active domestic medical facilitation of overseas (compensated) egg donation and the prohibition of domestic medical involvement in overseas (commercial) surrogacy.

In our CBR study we have found that the historical stigma attached to the ‘commercialisation’ of reproductive contributors is not shared by intended parents. For many participants, the lack of payment to the surrogate or egg donor in domestic arrangements was believed to be unfair to her, as she was then, effectively, the only volunteer surrounded by a number of professional participants – including doctors, counsellors and lawyers – all of whom were acting for profit. Some altruistic surrogacy arrangements ended up with an overall cost to the parents that was roughly similar to the cost of a commercial arrangement overseas. So, for example, Lachlan, an interviewee with two children born through surrogacy in Australia, noted that the cost of their arrangements had been about \$80,000 for the first child and \$50,000 for the second child, all of which went ‘to the medical and legal professions’ rather than to the women who had helped them:

The whole debate in terms of commercial surrogacy arrangements, if it’s ever spoken about as advocates against it, it’s always the quotation from someone in the legal or medical profession because they’re getting sizeable rents. You almost expect to pay double in terms of the process as well...it would be cheaper for us to go to India, for argument’s sake, than going here in Australia... everybody gets paid in this, apart from the women. ...Yes and [our surrogate] Veronica had an old fridge and the seal wasn’t working, I just wanted to go out and buy a new fridge for the family. There was a decision then of okay, would that be considered a material item and will that be considered [commercial payment when we are] going to the courts? So we made a decision well no, we won’t say anything.....So that’s a cause of frustration.

Like Lachlan, Lauren, another interviewee involved in a surrogacy arrangement in Australia, expressed a desire to pay her surrogate, and an anxiety about the ‘fuzzy’ definition of expenses in Australia:

I think also a con of the altruistic system in general is that a really sort of fuzzy line of what can and can’t be considered a surrogacy expense. So you’re always sort of worrying like oh am I breaking the law by reimbursing this. There’s no real sort of set list of what you can and can’t pay for and I think that causes anxiety for surrogates as well.

²⁶ Research Involving Human Embryos Act 2002, (Cth) s. 20. Note that the Victoria regulator sought legal advice before granting approval for importation of eggs from the World Egg Bank into Victoria, but it is not publically available: VARTA, Annual Report 2013 (2014), 15. Likewise the recent facilitation of travel for South African women into Australia as egg providers has been crafted around what is arguably a façade of ‘reasonable expense’: that is, the expense is both inflated and justified by the travel, which is the implicit inducement to egg donation. The simple payment of a comparable amount to the woman to stay and home and contribute eggs would likely be characterised as commercial. See ‘IVF Treatment: South African Agency Flies Egg Donors to Australia’ *Sydney Morning Herald* (Sydney, 8 February 2016).

Lauren also expressed a real sense of discontent about not being able to compensate her surrogate, saying:

[T]here's such an inequality for giving. I find that for someone to give their body for the sake of creating another family is just — I can't think of any greater gesture and so to not be able to return that in some way sort of makes me feel, what's the word, inadequate in a way I guess. I'll find other ways to be giving, giving with my heart, giving with my friendship and giving with my love. Yeah, but if I could I'd just — I'd give everything but yep not allowed. I'd really love to see it compensated. I wouldn't want to see it turn into a commercial operation but I would love a token amount just to sort of absorb some of those costs that surrogates aren't comfortable with sharing with their intended parents but also just to lighten the load on them a little bit. Maybe \$10,000 or \$20,000 like not a huge amount of money just — not as an incentive to do it but just to kind of — sorry my brain's just gone dead. Not to attract people for commercial reasons but more just to lighten the load on the families a little bit. So I'd really love to see that happen

Lauren's preference for modest compensation, which would not be enough to 'attract people for commercial reasons' is consistent with the findings of a recent UK survey of surrogates and intended parents, which found that 'the mean average of £10,000-£15,000 represents compensation, not "payment"'.²⁷ Indeed there is evidence that this level of compensatory payment is simply 'waved through' in the magistrates courts in the UK (which deal with parental orders for UK surrogacy), without any need for it to refer to itemized expenses.²⁸

For many of our participants, being able to pay surrogates modest compensation was fairer and hence more morally satisfactory for them than asking another woman to carry a pregnancy without receiving any compensation for her time and inconvenience. For example, Cybil's three-year-old son was born with the help of traditional surrogacy in Western Australia. Cybil explained that she would have preferred to be able to pay her child's surrogate. Her central rationale was that payment would create clearer boundaries, in contrast to the current system in which the definition of reasonable expenses is unclear:

Yeah, it would be much clearer for everyone what the boundaries are. I know that because you can't offer not only compensation but even gifts, like technically you can't even give them a bunch of flowers.

Some participants were also clear that they valued the service provision of commercial providers, not just to themselves, but also to the surrogate or egg donor. Gerry, who had used a surrogacy agency in Canada said:

²⁷ K Horsey et al, *Surrogacy in the UK: Myth busting and Reform* (Surrogacy UK, 2015), para 5.1.

²⁸ N Gamble, 'A Better framework for United Kingdom Surrogacy' in S Golombok et al (eds) *Regulating Reproductive Donation*. (Cambridge UP, 2016) 126-139.

I think I just really liked the way — I think we have covered this off before as well, but the agency is very respectful to the surrogate in what they call the fourth trimester, meaning, dealing with her effectively and caring — in a caring way about the fact that — how's she's going to feel post separation after the birth. I think for us, it's really important to have a sense that we're doing the right thing and that we're not exploiting anyone.

One of the Canadian agencies we spoke to assigned a full time support worker to each surrogate and a different employee to support each set of intended parents. The agent, Sally, explained that these workers played an invaluable role in resolving issues and ensuring that disputes did not arise in the course of the relationship between the parties. In contrast, some of the intended parents who undertook unpaid surrogacy within Australia felt that, after the clinic's initial counselling session, they were 'left on their own'. For example, Lachlan describes the limited service provided by the Australian clinic that he and his wife attended:

Canberra was a funny situation where the hospital that runs the clinic, there was one lady there involved and she only dealt with surrogacy on Tuesday. So if you called up on Monday she wouldn't respond until the Tuesday. If you sent an email on the Wednesday you had to wait the whole week until the Tuesday. As a result, it was very hard to get hold of her because there were a number of parents obviously wanting to get stuff and only Tuesday. So that became in itself — but you say to yourself okay, I need to call her tomorrow, type thing. So that had its own — there were intricacies.

While of course not all offshore providers necessarily commit much, or any, of their commercial fee into the level of service provision offered by Sally's Canadian agency²⁹ (and many of our participants undertook egg donation and surrogacy abroad with no preparatory or follow up counselling), we draw on this contrast between a Canadian agency and an Australian clinic to illustrate that it is not *the fee itself* which determines whether practices are fair and non-exploitative — yet the legality of surrogacy arrangements are determined solely by reference to this factor. A more responsive approach for law would be to ask: what practices are beneficial and how might they be facilitated (and perhaps also paid for) by a regime that seeks to avoid improper inducement or impaired consent?

In the UK's 'altruistic only' system, it is an offence for anyone other than the surrogate and the intended parents to negotiate a surrogacy arrangement 'on a commercial basis', and it is a criminal offence for intended parents, surrogates and agencies to advertise their willingness to participate in or facilitate surrogacy. As a result, as McFarlane J explained in *Re G (Surrogacy: Foreign Domicile)*,³⁰ the role of facilitating surrogacy arrangements has traditionally been left to 'groups of well-meaning amateurs'. If the mischief to which the ban on commercial involvement is directed is the prevention of exploitation, the evidence is by no means clear that this is best achieved by discouraging professional agencies' involvement in surrogacy. On the contrary, as Natalie Gamble has explained:

²⁹ Indeed two interviewees reported overseas arrangements in which they had paid significant sums up front and operators simply 'folded' and kept the money without delivering any service.

³⁰ [2007] EWHC 2814 (Fam).

The offer of payment does not necessarily preclude an informed choice; and nor does the absence of payment ensure it. A much more sophisticated approach is to require regulated intermediaries to ensure that surrogates and parents are given good quality information about the risks and offered counselling to reflect on the long term commitment involved before they proceed.³¹

III. EVASION, TOLERATION AND AMBIGUITY IN LAW

If prohibitions on commercial surrogacy can be readily avoided by buying an airline ticket, with, in practice, few or no penalties for doing so and active facilitation of parenthood by the courts and immigration services, what is the status of those prohibitions?

In the UK, the law has prevented the development of commercial surrogacy brokers, but it does not treat intended parents who engage in commercial surrogacy as criminals. Australia's prohibitions on the payment of gamete providers and surrogates are stricter, and in addition three Australian states and territories criminalise participation in commercial surrogacy even if it occurs elsewhere. The National Health and Medical Research Council's guidelines, which apply to all fertility practitioners in Australia, further state that it is 'ethically unacceptable to undertake or facilitate surrogate pregnancy for commercial purposes'.³² Yet prosecution, disciplinary or licensing action in response to breach or evasion of these prohibitions has been extremely rare, and uniformly unsuccessful.³³

Some of our interviewees from Australian jurisdictions where criminal prohibitions on commercial surrogacy have extra-territorial effect took a calculated gamble. Isaac and his partner Gordon entered into a surrogacy arrangement in Thailand. They understood that they were breaking the law but believed that, because so many other families had not been punished or detected, that they too would be unaffected:

One is I knew that technically by the law of New South Wales, we were breaking that law. [Another parent] kind of put my feelings in that regard at ease in saying "well, if they arrest you for it, they're going to arrest hundreds of other people who have done exactly the same thing that you're thinking of doing", which made me feel better about being more open about it.

Notably some interviewees felt that while their participation in commercial surrogacy was 'technically' illegal, it wasn't criminal in any real sense. Others who were more concerned about

³¹ N Gamble note 28 above.

³² The National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2007) (NHMRC Ethical Guidelines) provides, under the heading, 'Do not undertake or facilitate commercial surrogacy':

It is ethically unacceptable to undertake or facilitate surrogate pregnancy for commercial purposes. Clinics must not undertake or facilitate commercial surrogacy arrangements [13.1]

³³ J Millbank, 'The New Surrogacy Parentage Laws In Australia: Cautious Regulation or '25 Brick Walls'' (2011) 35 *Melbourne University Law Review* 165. Note also that a major Australian clinic set up an egg donation arm which initially offered \$5000 flat sums for egg donation on its website in 2015. The figure was later removed but there does not appear to have been any other action taken.

breaking the law undertook a variety of evasion strategies: some sought out surrogacy in Canada on the basis that it too was seen as an ‘altruistic’ jurisdiction; others moved to a different Australian state, like Victoria, from where it is not illegal to travel for commercial surrogacy; some simply falsified documentation in order to appear that they had done so.

Dian was born without a uterus and, after a negative experience in India that we come back to later, had had a child through a commercial surrogacy arrangement in the USA. She and her husband Wayne were very concerned about the NSW ban on overseas commercial surrogacy when they returned from the USA with their daughter. At the time of the interview a year later Wayne was still worried that they had acted against the law, but Dian was becoming less anxious:

Well, we didn’t want to do something that broke the law. Both [our sets of our] parents didn’t know anything about it. [We] kept them from that; because of that reason as well, we didn’t want to worry them. Wayne’s brother — I don’t know whether he’s currently a lawyer, but he was a lawyer at one stage, and he knew what we were doing. We used his address. He was extremely worried for us, but supportive, like he didn’t say ‘don’t do it’. I guess I didn’t want to implicate — I didn’t want to implicate other people.

Participants also experienced the law of the treating country as highly ambiguous. In some respects this is understandable, as some of the jurisdictions in which international commercial surrogacy have flourished in recent years are precisely those with a lack of clear regulation. However, we argue that this went further, to actually imbue the whole CBR process as one of law and not-law, often involving an active process of double-think. Harry, a gay man who went to Thailand with his partner and undertook two surrogacy arrangements simultaneously with embryos created from the same egg donor and each man’s sperm, said:

I mean Thailand didn’t have specific laws at the time. We were certainly aware that there [were] draft laws on the table, but at the time they didn’t have those laws. However through just common practice, we actually felt that the laws were quite protective of us, of doing surrogacy.

Here, Harry is speaking of then-current Thai laws, in which the surrogate (and her husband, if any) were the legal parents of any child born; a male genetic parent not married to the mother could generally not apply for custody before the child was seven years old, and any form of payment for surrogacy was unlawful. Harry nevertheless thought that these laws were ‘quite protective’ of him as an intended parent, who had no genetic relationship to one of the children, in comparison with the ‘draft laws’, passed in haste in 2015, which expressly criminalised all paid surrogacy, and limited unpaid surrogacy to domestic arrangements involving relatives of the surrogate.

Similarly, intended parents spoke of feeling ‘protected’ by contracts which provided that surrogates were obligated to surrender babies to them, in contrast to domestic arrangements where ‘she might change her mind and decide to keep it’. Yet, when pressed, they would acknowledge that such a contract was not likely to be enforceable. As Harry explained:

No, we never had a lawyer take us through contracts. So the contracts were, you know, we went through the contracts with the agent and they were in English and in Thai but

again, I don't think there would be much to be gained by going through that with a lawyer because I'm not sure — we were happy with what was actually written in the contract, but some of it I think wouldn't actually be legally binding if it was actually tested in court and things like that, because of the fact that it was quite a legal grey area

...

I think you needed to — I think the important thing for intended parents is to understand what environment they were operating in, but I think because there wasn't really explicit laws to refer to, that's why I think engaging with lawyers either here or there was less useful.

Likewise Tom who undertook surrogacy as a single gay man in India said of the contract he signed:

Look, I was following what people were saying about contracts and to get the contract looked at ... I think some of the advice that people have shared was it costs a lot of money to have your contracts looked at and it's not actually legal or legally viable in Australia anyway. There's no real — ... So I didn't actually — then I decided not to seek legal advice because I just thought it was almost pointless.

Essentially then, legal advice is 'almost pointless' for an unviable contract, which nevertheless is capable of going some way to protect the rights and liabilities of the parties throughout the arrangement.

One of the preconditions for the granting of a parental order to intended parents through surrogacy in both the UK and Australia is that no payment should have been made 'other than expenses reasonably incurred'. In the UK, the courts have the power to retrospectively authorise payments made in excess of reasonable expenses. Because the child's welfare is the paramount consideration when deciding whether to make a parental order, the UK courts are effectively presented with a *fait accompli*: if the child's settled home is with the intended parents, a parental order will invariably be in his or her best interests. Thus, UK courts routinely authorise payments made to the surrogate mother, even when they vastly exceed any plausible expenses.³⁴ At the same time, the statutory prohibition on payments may discourage some intended parents, concerned about having their financial arrangements scrutinised, from applying for parental orders. The legislation therefore fails to stop payments, while failing to provide legal certainty about what is and is not allowed, and also potentially deterring the acquisition of legal parenthood.

In contrast, in Australia there is no discretion in the surrogacy parentage transfer regimes controlled by state and territory courts. Thus intended parents in 'commercial' arrangements are not legal parents, and can never have parentage transferred.³⁵ Excluded from this process, parents can nevertheless approach the federal Family Court seeking parental responsibility orders (a lesser form of recognition than legal parentage) and, in a handful of these cases, the Court has also 'declared' the male genetic parent to have been a legal parent all along. Perversely, this

³⁴ See, for example, *Re L (A Minor)* [2010] EWHC 3146 (Fam), *Re P-M* [2013] EWHC 2328 (Fam).

³⁵ See Jenni Millbank, 'The New Surrogacy Parentage Laws in Australia: Cautious Regulation or '25 Brick Walls'?' (2011) 35 *Melbourne University Law Review* 165

means that for some male genetic parents in commercial surrogacy their legal parentage has been secured more readily than it has been for intended parents in domestic unpaid arrangements.³⁶ To add to the confusion, other judges of the Court have refuted this approach as a misreading of the legislation, leading to an as yet unresolved judicial lottery.³⁷

In a similar vein, in both the UK and Australia, as with Canada and many other 'altruistic' jurisdictions,³⁸ the State has actively acquiesced in facilitating the acquisition of citizenship for children born as a result of overseas commercial surrogacy arrangements.³⁹ This is the case in Australia even when the intended parents are resident in a state in which they are subject to extra-territorial criminalisation. In a parallel vein, potentially unlawful payments by Australian parents to egg providers abroad are not examined as part of State processes granting citizenship or parental responsibility in surrogacy arrangements. Gabriel, a gay man who undertook surrogacy in Mexico said:

it's obvious the Australian government's allowing it to happen. They're not stopping the kids getting their passports. If they started doing that then they're really saying, 'no you're not allowed to do it at all because it's illegal'. But the government's not doing that, they're letting it happen.

In this way, as discussed later, intended parents understood themselves as both legal parents and not-legal parents under Australian law: their children were granted passports and in practice they could use their overseas birth certificates, at the same time as those birth certificates do not record parentage for the purposes of Australian law and their parental relationship had not been legally formalised. If it is possible to establish a working parental relationship in the absence of a parental order, many struggle to see the point of going through yet more expensive 'red-tape'. Indeed, some Australian facilitators, such as Alec, actively discouraged parents from doing so because, unlike the UK, the result was not 'guaranteed':

If we had a system here where it was a guaranteed process and a simple process, of course I'd be recommending everybody get them, but 95 per cent .. [don't] get them, because we get by without it. Why would we want to spend a year and a half in the court system and spend \$30,000 on this stuff? It doesn't make sense.

The practical consequence of people bypassing the formal transfer of parenthood may be that the courts have to step in at a later point, perhaps following parental separation or death, in

³⁶ See Jenni Millbank, 'Resolving the Dilemma of Legal Parentage for Australians Engaged in International Surrogacy' (2013) 27 *Australian Journal of Family Law* 135

³⁷ See Family Law Council, *Report on Parentage and the Family Law Act* (2014).

³⁸ See Millbank above note 34; K Lozanski, 'Transnational surrogacy: Canada's contradictions' (2015) 124 *Social Science & Medicine* 383.

³⁹ Until recently, France was an outlier, in that the French authorities simply refused to recognise intended parents as the parents of children conceived through surrogacy. This is no longer the case, and as a result of decisions of the Grand Chamber of the European Court of Human Rights (in *Menesson v France* (Application no. 65192/11) and *Labassee v France* (Application no. 65941/11) 26 June 2014) and a domestic case involving two French men who had entered into surrogacy arrangements in Russia, it is now clear that 'Surrogate motherhood alone cannot justify the refusal to transcribe into French birth registers the foreign birth certificate of a child who has one French parent' (Cours de Cassation, Rulings on the transcription into French birth registers of children born abroad of a surrogate mother, July 3 2015).

order to resolve some of the difficulties that may arise when a child's social parents are not also her legal parents.

In practice, *de facto* tolerance of the evasion of reproductive travellers may be inevitable; as one of Culley et al's respondents put it: 'what are you going to do, confiscate their passports?'⁴⁰ But whether characterised as a pluralistic 'safety valve'⁴¹ or as out-and-out hypocrisy,⁴² there is at the very least a mixed message being sent about the status of the extra-territorial prohibition of international commercial surrogacy.

IV. INTERNET-ASSISTED REPRODUCTION AND THE UBIQUITY OF FACEBOOK

There is considerable evidence that the internet is by far the most important source of information for reproductive travellers,⁴³ and that healthcare professionals in their home country are very rarely people's primary source of information and advice.⁴⁴ In the UK, Hanefeld et al interviewed 77 outbound patients and found that most had identified a specific clinic or provider through facilitators in the UK or online forums.⁴⁵ In Australia, Hammarberg et al's study found that those travelling abroad for surrogacy sourced most of their information 'online and from other parents through surrogacy'. Our preliminary findings strongly reflect this trend, with patients actively amassing information from a variety of internet sources. The quality and accuracy of online material is decidedly variable,⁴⁶ and much of it is unverifiable, yet our participants regularly referred to this process as 'research'.

Potential travellers visit clinics' websites, but more significantly, seek advice and information from online forums, social media, and several layers of intermediaries variously described as facilitators, brokers, consultants and agencies.⁴⁷ Many of these are run by people who have previously undergone fertility treatment abroad, who go on to set up businesses through which they can share, and make a living from, their personal experience and knowledge of overseas fertility services.

In our study, potential reproductive travellers had sought peer-to-peer information, advice and support from fellow members of internet forums and Facebook groups. This often

⁴⁰ L Culley N Hudson, E Blyth, W Norton, A Pacey and F Rapport, 'What are you going to do, confiscate their passports?' Professional perspectives on cross-border reproductive travel' (2013) 31 *Journal of Reproductive and Infant Psychology* 46, 52.

⁴¹ See e.g. G Pennings, 'Legal harmonization and reproductive tourism in Europe' (2004) 19 *Human Reproduction* 2689.

⁴² K Lozanski, 'Transnational surrogacy: Canada's contradictions' (2015) 124 *Social Science & Medicine* 383.

⁴³ E Blyth, 'Fertility patients' experiences of cross-border reproductive care' (2010) 94 *Fertility and Sterility* e1, e121; W Van Hoof, G Pennings and P De Sutter, 'Cross-border reproductive care for law evasion: should physicians be allowed to help infertility patients evade the law of their own country?' (2016) *European Journal of Obstetrics & Gynecology and Reproductive Biology* 101.

⁴⁴ See further F Shenfield, J de Mouzon, G Pennings, AP Ferraretti, A Nyboe-Andersen, G de Wert, V Goossens and the ESHRE Taskforce on Cross Border Reproductive Care, 'Cross border reproductive care in six European countries' (2010) 25 *Human Reproduction* 1361.

⁴⁵ J Hanefeld, N Lunt, R Smith and D Horsfall, 'Why do medical tourists travel to where they do? The role of networks in determining medical travel' (2015) 124 *Social Science and Medicine* 356, 360.

⁴⁶ E Blyth 'Fertility patients' experiences of cross-border reproductive care' (2010) 94 *Fertility and Sterility* e11, e14.

⁴⁷ J Snyder, VA Crooks, K Adams, P Kingsbury and R Johnston 'The 'patient's physician one-step removed': the evolving roles of medical tourism facilitators' (2011) 37 *Journal of Medical Ethics* 530.

involves users requesting information about other people's experiences at specific overseas' clinics or agencies, which fellow forum-users will answer.⁴⁸ As Tom says:

Yeah, at the time Yahoo Groups were really popular... so I was accessing those. They were really popular in terms of people communicating and providing stories and getting updated information and asking questions, in mostly a respectful manner most of the time so it was really good... Well, now I guess the Facebook groups have taken over the Yahoo Groups.... Some of the Facebook groups are country-specific, so there's one or two for Nepal, or there used to be one for Thailand...

Once people have decided to travel abroad for treatment, they often rely upon personal recommendations in order to select a particular clinic. In our CBR study Olivia chose a US-based clinic for egg donation based upon the recommendation of a 'real life' friend:

Because obviously going to another country I had absolutely no idea. You don't know whether the websites are actually legitimate, I mean there is so much fraud online and the amount of money that you're talking about with doing IVF overseas. Even having a Skype conversation or a telephone conversation you've got no guarantee. So I felt I would not have gone overseas unless I knew someone who had been at that clinic.

In one respect, Olivia's experience is unusual: while all of our interviewees had, like Olivia, relied upon personal recommendations, most of these had been from 'cyber' friends. Cheryl, who travelled to India for surrogacy noted that 'All of these clinics, American, Indian, Greek, they've all got slick websites and you — they all sound amazing'. Cheryl said that what 'tipped the balance' for her was a 'very honest' forum, even though it was hosted by the clinic itself:

I did an awful lot of research. The particular clinic that I ended up using in India has a chat room. They're very happy to give you access to their chat room. It's for their clients and prospective clients. It's a very honest chat room. You get a very, very honest account of the experiences that lots and lots and lots of people had had using this clinic. That made me particularly comfortable with using that clinic. ... And you could contact those people through the chat room as well. You could send them private messages, so being able to message them and say 'I'm from Australia as well and I've got a question about this that' was something that made me — well it tipped my decision in their favour.

The central role played by informal online networks and patient testimonies highlights, as Hanefeld et al put it, 'the importance of 'soft' versus 'hard' information to patients'.⁴⁹ The information that patients are seeking online thus appears to be qualitatively different from what

⁴⁸ Indeed, TripAdvisor-type websites are starting to emerge to enable consumers to compare fertility services and rank them according to different criteria, for example on *fertility.treatmentabroad.com*, it is possible to search and compare different fertility treatments from clinics in a long list of countries (from Albania to Vietnam), with star-rankings, patient-reviews, and links to enquiry forms and clinic websites.

⁴⁹ J Hanefeld, N Lunt, R Smith and D Horsfall, 'Why do medical tourists travel to where they do? The role of networks in determining medical travel' (2015) 124 *Social Science and Medicine* 356, 362.

doctors and regulators might expect. Success rates and professional accreditations matter, but patients are often more interested in what treatment will *feel* like: the attitude of staff, the clinic environment, the ‘gut feelings’ other patients had had about their treatment. Whether it feels safe to be treated somewhere is not the result of evaluating technical data from the clinic or local regulator, but comes instead from personal recommendations and first person narratives, largely gathered online.⁵⁰ As Leah, who undertook egg donation in Greece said:

[Y]ou do your own research. You get on the websites and you get on the blogs and all that sort of stuff and that provides you with far more of an education, be it right information or not — far more education and reassurance than any doctor’s given me; because you’re talking to other women that have been there, done that...

Although the internet is the primary source of ‘soft’ information about the experience of fertility treatment, it is also worth noting the growing popularity of fertility and surrogacy ‘fairs’ or ‘roadshows’, which are huge exhibitions in which visitors can gather information from regulated clinics and the local regulator, while also meeting people from overseas clinics and ‘alternative’ therapists. Discussions about one’s need for fertility services have emerged from the strict confidentiality of the doctor-patient relationship to become instead a marketing opportunity for private providers. But while these ‘fairs’ provide clinics with the chance to sell their services, potential patients also value the opportunity to find out if they feel a ‘connection’ with the clinic staff and their approach.

Social media websites like Facebook also play an ambiguous role as sources of information and support. Patients might become ‘Facebook friends’ with an overseas agent or clinic, and gain considerable reassurance from the posts of other patients or clients. The distinction between peer support and viral marketing from commercial brokers in such a setting is not always clear. In the context of travel for cosmetic surgery, Holliday et al have pointed out that, to agents, Facebook is ‘an important marketing tool’, whereas patients ‘did not recognise (or refused) the ‘marketing’ definition of agents’ Facebook pages and saw them instead as open forums for discussion’.⁵¹ The familiarity of Facebook allows it to be both a source of peer support and authentic advice (from the point of view of patients), and a staggeringly successful (because invisible) advertising mechanism for agents.

In our study, there were also instances where Facebook was used by intended parents to breach the privacy of egg donors or surrogates, for example to identify and approach these women privately, or to seek and store information about them without permission. Umar and Gabriel were at the beginning of a surrogacy and egg donor arrangement in Mexico. Although egg donation is anonymous in Mexico, Umar had found their egg donor’s Facebook profile because the clinic had given them the egg donor’s name, without her knowledge. Gabriel said:

⁵⁰ W Van Hoof, V Provoost, and G Pennings ‘Reflections of Dutch patients on IVF treatment in Belgium: a qualitative analysis of internet forums’ (2013) 28 *Human Reproduction* 1013; JG Payne ‘Reproduction in transition: cross-border egg donation, biodesirability and new reproductive subjectivities on the European fertility market’ (2015) 22 *Gender, Place & Culture* 107.

⁵¹ R Holliday, D Bell, O Cheung, M Jones and E Probyn ‘Brief Encounters: Assembling cosmetic surgery tourism’ (2015) 124 *Social Science and Medicine* 298.

Yeah, Umar has already cut out the pictures and cropped them. [Laughs] So yes we will tell the child who they are. Like I said we'll probably inform the egg donor or just message her on Facebook to say thank you and this is what you've done for us. We want to keep in touch somehow if you're happy to. But I guess that's her call. But yeah, we're more than happy to do that.

One response to the issues raised by overseas travel is to try to educate people about the implications of undertaking CBR, by providing information about clinical standards of care and the legal status of children born from such arrangements. Counsellors and patient support group representatives interviewed by Culley et al in the UK, for example, thought the only feasible response to reproductive travel is to educate people, and ensure that 'they go into it with their eyes open and fully aware of the implications'.⁵²

Yet it is hard to intervene in order to provide high quality information when people self-refer to overseas clinics, on the basis of Facebook recommendations. In the UK, the HFEA has a page on its website entitled: 'Considering fertility treatment abroad: issues and risks'.⁵³ This politely suggests a number of issues that people should 'take into consideration', and advises people only to select clinics with a 'proven record on quality and standards'. There is, of course, no guarantee that anyone contemplating treatment outside the UK will read this page, or follow its advice. In the Australian system with seven jurisdictions and only two official regulators, VARTA and the WA Reproductive Technology Council, official information is even less widely available than in the UK, leaving Australians even less able to access accurate and reliable advice.⁵⁴

There is also a mismatch between the view that healthcare professionals have 'a key role to play in 'educating' people about possible risks',⁵⁵ and the fact that healthcare professionals are seldom the first port of call for information. If people seek out information via Google, Facebook, and internet chatrooms, there may be little opportunity for clinicians to educate them about risks and potential pitfalls, a problem which is, as we see in the following section, exacerbated by domestic laws which criminalise CBR, and hence deter patients from incriminating themselves in front of healthcare professionals.

V. THE ROLE OF DOMESTIC REPRODUCTIVE SERVICE PROVIDERS

⁵² L Culley N Hudson, E Blyth, W Norton, A Pacey and F Rapport, 'What are you going to do, confiscate their passports?' Professional perspectives on cross-border reproductive travel' (2013) 31 *Journal of Reproductive and Infant Psychology* 46.

⁵³ <http://www.hfea.gov.uk/fertility-clinics-treatment-abroad.html>

⁵⁴ Bearing in mind that some issues, such as male genetic parentage in surrogacy, are still contested at judicial level, making any clear advice impossible.

⁵⁵ L Culley N Hudson, E Blyth, W Norton, A Pacey and F Rapport, 'What are you going to do, confiscate their passports?' Professional perspectives on cross-border reproductive travel' (2013) 31 *Journal of Reproductive and Infant Psychology* 46.

The reordering of sources of information about fertility treatment – from the medical profession to the internet – is significant. It suggests that patients are increasingly willing to bypass local healthcare professionals in order to ‘take matters into their own hands’. Even if doctors are still trusted sources of information, there are other factors which make the internet an attractive source of information. When people are seeking out information about treatments that may be unlawful at home, or which are stigmatised, the anonymity of the internet may be particularly appealing. Restrictive legal provisions then actively contribute to the bypassing of medical professionals, concerned about their professional registration, as a source of advice and support.⁵⁶

Shenfield et al note in the ESHRE Good Practice Guide to Cross Border Reproductive Care that, ‘[c]ollaboration between the home practitioner and the receiving center offers the best chance of optimal care for the cross border patient’, but add that this ‘may pose a problem ... where it is forbidden for doctors to give information about alternatives that are not legal in the country of residence of the patient’.⁵⁷ Indeed, laws which inhibit doctors from offering advice and assistance to patients who are contemplating fertility treatment overseas create a professional conflict of interest in which doctors must choose between making the care of their patient their first concern, which would militate in favour of providing advice and support, and not being seen to endorse or support illegal behaviour, which might instead prompt them to leave patients to their own devices

In Hammarberg et al’s survey study of Australians travelling abroad for surrogacy, fewer than half of the 249 intended parents who responded had sought information from Australian IVF professionals — and of those who did, around one-third reported a negative reaction.⁵⁸ This was reflected by our interviewees. Cheryl said:

the main IVF doctor that I saw here in Sydney was very against offshore surrogacy. I mentioned it to her just to get her idea and she said ‘oh that’s terrible. These are women that are terribly exploited and you’ll go over there and you’ll get a disease and you’ll be in some terrible baby factory and what not’. Anyway, she said those things and then I just shut down that dialogue with her.

Some reported that fertility doctors were unwilling to provide any form of information at all. Dian, for instance, said:

Then [my partner] Wayne mentioned the word — the phrase ‘commercial surrogacy’. At that point Dr C said ‘no’. He just doesn’t want to know anything about it. He said don’t talk to me about that. It’s illegal, it’s — basically, the door was shut at that point here in Australia.

⁵⁶ J Millbank, ‘Responsive regulation of cross-border assisted reproduction’ (2015) 23 *Journal of Law and Medicine* 346.

⁵⁷ F Shenfield, J de Mouzon, G Pennings, AP Ferraretti, A Nyboe-Andersen, G de Wert, V Goossens and the ESHRE Taskforce on Cross Border Reproductive Care ‘Cross border reproductive care in six European countries’ (2010) 25 *Human Reproduction* 1361, 1626.

⁵⁸ K Hammarberg, M Stafford-Bell and S Everingham, ‘Intended Parents’ Motivations and Information and Support Needs When Seeking Extraterritorial Compensated Surrogacy’ (2015) 31 *Reproductive Biomedicine Online* 689, 694.

Concern about breaching a broadly-worded and unclear ethical prohibition on ‘facilitating’ commercial surrogacy⁵⁹ has prevented fertility experts in Australia from engaging in even basic information-giving to their patients, such as what is involved in safe egg stimulation and embryo transfer protocols, or the risks of departing from these protocols. It has also prevented the provision of basic fertility testing or preparatory care (such as checking hormone levels, ovarian reserve, or sperm counts) for patients who are planning to undertake treatment abroad. For Dian this meant that she had travelled to India twice and undergone egg retrieval, despite the fact that a simple hormone test could have told her in advance that IVF using her own eggs would be unlikely to work.

So I got there by myself. The second or third day, while I — maybe the second day — after arriving in New Delhi I had a consultation with Dr I (India). They had done a blood test. She said that my [hormone] level was too high; too high or too low, I can’t remember, but as far as she’s concerned it would just be a complete waste of time to do an IVF treatment on me.

So I was quite devastated, but then she said that we should just go ahead with an egg donor. At this stage the whole [issue of an] egg donor had not even cropped up. [Wayne] wasn’t there, and she wanted me to make the decision right there and then.

Both clinically and emotionally, we suggest that this was an adverse experience that could have been avoided if Dian had undergone basic preliminary investigations and preparatory care at home, before travelling to India. Professionals within Australia have also expressed the concern that media coverage of cross border surrogacy, coupled with difficulties in accessing frank advice from domestic healthcare professionals once commercial surrogacy is mentioned, has meant that some women are travelling abroad for surrogacy as a ‘fertility cure’, when they are, in fact, capable of carrying a pregnancy.⁶⁰

In contrast to surrogacy, the Australian prohibitions on commercial trading in gametes are far more specifically worded, criminalising only the giving and receipt of valuable consideration, rather than potentially implicating anyone involved in ‘facilitating’ the practice. This has meant that some fertility doctors *are* willing to recommend overseas egg donation and we found that some even facilitate shared care, with the provision of scans and tests domestically before the woman travels, as well as follow up care. Thus, if Dian had told her fertility doctor that she was travelling to receive paid egg donation rather than to pursue commercial surrogacy, she would be likely to have received domestic medical assistance and advice. In a parallel vein, general practitioners (who are not covered by the same ethical guidelines as fertility specialists) were reported by our interviewees to be assisting patients with blood and semen tests in

⁵⁹ See above note 26. The Guidelines are currently under review. The 2015 public consultation draft continues, but somewhat clarifies, the prohibition on providing or assisting with IVF as part of a paid surrogacy arrangement, ‘Clinics and clinicians must not practice, promote or recommend commercial surrogacy, nor enter into contractual arrangements with commercial surrogacy providers’: NHMRC, *Draft Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research: Public Consultation* (2015) cl 8.7.1 <<http://consultations.nhmrc.gov.au/files/consultations/drafts/artdraftethicalguidelines150722.pdf>>.

⁶⁰ Project roundtable; February 2016, parliamentary inquiry roundtable January 2015.

preparation for overseas surrogacy, as well as with prescription medications and blood tests in advance and pregnancy tests post-travel for those receiving egg donation abroad.

After years of unsuccessful IVF in Australia, Leah travelled to Greece to undergo IVF and egg donation. She explained that her GP in Australia was helping her:

So how we coordinate it is that he tells me what I need. He writes it down for me. I take it to my GP who's fully aware of my journey. ...so I just have to make sure that he's written down for me the correct spelling of the medication that I need, what it's for. Then I just tell him a little bit about the background to why we're doing it and then he'll write me an Australian script for it, so that's how we're coordinating it at the moment.

The implications of this finding need further exploration, but at a minimum suggest that access to local medical care and advice for reproductive travellers is often filtered through general practitioners rather than IVF clinicians, and is more effectively obtained for Australian women who are seeking egg donation compared to those seeking surrogacy.

VI. CONCLUSION: LEARNING LESSONS FROM THE EXPERIENCE OF CROSS-BORDER REPRODUCTIVE TREATMENT

It would be possible to regard reproductive travel as an aberration, relied upon *in extremis* by people who are prevented, either by law or de facto, from accessing reproductive services at home. In response to the increasing numbers of people travelling for reproductive purposes, enabling more people to access local fertility services might therefore be a plausible and laudable regulatory objective.⁶¹ But while we would support measures to improve access to services, not least because these might also meet the needs of those who cannot afford to travel, we would like to suggest that we should also be interested in what local fertility providers and regulators can learn from the experiences of reproductive travellers.

As discussed in this article, our preliminary fieldwork has thrown up four themes: that the legal distinction between 'altruistic' and 'commercial' gamete donation and surrogacy is increasingly unsustainable; that role of the law in cross-border reproduction is profoundly equivocal; that Facebook is now the principal source of information and peer support for reproductive travellers and lastly, that domestic reproductive service providers are often sidestepped. Each theme suggests that the cross-border reproductive traveller does not conform to regulators' assumptions about patient behaviour.

An underlying regulatory assumption is often that treatment at home is 'better' than the international alternatives. Implicit here is the premise that the law will best protect patients through discouraging international travel. Here, the patient experience diverges. It is clear that patients paying for treatment overseas feel as though they are more in control of their treatment,

⁶¹ GKD Crozier and D Martin, 'How to address the ethics of reproductive travel to developing countries: A comparison of national self-sufficiency and regulated market approaches' (2012) 12 *Developing World Bioethics* 45.

and that, in contrast to their experience of domestic fertility services, they do not have to be grateful for what they receive. Indeed, in many of our interviews patients have praised the standard of care they received overseas, considering it superior to that available at home. Opting out of local, regulated services is not necessarily always an unwelcome last resort then, but may have positive advantages for some patients. If this is the case, we should be interested in listening to what patients say is ‘better’ about treatment overseas, rather than just dismissing their accounts as wishful thinking.

Overseas clinics may offer more support and more contact time with clinicians and nursing staff,⁶² as well as a greater choice of donors or surrogates. Overseas clinics also make excellent use of social media to contact patients and to facilitate a high quality ‘care experience’. Nicky Hudson and Lorraine Culley, for example, found that treatment overseas gave their interviewees ‘active involvement in deciding on treatment protocols, choice about donors, control over the timing of treatment and good access to the clinician leading their care’.⁶³

We should be interested in this apparent disjunction between what matters most to would-be parents and what matters most to doctors, regulators and legislators. In Van Hoof et al’s study of internet forums, in which Dutch patients shared their experiences of having received IVF treatment in Belgium, ‘Respect for the person behind the patient’ was identified as the main reason for the patients’ belief that the quality of care was higher in Belgium.⁶⁴ Van Hoof et al comment that ‘patient centred care is generally seen as a dimension of care that has nothing to do with effectiveness and efficiency’, whereas forum users considered that the ‘central position of the patient [was] key for every dimension of good quality of care’.⁶⁵ This is a revealing illustration of the gap between the normal markers for success, as judged objectively, and the marker of high-quality care for patients, in which patient-centred care is not just a desirable extra, but is central to every aspect of what matters to them. This is borne out by several of the intending parents we interviewed. For example, Rosalind, who travelled to Greece to use donated eggs observed:

We’ve spent nearly 60,000 dollars in Australia and not one of my doctors have called and said, hey how are you or let’s do this now or anything like that....So that’s why we chose him because he just took this real personal approach with us and it was him that was in contact with us.

Clinicians, regulators and politicians have tended to assume that patients choose clinics on the basis of their success rates and the costs of treatment. Policymakers treat anecdotal first-person accounts of what it was ‘like’ to be treated there with scepticism because, by definition, anecdotal ‘evidence’ is not evidence at all. But while it may not be statistically significant, in

⁶² EJ Sobo, E Herlihy and M Bicker, ‘Selling medical travel to US patient-consumers: the cultural appeal of website marketing messages’ (2011) 18 *Anthropology & Medicine* 119.

⁶³ N Hudson and L Culley, ‘The bloke can be a bit hazy about what’s going on’: men and cross-border reproductive treatment’ (2013) 27 *Reproductive Biomedicine Online* 253.

⁶⁴ W Van Hoof, V Provoost, and G Pennings ‘Reflections of Dutch patients on IVF treatment in Belgium: a qualitative analysis of internet forums’ (2013) 28 *Human Reproduction* 1013, 1021.

⁶⁵ *Ibid*, 1021.

practice, the anecdotal clearly matters to patients.⁶⁶ Personal connections matter too. Patients want to receive treatment from caring clinicians, and they want to feel a ‘connection’ with their donor or surrogate. In our interviews, we note how frequently the language of intimate relationships is invoked in relation to donors and surrogates. Clinicians might assume that patients are principally interested in the health and screening results of potential donors and/or surrogates, whereas patients may be looking for an emotional bond with them. The most striking example of this from our CBR study was an intended mother who explained that she and her partner had ‘fallen in love’ with an egg donor, and that, for them, this trumped the discovery that she was a carrier of the Tay Sachs gene.⁶⁷

A gap between what matters to experts and what matters to patients is also evident in relation to the law, including but not limited to criminal prohibitions, citizenship and the rules of legal parentage. For example, in our study, it is striking how few intended parents of children born through surrogacy had sought legal formalisation of their relationship. Tom, who had undertaken surrogacy in India said:

I’m not going to the Family Court [to seek parental responsibility]. I’m fine with [the Indian birth certificate] as being a formal document. Because my name is on it *I feel that gives me the parental rights that I need even though legally I know I’m not actually the parent in Australia*. That’s the weird thing is that in India I’m the legal parent and the surrogate has no parental rights and I come back to Australia and I don’t have any parental rights but the surrogate has got all the parental rights, and she’s not even actually living in the country. So that’s a little bit bizarre. (emphasis added)

Many interviewees appeared unconcerned about, or actively avoided knowing about the risks to which their family was exposed as a result of their lack of legal parentage. What mattered instead was the lived experience of the practicalities of new parenthood: being able to get back into Australia, obtain a Medicare card to access medical treatment for the child, and later to enrol him or her in school. This was particularly the case for those whose names appeared on the foreign-issued birth certificate, who had encountered a ‘no-questions-asked’ response from authorities. Charlotte, a parent through surrogacy and egg donation in the US, described her decision not to seek legal advice as ‘low profile’: ‘I never really went into it. I just assumed everything would be fine because I’m on their birth certificate’. In our interviews, it was common for genetic and non-genetic parents to take such a view, relying upon a document that they acknowledge, when

⁶⁶ In tandem researchers based in destination countries are addressing the experiences of women who become patients in order to service the fertility industry. Egg donors and surrogates are assuming the risks, discomforts and inconveniences of fertility treatment and/or pregnancy for the benefit of others. Egg donors and surrogates should have the same rights to give informed consent to treatment as any other patients. This means that they should not be paternalistically prevented from agreeing to act as an egg donor or a surrogate, but it also means that they are entitled to make decisions about their medical care in the same way as any other patient: S Rudrappa and C Collins ‘Altruistic Agencies and Compassionate Consumers: Moral Framing of Transnational Surrogacy’ (2015) 29 *Gender and Society* 937; M Tanderup et al, “Informed Consent in Medical Decision-Making in Commercial Gestational Surrogacy: A Mixed Methods Study in New Delhi, India” (2105) 94 *Acta Obstet Gynecol Scand* 465.

⁶⁷ For a detailed discussion of how people in our study using donated gametes responded to the possibility of disability see Roxanne Mykitiuk and Isabel Karpin “Fit or Fitting In Deciding Against Normal When Reproducing the Future (2017) 31 *Continuum* (forthcoming).

pushed, would not be likely to stand up to challenge. Like the unenforced or ambiguous laws of the treating country, and the ‘blind-eye’ approach of domestic regulators, the birth certificate both is, and is not, ‘legal protection’.

We suggest that any attempt to further reform or refine laws relating to CBR must attend to the subjective and lived experience of law, which like the personal experience of treatment, may stand in contradiction to policy maker’s understandings of participants’ motivations or of law’s effect upon behaviour. These experiences can usefully be explored to complicate, for example, the dominant assumption that payment in reproductive endeavours is exploitative and inevitably impairs informed consent. Our interviews explore both cross-border compensated surrogacy and egg donation and domestic uncompensated arrangements. Though we are still at the beginning of our work, it is already clear that the picture is far more complex than might have been expected, both morally and legally. Indeed, as this preliminary snapshot from our interviews has shown, some participants chose compensated arrangements precisely because they considered an uncompensated arrangement to be ethically questionable.

Perhaps more importantly, our research has begun to demonstrate that the incentive of legal parentage under Australian law, or threat of its denial, will not drive intended parents away from paid surrogacy or egg donation. The law, as it currently stands, works in obstructive and confounding ways that push people outside its reach or encourage them to ignore its limits and this is ultimately counter-productive and likely to cause harm to the participants and their future children. There is still a great deal to learn about cross-border reproductive treatment. Large-scale bypassing of domestic fertility services is a relatively new phenomenon and we have no reliable way of recording its outcomes. In order to ensure that the law is capable of minimising the risk of harm to all participants, we argue that it is necessary to learn *from* the experience of those undertaking cross-border reproductive treatment, at and outside the limits of the law.